



■ *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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Recently Updated:

Dates in () indicate the most recent update of state information.

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 2010, 2011 and 2012. The cost report data only includes Medicare cost reports submitted by nursing facilities and does not represent all licensed facilities. 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

How To Use This Publication

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 2011, 2012 and 2013.

An aerial photograph capturing the rolling hills of Alabama. The landscape is a patchwork of vibrant green fields, likely cotton, with distinct brownish-red rows indicating the direction of cultivation. The hills roll from the foreground towards the background, creating a sense of depth and texture. A single utility pole stands prominently in the middle ground, adding a vertical element to the composition.

Alabama

INTRODUCTION

Nursing facilities in Alabama are licensed by the Alabama State Board of Health - Division of Licensure and Certification under the designation of "Nursing Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN ALABAMA

Licensed Nursing Facilities*	233
Licensed Nursing Beds*	27,131
Beds per 1,000 Aged 65 >**	35.96
Beds per 1,000 Aged 75 >**	87.59
Occupancy Percentage - 2013***	86.71%

*Source: Alabama Department of Public Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$2,757,204 or greater (as of October 1, 2013).
- 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.

The inclusion of the supplemental provider privilege assessment and the monthly surcharge in the FPT are currently scheduled to sunset on August 31, 2015. There is no present indication whether these policies will be continued after the sunset date. Alabama's FPT is in compliance with federal regulations. 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 recently established interim rates effective July 1, 2014. State rate setting officials indicated that these rates will be adjusted for inflation either on October 1, 2014, or January 1, 2015, when rates are rebased using the cost report ending June 30, 2014. These rates will retroactively adjust nursing facilities for the reimbursement they would have received if interim rates effective July 1, 2014, were calculated with an inflation adjustment. Going forward, the state will adjust interim rates for inflation on October 1 of each fiscal rate year.

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 \$117.98 effective January 1, 2014. 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 \$39.06, effective January 1, 2014.

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, 2014, were \$29.35 for nursing facilities with 75 or fewer beds and \$24.73 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 \$41,358 as of July 1, 2014. 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.

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

ALABAMA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	85.50	86.00	86.00	115.00	115.50	116.00	149.00	149.00	149.00			
Average Daily Census	74.14	72.75	75.02	101.30	97.79	101.35	131.61	131.72	130.21			
Occupancy	83.3%	83.5%	83.5%	89.7%	89.8%	90.3%	93.0%	93.6%	93.7%			
Payor Mix Statistics												
Medicare	8.1%	8.1%	7.7%	12.1%	11.6%	11.8%	16.3%	15.3%	16.2%			
Medicaid	62.4%	60.5%	60.7%	69.7%	69.4%	71.0%	76.8%	76.5%	77.9%			
Other	14.0%	14.4%	13.0%	21.1%	21.7%	19.7%	34.5%	32.6%	31.7%			
Avg. Length of Stay Statistics (Days)												
Medicare	29.70	27.87	29.06	42.12	42.31	40.84	57.75	58.34	65.18			
Medicaid	301.57	311.48	316.74	377.48	389.40	396.07	470.77	488.20	524.23			
Other	90.78	94.77	77.59	151.10	135.38	127.74	221.65	233.99	208.46			
Revenue (PPD)												
Inpatient	\$167.09	\$171.02	\$175.62	\$181.44	\$187.29	\$190.80	\$208.55	\$207.12	\$212.70			
Ancillary	\$29.06	\$28.32	\$30.82	\$41.71	\$40.04	\$42.73	\$56.61	\$56.18	\$60.44			
TOTAL	\$199.25	\$204.38	\$209.21	\$218.83	\$223.22	\$230.97	\$257.10	\$255.35	\$263.17			
Expenses (PPD)												
Employee Benefits	\$11.35	\$10.93	\$10.73	\$15.42	\$13.59	\$14.40	\$20.58	\$18.92	\$19.88			
Administrative and General	\$31.00	\$32.21	\$32.75	\$37.31	\$38.06	\$37.64	\$42.37	\$43.45	\$44.31			
Plant Operations	\$8.68	\$8.76	\$9.09	\$10.32	\$9.99	\$10.55	\$12.23	\$12.20	\$12.07			
Laundry & Linens	\$2.09	\$2.27	\$2.27	\$2.76	\$2.89	\$2.97	\$3.41	\$3.53	\$3.68			
Housekeeping	\$4.97	\$4.87	\$4.79	\$6.12	\$6.00	\$6.09	\$7.31	\$7.23	\$7.35			
Dietary	\$14.66	\$14.79	\$14.88	\$16.39	\$16.48	\$16.67	\$19.11	\$19.18	\$19.40			
Nursing & Medical Related	\$67.05	\$67.35	\$68.87	\$73.93	\$76.04	\$76.81	\$84.41	\$85.53	\$86.02			
Ancillary and Pharmacy	\$16.66	\$17.59	\$17.80	\$26.09	\$23.63	\$25.72	\$35.87	\$34.27	\$39.07			
Social Services	\$1.57	\$1.62	\$1.61	\$2.24	\$2.34	\$2.30	\$3.30	\$3.30	\$3.46			

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*	18
Licensed Nursing Beds*	692
Beds per 1,000 Aged 65 >**	9.39
Beds per 1,000 Aged 75 >**	29.00
Occupancy Percentage - 2013***	89.03%

*Source: Alaska HSS/HCS/Health Facilities Licensing & Certification

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

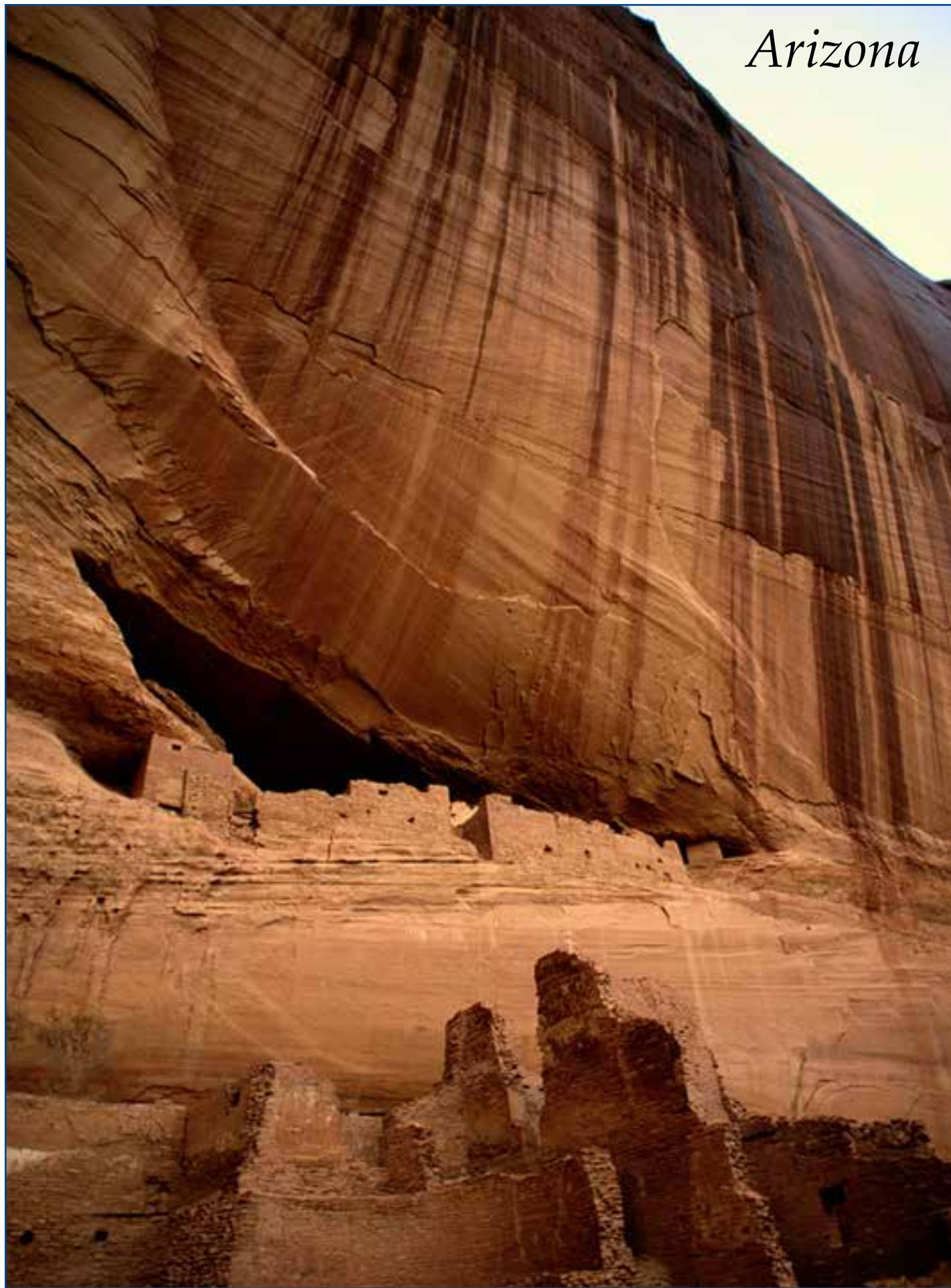
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	58.25	59.50	59.50	59.50	62.00	62.00	60.75	76.00	82.00			
Average Daily Census	81.03	71.64	55.60	105.70	86.98	56.42	130.37	113.57	69.46			
Occupancy	87.6%	89.5%	81.7%	91.3%	96.6%	82.6%	95.1%	97.7%	90.8%			
Payor Mix Statistics												
Medicare	6.2%	7.2%	8.6%	7.6%	10.9%	13.2%	9.0%	11.3%	20.2%			
Medicaid	82.4%	78.9%	70.3%	86.3%	79.3%	84.3%	90.3%	86.0%	87.9%			
Other	3.5%	6.4%	3.5%	6.1%	8.9%	4.4%	8.7%	9.8%	10.4%			
Avg. Length of Stay Statistics (Days)												
Medicare	64.85	43.57	57.98	90.04	43.66	64.97	115.24	47.34	67.74			
Medicaid	240.56	211.98	182.81	441.38	362.00	273.04	642.19	578.61	585.17			
Other	49.41	103.66	34.22	70.82	120.45	46.23	92.23	138.12	136.24			
Revenue (PPD)												
Inpatient	\$531.72	\$499.82	\$500.96	\$537.80	\$547.34	\$549.93	\$543.89	\$548.64	\$834.41			
Ancillary	\$95.12	\$72.91	\$79.46	\$114.72	\$99.43	\$112.02	\$134.32	\$132.22	\$200.71			
TOTAL	\$639.01	\$574.04	\$580.42	\$652.52	\$596.34	\$596.83	\$666.04	\$654.34	1,002.56			
Expenses (PPD)												
Employee Benefits	\$29.54	\$33.40	\$93.02	\$51.44	\$59.18	\$110.99	\$73.35	\$84.74	\$116.58			
Administrative and General	\$59.40	\$52.39	\$44.74	\$73.32	\$60.22	\$52.03	\$87.24	\$72.00	\$101.15			
Plant Operations	\$22.36	\$20.56	\$21.82	\$24.52	\$23.25	\$24.53	\$26.68	\$26.59	\$34.82			
Laundry & Linens	\$5.87	\$4.69	\$4.42	\$5.90	\$6.26	\$5.86	\$5.94	\$7.76	\$7.17			
Housekeeping	\$15.26	\$10.47	\$10.64	\$15.52	\$14.26	\$14.85	\$15.79	\$14.56	\$17.22			
Dietary	\$24.11	\$21.66	\$23.39	\$25.98	\$22.42	\$25.24	\$27.84	\$26.78	\$30.08			
Nursing & Medical Related	\$226.72	\$197.73	\$168.85	\$241.53	\$260.99	\$199.54	\$256.35	\$267.98	\$244.45			
Ancillary and Pharmacy	\$35.26	\$29.38	\$27.99	\$43.48	\$29.87	\$30.62	\$51.69	\$46.33	\$70.64			
Social Services	\$9.16	\$8.98	\$7.52	\$9.77	\$9.46	\$7.64	\$10.39	\$10.14	\$8.49			

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*	146
Licensed Nursing Beds*	16,150
Beds per 1,000 Aged 65 >**	15.40
Beds per 1,000 Aged 75 >**	37.06
Occupancy Percentage - 2013***	72.18%

*Source: Arizona Department of Health Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 with 43,500 or greater annual Medicaid days 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.

Arizona reimburses 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.

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

The state-established FFS rates are rebased according to state law at least every five years. The state 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). 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.

As previously mentioned, effective July 1, 2011, nursing facilities are eligible for supplemental payments derived from the state's nursing facility provider assessment. The projected average reimbursement from these payments was approximately \$20.00 per Medicaid day, which more than offsets the previous 5.0% reduction (\$7.28 to \$9.43) to all non-ventilator level of care rates. According to representatives of the Arizona Health Care Association, the most recent estimate of the average reimbursement from the program is approximately \$29.00 per Medicaid day.

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.

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:

Primary Care Component					
Category	FY 2013	FY 2014	% change	FY 2015	% change
Urban:	Level I	\$64.05	\$65.01	1.5%	\$66.31
	Level II	\$77.37	\$78.53	1.5%	\$80.10
	Level III	\$106.41	\$108.01	1.5%	\$110.17
Rural:	Level I	\$59.60	\$60.49	1.5%	\$61.70
	Level II	\$72.01	\$73.09	1.5%	\$74.55
	Level III	\$100.49	\$102.00	1.5%	\$104.04

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.

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.

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.

The total capitulated 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	FY 2013	FY 2014	% change	FY 2015	% change
Urban:					
Level I	\$64.05	\$65.01	1.5%	\$66.31	2.0%
Level II	\$77.37	\$78.53	1.5%	\$80.10	2.0%
Level III	\$106.41	\$108.01	1.5%	\$110.17	2.0%
Indirect	\$64.85	\$65.82	1.5%	\$67.14	2.0%
Capital	\$13.90	\$14.11	1.5%	\$14.39	2.0%
Total Rate					
Level I	\$142.80	\$144.93	1.5%	\$147.83	2.0%
Level II	\$156.11	\$158.45	1.5%	\$161.62	2.0%
Level III	\$185.16	\$187.94	1.5%	\$191.70	2.0%
Rural:					
Level I	\$59.60	\$60.49	1.5%	\$61.70	2.0%
Level II	\$72.01	\$73.09	1.5%	\$74.55	2.0%
Level III	\$100.49	\$102.00	1.5%	\$104.04	2.0%
Indirect	\$64.85	\$65.82	1.5%	\$67.14	2.0%
Capital	\$13.90	\$14.11	1.5%	\$14.39	2.0%
Total Rate					
Level I	\$138.35	\$140.43	1.5%	\$143.24	2.0%
Level II	\$150.76	\$153.02	1.5%	\$156.08	2.0%
Level III	\$179.24	\$181.93	1.5%	\$185.57	2.0%

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, fiscal year 2010 and 2011 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.

The above displayed rates do not factor in the additional reimbursement that nursing facilities have received in fiscal year 2013 from the previously mentioned supplemental payments. Although there is no total average rate available that incorporates the effects of the supplemental payments, the average reimbursement from the supplemental payments is approximately \$20.00 per day. This more than offset the reductions in the fiscal year 2012 rates (\$7.28 to \$9.43). Given this factor, overall nursing facility reimbursement increased in fiscal year 2013. Representatives of the Arizona Health Care Association estimate that the statewide average rate for fiscal year 2014 is approximately \$165.00 per day.

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

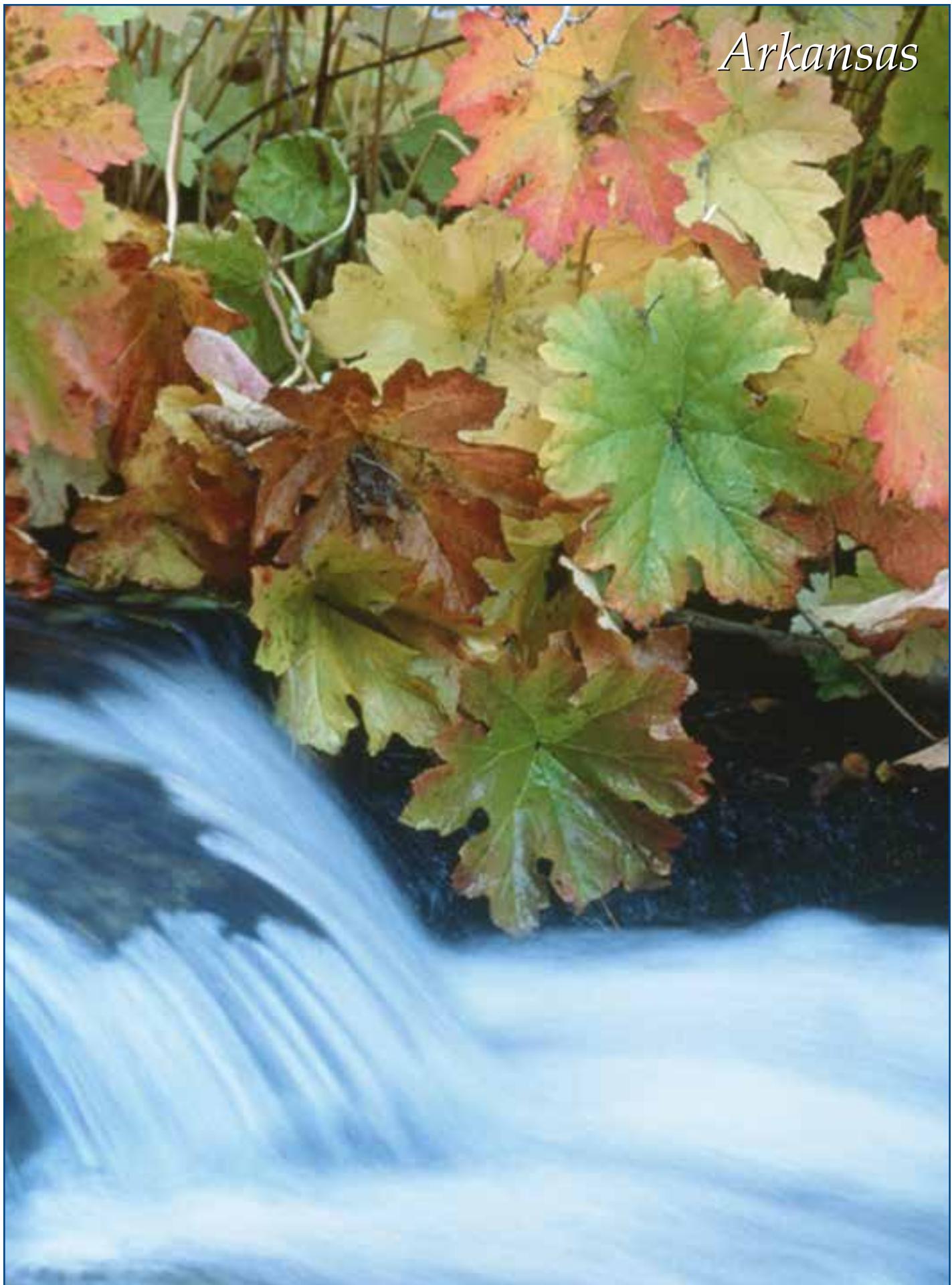
Arizona reimburses nursing facilities for holding beds for residents absent from the facility due to therapeutic leave or hospitalization. Whether a nursing facility receives bed hold payments is determined by the program contractor case manager on a case-by-case basis. Payments for bed hold days for 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 no current or proposed state legislation affecting the current Medicaid reimbursement methodology in Arizona. However, according to professionals from AHCCCS, the governor is considering a 3.0% rate reduction in the future. The likelihood of a reduction is unclear.

ARIZONA COST REPORT STATISTICS												
	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
General Statistics												
Number of Beds	80.00	71.50	69.00	112.00	117.00	111.00	130.00	128.25	128.50			
Average Daily Census	76.65	76.00	66.18	96.69	93.21	90.86	117.21	119.58	122.74			
Occupancy	68.8%	66.9%	67.4%	81.4%	77.0%	74.9%	86.0%	84.6%	85.8%			
Payor Mix Statistics												
Medicare	6.8%	6.9%	5.1%	11.1%	11.2%	10.4%	19.2%	19.0%	19.6%			
Medicaid	56.0%	53.0%	49.6%	65.0%	67.3%	65.4%	73.2%	74.7%	76.9%			
Other	16.0%	13.1%	15.0%	24.6%	24.2%	24.4%	48.6%	52.8%	55.5%			
Avg. Length of Stay Statistics (Days)												
Medicare	23.43	23.42	22.24	25.95	27.82	26.63	32.20	30.91	30.77			
Medicaid	170.57	184.07	172.70	227.03	227.73	220.79	307.78	340.84	322.45			
Other	23.92	23.83	24.31	50.73	34.80	33.97	83.98	131.00	121.10			
Revenue (PPD)												
Inpatient	\$171.38	\$170.97	\$183.36	\$188.05	\$191.66	\$208.60	\$227.51	\$232.01	\$257.78			
Ancillary	\$44.15	\$46.08	\$46.71	\$60.25	\$68.38	\$82.64	\$89.06	\$96.32	\$127.70			
TOTAL	\$229.03	\$238.08	\$249.63	\$248.64	\$262.95	\$301.20	\$312.42	\$345.02	\$376.23			
Expenses (PPD)												
Employee Benefits	\$14.92	\$14.89	\$15.73	\$18.31	\$20.14	\$19.49	\$30.95	\$26.03	\$26.43			
Administrative and General	\$28.47	\$29.08	\$33.39	\$34.22	\$35.61	\$43.34	\$46.46	\$50.13	\$65.14			
Plant Operations	\$8.76	\$9.15	\$9.30	\$9.78	\$10.12	\$11.48	\$13.36	\$15.42	\$17.95			
Laundry & Linens	\$1.53	\$1.24	\$1.41	\$2.12	\$2.18	\$2.08	\$2.60	\$2.69	\$2.64			
Housekeeping	\$3.94	\$3.78	\$3.97	\$4.50	\$4.75	\$4.97	\$5.99	\$6.62	\$7.48			
Dietary	\$13.95	\$13.68	\$14.07	\$14.91	\$15.87	\$17.80	\$20.12	\$22.38	\$26.00			
Nursing & Medical Related	\$73.60	\$73.59	\$74.69	\$82.52	\$85.60	\$88.62	\$105.40	\$108.13	\$115.49			
Ancillary and Pharmacy	\$22.77	\$23.36	\$23.65	\$30.76	\$34.68	\$36.08	\$49.66	\$54.73	\$63.65			
Social Services	\$1.85	\$1.90	\$1.82	\$2.56	\$2.61	\$3.02	\$4.35	\$4.16	\$4.93			

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*	259
Licensed Nursing Beds*	25,701
Beds per 1,000 Aged 65 >**	54.36
Beds per 1,000 Aged 75 >**	130.33
Occupancy Percentage - 2013***	72.16%

*Source: Arkansas Health Services Permit Agency

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 80% 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 certain conditions are met.

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 2016	
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 April 1, 2014, and were projected for 2018. The calculation indicates that the state will have a surplus of 6,176 beds in 2018. In addition, only nine Arkansas counties possess bed need.

QUALITY ASSURANCE FEE

The quality assurance fee (QAF) was established in 2001. The QAF is \$11.76 per patient day effective July 1, 2013. This is less than the prior QAF (\$12.13) effective July 1, 2011 (\$10.43), and for fiscal years 2011 (\$9.93), 2010 (\$9.62) and 2009 (\$8.95). 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. The change in the QAF on October 1, 2011, reflects the sunset of the Tax Relief and Health Care Act of 2006 on the same date. This act temporarily reduced the federal standard on QAFs from 6.0% to 5.5% of total revenue. The ceiling reverted back to 6.0% on October 1, 2011. 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. Cost report data for fiscal year 2013 will be utilized to rebase the Direct Care, Indirect, Administrative and Operating and FMR cost component rates effective July 1, 2013. In non-rebasing years, the statewide Indirect, Administrative and Operating cost component rate is inflated by the inflation rate discussed below. The next scheduled rebasing of the Indirect, Administrative and Operating is on July 1, 2016.

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. For fiscal year 2014, this index will equate to 2.4%, which is greater than the index utilized (2.1%) in fiscal year 2013. The indexes for fiscal years 2012 and 2011 were 2.5% and 2.1%, respectively.

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:

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

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.

Arkansas's weighted average, final Medicaid rates for fiscal years 2007, 2008, 2009, 2010, 2011 and 2012 were \$130.61, \$138.48, \$142.92, \$148.46, \$154.18 and \$161.81 per patient day, respectively. The weighted average final Medicaid rate of \$165.32 for fiscal year 2013 represents a 2.17% increase from the prior year's rate. The weighted average rate for fiscal year 2014 has yet to be determined.

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	87.00	89.00	87.00	105.00	105.00	104.50	120.00	120.25	122.00	
Average Daily Census	65.59	66.76	65.53	81.13	81.90	80.56	97.56	99.33	96.64	
Occupancy	67.1%	68.6%	65.9%	77.8%	78.3%	77.8%	86.7%	87.0%	87.3%	
Payor Mix Statistics										
Medicare	7.6%	7.3%	7.6%	10.5%	10.1%	10.0%	14.1%	13.3%	13.6%	
Medicaid	62.0%	59.0%	61.6%	68.9%	68.8%	69.9%	75.4%	76.4%	76.5%	
Other	15.4%	14.8%	14.3%	21.6%	21.8%	20.7%	36.4%	31.8%	31.5%	
Avg. Length of Stay Statistics (Days)										
Medicare	30.81	29.73	30.60	39.33	38.67	38.40	48.58	51.53	51.23	
Medicaid	304.52	340.94	300.41	457.42	494.42	441.26	783.90	805.34	754.81	
Other	123.55	109.42	103.06	194.29	165.21	164.73	350.17	273.59	287.87	
Revenue (PPD)										
Inpatient	\$158.97	\$157.84	\$165.25	\$173.70	\$176.05	\$178.94	\$197.12	\$195.40	\$196.40	
Ancillary	\$18.82	\$22.22	\$22.44	\$29.92	\$33.01	\$32.22	\$42.94	\$49.44	\$43.12	
TOTAL	\$176.80	\$187.80	\$192.18	\$195.72	\$206.51	\$208.01	\$229.53	\$238.94	\$237.77	
Expenses (PPD)										
Employee Benefits	\$10.90	\$11.23	\$11.78	\$12.42	\$12.65	\$13.32	\$14.55	\$14.43	\$15.12	
Administrative and General	\$24.18	\$26.77	\$25.54	\$31.56	\$33.51	\$33.54	\$37.50	\$39.70	\$39.08	
Plant Operations	\$6.85	\$6.93	\$6.99	\$7.91	\$7.90	\$8.14	\$9.08	\$9.41	\$9.40	
Laundry & Linens	\$1.73	\$1.65	\$1.57	\$2.17	\$2.18	\$2.09	\$2.74	\$2.81	\$2.75	
Housekeeping	\$4.19	\$4.48	\$4.31	\$4.99	\$5.19	\$5.10	\$5.83	\$6.05	\$6.24	
Dietary	\$13.74	\$13.93	\$14.50	\$15.23	\$16.03	\$16.36	\$17.70	\$18.10	\$18.56	
Nursing & Medical Related	\$60.83	\$61.69	\$64.39	\$65.74	\$67.42	\$68.43	\$70.47	\$72.27	\$73.00	
Ancillary and Pharmacy	\$12.15	\$12.90	\$13.51	\$18.58	\$18.28	\$19.35	\$24.88	\$26.12	\$25.85	
Social Services	\$1.30	\$1.32	\$1.26	\$1.90	\$2.12	\$1.94	\$2.65	\$2.61	\$2.68	

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*	1,226
Licensed Nursing Beds*	114,764
Beds per 1,000 Aged 65 >**	22.96
Beds per 1,000 Aged 75 >**	54.03
Occupancy Percentage - 2013***	86.08%

*Source: California Office of Statewide Health Planning and Development

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 QAF for fiscal year 2011 was \$13.08 per resident day for nursing facilities with less than 100,000 total resident days and \$11.93 per resident day for nursing homes with 100,000 or more total resident days. These rates are an increase from the 2009-2010 rates of \$11.16 and \$10.12, respectively. Effective October 1, 2011, the Tax Relief and Health Care Act of 2006 is scheduled to sunset. This act reduced the maximum QAF that states could charge from 6.0% to 5.5% of total revenue. Therefore, the ceiling reverted to 6.0% on October 1, 2011. Medi-Cal has increased its QAF to reflect the new ceiling. Effective August 1, 2011, the QAF is \$14.33 per resident day for nursing facilities with less than 100,000 total resident days and \$13.43 per resident day for nursing homes with 100,000 or more total resident days.

Effective January 1, 2012, the QAFs were slightly increased to \$14.42 per resident day for nursing facilities with less than 100,000 total resident days and \$13.46 per resident day for nursing homes with 100,000 or more total resident days. The slight QAF increase is due to the inclusion of freestanding pediatric subacute facilities in the QAF assessment as allowed per ABx1 19. Effective August 1, 2012, the QAFs increased to \$15.61 for facilities with less than 100,000 days and \$14.88 for facilities with 100,000 or more total resident days. The QAFs were again increased on August 1, 2013. The QAF for facilities with fewer than 100,000 days is \$15.43 and the QAF for facilities with 100,000 or more total resident days is \$14.40.

Effective August 1, 2014, the QAFs moderately increased to \$16.03 for facilities with less than 100,000 days and \$15.15 for facilities with 100,000 or more total resident days. According to the California Association of Health Facilities, effective August 1, 2015, the fees are proposed to increase to \$16.26 for facilities with less than 100,000 days and \$15.39 for facilities with 100,000 or more total resident days. However, the state is waiting for approval from the Centers of Medicare and Medicaid (CMS) prior to finalizing the new fees.

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. This

California

legislation aims 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 2006 to 2015 are as follows:

Fiscal Year	Max. Allowable Rate Increase
2006	8.00%
2007	5.00%
2008	5.50%
2009	5.50%
2010	0.00%
2011	3.93%
2012	2.40%
2013	0.00%
2014	2.00%
2015	2.00%

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.

The state recently extended the AB 1629 methodology legislatively for the next five years and included a 3.62% annual rate increase. Given this factor, the interim rates for fiscal year 2016 (effective August 1, 2015) were calculated by inflating August 1, 2014, rates by 3.62%, after the rates had been adjusted for the change in rate add-ons from fiscal year 2015 to fiscal year 2016.

Final fiscal year rates will be based on 2013 cost report data after the state has completed auditing these cost reports. However, these rates will be limited to the 3.62% rate increase.

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. Since fiscal year 2012 rates were based on fiscal year 2011 rates (effective August 1, 2010), and fiscal year 2013 rates were frozen at fiscal year 2012 levels, the most recently established benchmarks were effective August 1, 2010. However, given that the state recently rebased rates effective August 1, 2013, the state recalculated these benchmarks. The table below presents the fiscal year 2015 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 Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 96.97 27.43 23.60 23.98 3.58
2	Butte, Humboldt, Inyo, Madera, Mendocino, Merced, San Luis Obispo, Tehama and Yolo	Direct Care Labor Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 110.88 30.67 24.72 21.72 2.89
3	Calaveras, Glenn, Plumas, San Joaquin, Shasta, Siskiyou, Stanislaus, Sutter and Ventura	Direct Care Labor Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 129.56 33.56 25.67 23.47 3.06
4	Amador, El Dorado, Nevada, Placer and Tuolumne	Direct Care Labor Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 121.57 38.59 28.00 39.36 2.97
5	Los Angeles	Direct Care Labor Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 112.14 31.82 23.97 22.55 3.27
6	Fresno, Orange, Riverside, San Bernardino, San Diego, Santa Cruz and Solano	Direct Care Labor Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 127.22 34.44 26.99 25.51 3.42
7	Alameda, Contra Costa, Marin, Monterey, Napa, Sacramento, San Francisco, San Mateo, Santa Barbara, Santa Clara and Sonoma	Direct Care Labor Indirect Care Labor Direct/Indirect Care Non-Labor Administration Professional Liability	\$ 157.63 43.47 27.63 28.35 2.89

Capital costs are reimbursed based on an FRVS that estimates the value of the capital-related assets necessary to care for Medi-Cal

California

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 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%).

Both rate components will be recalculated in fiscal year 2016, but the increase of these rates will be limited by the overall rate increase limit (3.62%).

In addition to the Medi-Cal rates, in fiscal year 2014 the state began reimbursing nursing homes an annual supplemental payment based on a Q&A Program. 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 2016, 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	14.285
Influenza Vaccination	7.14375
Pneumococcal Vaccination	7.14375
Pressure Ulcers	14.285
Control of Bowel or Bladder	14.285
Urinary Tract Infection	14.285
Self-Report Moderate to Severe Pain (Short-term)	7.14375
Self-Report Moderate to Severe Pain (Long-term)	7.14375
Activities of Daily Living	14.285
Total	100

These measures will be utilized to pay out rewards effective April 1, 2016. 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); however,

the point total varied moderately for fiscal year 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 will be 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. These amounts will change annually based on the quality survey results. Payout amounts have yet to be determined for fiscal year 2016.

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 year 2015. Payments for the prior fiscal year were only \$36.6 million. Payments for fiscal year 2015 were effective April 1, 2015, and were calculated utilizing state fiscal year 2014 (July 1, 2013, to June 30, 2014) data. Fiscal year 2016 payments will be made effective April 1, 2016, and will be based on fiscal year 2015 data (July 1, 2014, to June 30, 2015). Funding for the program will remain at \$90 million. In addition, a new benchmark (staff retention) will be included in the scoring methodology utilized to determine fiscal year 2017 supplemental payments. It is currently unclear what weight this benchmark will have on the scoring methodology.

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 will be implemented in fiscal year 2016 will 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.

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.

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 the Medi-Cal program, the state will reimburse the new owner the reimbursement rates associated with the change of ownership. per diem payment rate of the

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previous provider until the new owner or operator has submitted six or more months of audited cost data.

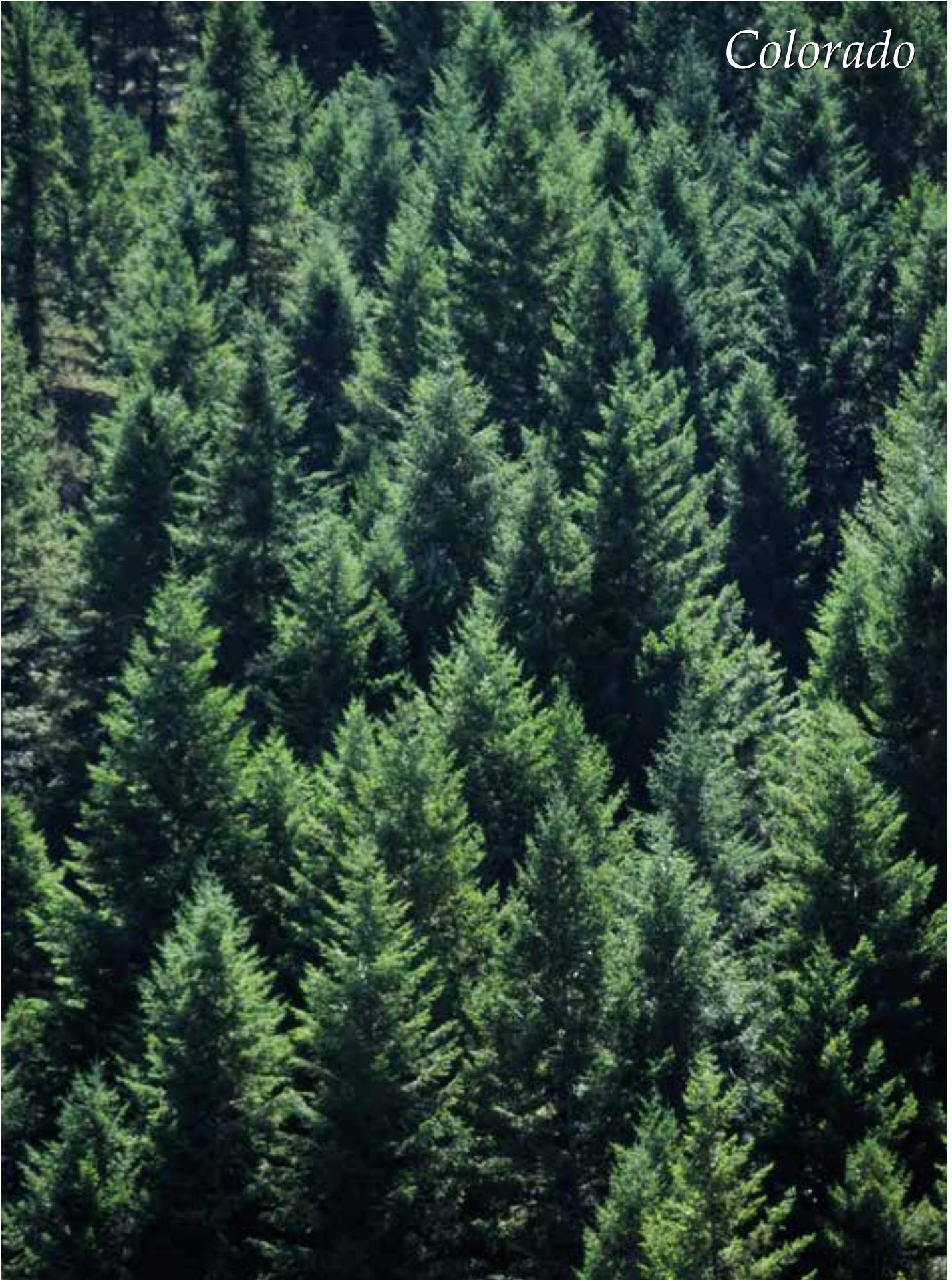
Nursing homes in California are eligible to be reimbursed by Medi-Cal for holding a bed for a resident that required hospitalization. Bed hold reimbursement is limited to a maximum of seven days per hospitalization. The nursing home is reimbursed its current per diem rate minus a per diem raw food cost. Effective August 1, 2014, this per diem is \$6.84. The per diem for raw food cost will not be updated until fiscal year 2016 nursing facility rates are finalized.

PROPOSED CHANGES TO THE MEDI-CAL 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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	64.00	63.25	62.00	99.00	99.00	99.00	120.00	120.00	120.00			
Average Daily Census	61.47	62.25	60.52	87.93	87.41	87.85	113.79	112.78	113.60			
Occupancy	84.0%	83.9%	83.9%	89.6%	89.1%	89.2%	92.8%	92.8%	92.9%			
Payor Mix Statistics												
Medicare	7.7%	7.5%	7.4%	13.0%	13.4%	13.3%	19.8%	19.9%	20.7%			
Medicaid	57.6%	57.4%	57.4%	70.9%	69.8%	69.6%	80.7%	79.5%	79.4%			
Other	7.5%	7.9%	8.6%	14.9%	15.8%	15.9%	28.5%	28.9%	29.3%			
Avg. Length of Stay Statistics (Days)												
Medicare	31.16	31.60	30.69	39.70	40.24	39.07	53.92	56.79	54.51			
Medicaid	173.51	184.10	181.41	264.38	290.92	278.54	431.00	479.74	467.71			
Other	31.71	31.66	29.14	56.90	56.87	51.37	146.68	135.51	124.50			
Revenue (PPD)												
Inpatient	\$190.04	\$193.28	\$195.69	\$216.58	\$222.44	\$230.59	\$262.45	\$268.51	\$279.35			
Ancillary	\$37.32	\$39.66	\$40.67	\$63.98	\$71.06	\$73.91	\$103.56	\$116.07	\$125.50			
TOTAL	\$236.71	\$247.56	\$255.34	\$293.98	\$307.97	\$325.82	\$363.53	\$386.16	\$409.61			
Expenses (PPD)												
Employee Benefits	\$14.68	\$15.34	\$15.88	\$19.21	\$20.12	\$20.92	\$26.47	\$27.91	\$28.86			
Administrative and General	\$44.77	\$46.79	\$49.04	\$55.70	\$57.53	\$59.76	\$68.58	\$69.05	\$72.47			
Plant Operations	\$7.44	\$7.50	\$7.70	\$8.95	\$8.96	\$9.26	\$11.32	\$11.31	\$11.84			
Laundry & Linens	\$2.34	\$2.27	\$2.33	\$3.02	\$3.01	\$3.08	\$3.80	\$3.92	\$4.00			
Housekeeping	\$4.14	\$4.29	\$4.37	\$5.07	\$5.21	\$5.32	\$6.33	\$6.48	\$6.64			
Dietary	\$13.65	\$13.91	\$14.19	\$15.59	\$15.98	\$16.30	\$18.14	\$18.44	\$19.06			
Nursing & Medical Related	\$70.96	\$71.89	\$73.94	\$82.42	\$83.11	\$84.72	\$96.96	\$98.80	\$100.82			
Ancillary and Pharmacy	\$19.47	\$20.12	\$21.12	\$31.49	\$32.26	\$32.98	\$45.19	\$46.91	\$47.82			
Social Services	\$3.22	\$3.27	\$3.32	\$4.39	\$4.44	\$4.60	\$5.90	\$5.88	\$6.09			

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

A dense forest of tall evergreen trees, likely pines or firs, filling the frame. The trees are closely packed, creating a textured pattern of green and dark shadows. The lighting suggests a bright day with sunlight filtering through the canopy.

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*	226
Licensed Nursing Beds*	21,124
Beds per 1,000 Aged 65 >**	30.46
Beds per 1,000 Aged 75 >**	77.68
Occupancy Percentage - 2013***	81.28%

*Source: Colorado Department of Public Health & Environment

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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, 2014) is \$13.30 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 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. Nursing facilities are reimbursed the QAF as a supplemental payment. In addition, the QAF is used to fund 100% of the state's obligation of various supplemental payments to nursing facilities.

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.

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. Specifically, 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.

Effective July 1, 2010, Colorado implemented changes to the reimbursement methodology in which nursing facilities receive monthly lump sum supplemental payments in addition to the per diem claims sent through the Medicaid Managed Information System (MMIS). These newly implemented supplemental rate payments are funded by the QAF. This includes the General Fund Growth Cap supplemental payment and the Rate True-up payment. In an effort to contain rising Medicaid costs, Colorado implemented the General Fund Growth Cap to assure that rates do not increase above budgeted levels. This cap will annually limit the rate of growth that can be reimbursed through MMIS. The cap is implemented by comparing each facility's MMIS rate

Colorado

to the actual per diem rate (core rate) the facility would receive utilizing the reimbursement methodology that will be detailed later in this overview. The MMIS rate is an established facility-specific base rate that will be cumulatively inflated each year by the General Fund Growth Cap percentage. The MMIS rate utilized in each year is a nursing facility's rate effective for the prior fiscal year. This rate (effective July 1, 2013) was inflated 3.767% for fiscal year 2015 (effective July 1, 2014). For the prior years, the facility-specific base rates were inflated 3.853% and 3.167% in fiscal years 2013 and 2014, respectively.

This rate represents the actual per diem rate that nursing facilities will receive in fiscal year 2015. However, the facility is reimbursed the difference between the MMIS rate and core rate on a monthly supplemental basis. This supplemental payment is determined utilizing the facility's total Medicaid days for the prior calendar year.

For fiscal year 2015, Medicaid days for calendar year 2013 were utilized to calculate this supplemental base. The first step in this calculation is to multiply the facility's calendar year Medicaid days by the variance between the two rates. For example, if the facility's core per diem rate was \$10 greater than its MMIS rate and the subject had 10,000 Medicaid days in calendar year 2013, the facility's annual supplemental payment will be \$100,000 ($\$10 \times 10,000 = \$100,000$). This amount is divided by 12 and paid out monthly as a supplemental rate payment throughout the rate year. However, prior to being paid out monthly, this supplemental payment is adjusted by the percentage of the payment that will actually be funded from revenue generated from the state's QAF. For fiscal year 2015, only 41.06% of the supplemental payment was funded. Therefore, the fictional nursing facility would only receive a total payment of \$41,060 ($\$100,000 \times 41.06\% = \$41,060$). This percentage funded in the previous fiscal years is as follows: fiscal year 2014 - 30.7%; fiscal year 2013 - 30.28% and fiscal year 2012 - 54.19%.

Colorado implemented a 1.5% rate reduction in fiscal year 2012 that is a permanent part of the rate calculation. This reduction is applied to the inflated MMIS rate that facilities receive on a per-day basis during the rate year. However, the supplemental payment is still calculated utilizing the MMIS rate prior to being adjusted for the rate reduction.

The Rate True-up supplemental payment reimburses nursing facilities for the difference between the prior year's core per diem rate and the adjusted MMIS rate. The MMIS rate is adjusted upward for any supplemental reimbursement the nursing facility had received from the prior year's General Fund Growth Cap and adjusted downward to account for any rate reduction. For fiscal year 2015, Medicaid days for calendar year 2013 were utilized to calculate this supplemental base and 41.06% of the Rate True-up supplemental payment was funded.

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. 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. All changes to the core rate for fiscal year 2014 will be reconciled as an Acuity Adjustment supplemental payment during fiscal year 2015. This supplemental payment is funded by revenue generated from the QAF and may not be fully funded in a given rate fiscal year. For example, only 88.6% of this supplemental payment was funded in fiscal year 2011. However, 100.0% of the Acuity Adjustment has been funded since fiscal year 2012.

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. Every fourth year, the Administrative and General cost component price will be recalculated. In non-recalculation years, the price will be inflated by the annual percentage change in the previously referred inflation index. The latest available publication prior to the July 1 rate setting will be used to determine the inflation index.

However, effective July 1, 2010, nursing facilities are subject to a General Fund Growth Cap that is determined annually. In addition to this cap, the state implemented a permanent 1.5% rate reduction for fiscal year 2012.

The state rebased the Administrative and General cost component price in fiscal year 2013 (effective July 1, 2012) utilizing 2010 cost report data. The Administrative and General cost component price was inflated 1.02289% and 1.02646% in fiscal years 2014 and 2015, respectively.

RATE METHODOLOGY

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 estimates are then 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 price is inflated for the next three rate periods and will be recalculated in the succeeding fourth rate year. The next scheduled recalculation of the price is on July 1, 2016. However, it is currently unclear what percentage of the median cost will be utilized to determine the applicable price.

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 Boechk 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 \$95,888 per bed for rates effective July 1, 2014. 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 General Growth Fund Cap (previously detailed); the Rate True-Up (previously detailed); the Acuity Adjustment (previously detailed); and reimbursement of the QAF (previously detailed). These supplemental payments will be funded by revenue generated from the QAF.

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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, all of the supplemental payments were 100.0% funded in fiscal year 2015.

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 - \$1.56.
- Nursing facilities with a CPS percentage greater than the mean plus two standard deviations - \$3.11.
- Nursing facilities with a CPS percentage greater than the mean plus three standard deviations - \$4.67.

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.

Under the new rate methodology, 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.

The nursing facility's per diem rate will equate will to the MMIS base rate adjusted for any rate reductions. 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) and the Pay for Performance Program. 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 2015, the General Fund Growth Cap and Rate True-Up were only 41.06% funded.

Excluding supplemental payments, the average nursing facility Medicaid rate in the state was \$201.66 effective July 1, 2014. This represents a 3.2% increase from the rate effective July 1, 2013 (\$195.50). The rates for the prior two years were \$188.37 and \$183.25 on July 1, 2012, and July 1, 2011, respectively.

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	60.00	60.50	63.25	91.50	93.00	95.50	120.00	118.75	117.00	
Average Daily Census	59.36	59.41	62.93	82.54	81.64	80.41	108.25	100.80	104.07	
Occupancy	78.8%	76.8%	76.1%	85.6%	84.7%	83.7%	90.3%	91.0%	89.7%	
Payor Mix Statistics										
Medicare	4.6%	5.1%	4.9%	8.3%	7.6%	7.5%	12.5%	11.9%	13.5%	
Medicaid	54.7%	56.1%	56.7%	65.2%	66.6%	68.7%	74.4%	75.3%	76.5%	
Other	18.5%	17.7%	17.0%	29.7%	26.3%	26.1%	40.4%	38.5%	38.3%	
Avg. Length of Stay Statistics (Days)										
Medicare	27.69	27.98	27.71	33.99	34.83	34.17	46.28	46.09	44.60	
Medicaid	292.93	283.32	293.16	364.38	380.54	399.51	514.16	557.29	597.80	
Other	58.06	64.03	62.22	99.07	105.24	100.32	181.83	193.97	206.30	
Revenue (PPD)										
Inpatient	\$193.90	\$202.13	\$212.36	\$216.11	\$223.16	\$232.65	\$240.59	\$247.64	\$262.21	
Ancillary	\$27.26	\$30.17	\$27.64	\$43.34	\$48.42	\$44.75	\$68.75	\$67.12	\$64.12	
TOTAL	\$233.96	\$241.66	\$247.23	\$264.48	\$274.92	\$278.82	\$319.32	\$321.41	\$332.40	
Expenses (PPD)										
Employee Benefits	\$16.54	\$15.27	\$17.01	\$21.53	\$18.86	\$20.95	\$30.47	\$28.26	\$26.21	
Administrative and General	\$33.05	\$34.92	\$38.43	\$39.15	\$41.59	\$45.05	\$47.54	\$47.55	\$52.97	
Plant Operations	\$8.47	\$8.23	\$9.00	\$9.65	\$9.80	\$10.41	\$11.85	\$12.38	\$12.33	
Laundry & Linens	\$1.68	\$1.63	\$1.74	\$2.44	\$2.43	\$2.49	\$3.06	\$2.96	\$3.13	
Housekeeping	\$4.57	\$4.95	\$5.03	\$5.50	\$5.74	\$5.86	\$6.55	\$7.00	\$7.02	
Dietary	\$15.86	\$15.54	\$16.04	\$18.06	\$18.09	\$18.93	\$21.58	\$21.43	\$22.01	
Nursing & Medical Related	\$79.48	\$82.78	\$83.58	\$90.90	\$91.66	\$93.32	\$106.87	\$105.29	\$105.99	
Ancillary and Pharmacy	\$15.10	\$15.76	\$15.62	\$22.70	\$21.86	\$21.19	\$33.02	\$31.82	\$32.15	
Social Services	\$2.56	\$2.84	\$2.80	\$4.02	\$4.32	\$4.22	\$5.47	\$5.42	\$5.48	

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

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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*	235
Licensed Nursing Beds*	27,815
Beds per 1,000 Aged 65 >**	48.88
Beds per 1,000 Aged 75 >**	109.57
Occupancy Percentage - 2013***	90.29%

*Source: Connecticut Department of Public Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

CERTIFICATE OF NEED

The Office of Health Care Access (OHCA) regulates the Certificate of Need (CON) program and enacted a moratorium on the construction of new nursing facility beds in 1991. This moratorium was set to expire on June 30, 2012, but was extended to June 30, 2016. 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 that 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, must file a CON.

Exceptions to this moratorium include, but are not limited to, beds limited to serving those with traumatic brain injury and AIDS, nursing homes that serve life care communities and the relocation of beds between facilities.

BED NEED METHODOLOGY

Connecticut does not have a bed need methodology in place given the current moratorium.

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

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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 in fiscal year 2015 (effective July 1, 2014) and 2016 (effective July 1, 2015). In addition, non-FRV nursing facility rates will remain frozen in state fiscal year 2017 (effective July 1, 2017).

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. The current cost component limit amounts (July 1, 2015 - June 30, 2016) are as follows:

Fairfield County	Direct	Indirect	Admin./General
CCNH Licensure	\$191.87	\$61.75	\$32.95
RHNS Licensure	\$173.45	\$61.75	\$32.95
Non-Fairfield County			
CCNH Licensure	\$170.19	\$61.75	\$32.95
RHNS Licensure	\$116.40	\$61.75	\$32.95

These standards have not changed since July 1, 2013.

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.

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.

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.

Connecticut

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

According to Connecticut rate setting professionals, the state is in the process of developing a wage enhancement incentive. Approximately \$34 million of funding will be dedicated to this program, which will provide nursing facilities with increased reimbursement for wage increases to employees under certain circumstances. The details of this program are still being finalized, but the program will be retroactively effective to July 1, 2015. According to rate setting officials, on average this wage enhancement will result in a \$2.91 rate increase per facility.

Specifically, nursing facilities will be reimbursed their proportion share of total funding (\$34 million) based on projected costs related to actual increases in wages for direct service, housing service, laundry service and professional care of residents service staff. These wage increases will be required to be implemented by June 30, 2016.

CONNECTICUT COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	70.00	87.75	88.50	105.00	120.00	120.00	130.00	145.75	145.75			
Average Daily Census	60.70	74.39	80.34	97.31	108.71	110.99	120.61	129.35	128.77			
Occupancy	85.0%	87.4%	86.6%	89.8%	91.8%	91.7%	92.4%	94.5%	94.3%			
Payor Mix Statistics												
Medicare	9.0%	9.0%	9.0%	12.8%	12.0%	12.0%	17.7%	16.0%	16.1%			
Medicaid	62.6%	61.9%	61.2%	71.3%	71.1%	71.7%	79.1%	78.9%	79.5%			
Other	9.6%	10.6%	10.7%	15.5%	16.8%	16.5%	20.9%	24.9%	24.6%			
Avg. Length of Stay Statistics (Days)												
Medicare	24.01	27.15	28.07	34.77	34.65	34.69	42.27	44.41	45.15			
Medicaid	316.47	328.51	338.62	428.59	477.92	493.33	583.94	713.03	854.76			
Other	46.78	49.14	48.23	80.63	87.02	84.23	161.67	162.62	148.11			
Revenue (PPD)												
Inpatient	\$273.21	\$297.54	\$299.96	\$335.35	\$365.69	\$375.10	\$379.58	\$407.89	\$420.99			
Ancillary	\$30.80	\$32.81	\$35.65	\$47.82	\$47.50	\$50.17	\$67.58	\$65.06	\$70.82			
TOTAL	\$314.59	\$345.69	\$354.20	\$384.21	\$414.35	\$428.47	\$448.66	\$463.54	\$479.54			
Expenses (PPD)												
Employee Benefits	\$28.27	\$30.70	\$31.16	\$33.76	\$37.86	\$39.13	\$43.32	\$45.08	\$45.55			
Administrative and General	\$43.57	\$44.28	\$46.07	\$47.87	\$49.01	\$50.18	\$54.70	\$55.99	\$58.06			
Plant Operations	\$10.95	\$10.36	\$10.59	\$14.25	\$13.16	\$12.87	\$17.04	\$15.58	\$15.65			
Laundry & Linens	\$3.27	\$3.07	\$3.06	\$4.12	\$3.96	\$3.83	\$4.98	\$4.86	\$5.14			
Housekeeping	\$5.93	\$6.18	\$6.37	\$7.39	\$7.39	\$7.83	\$9.17	\$9.37	\$9.61			
Dietary	\$17.97	\$18.34	\$18.34	\$20.25	\$20.27	\$20.40	\$22.14	\$22.72	\$22.80			
Nursing & Medical Related	\$96.10	\$98.27	\$98.42	\$104.02	\$105.43	\$105.92	\$114.62	\$116.78	\$115.33			
Ancillary and Pharmacy	\$18.53	\$17.64	\$19.44	\$25.58	\$24.40	\$25.22	\$35.77	\$34.43	\$34.25			
Social Services	\$2.20	\$2.25	\$2.42	\$3.23	\$3.28	\$3.29	\$4.59	\$4.56	\$4.34			

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*	50
Licensed Nursing Beds*	5,133
Beds per 1,000 Aged 65 >**	33.54
Beds per 1,000 Aged 75 >**	82.14
Occupancy Percentage - 2013***	87.81%

*Source: Delaware Department of Health and Social Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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

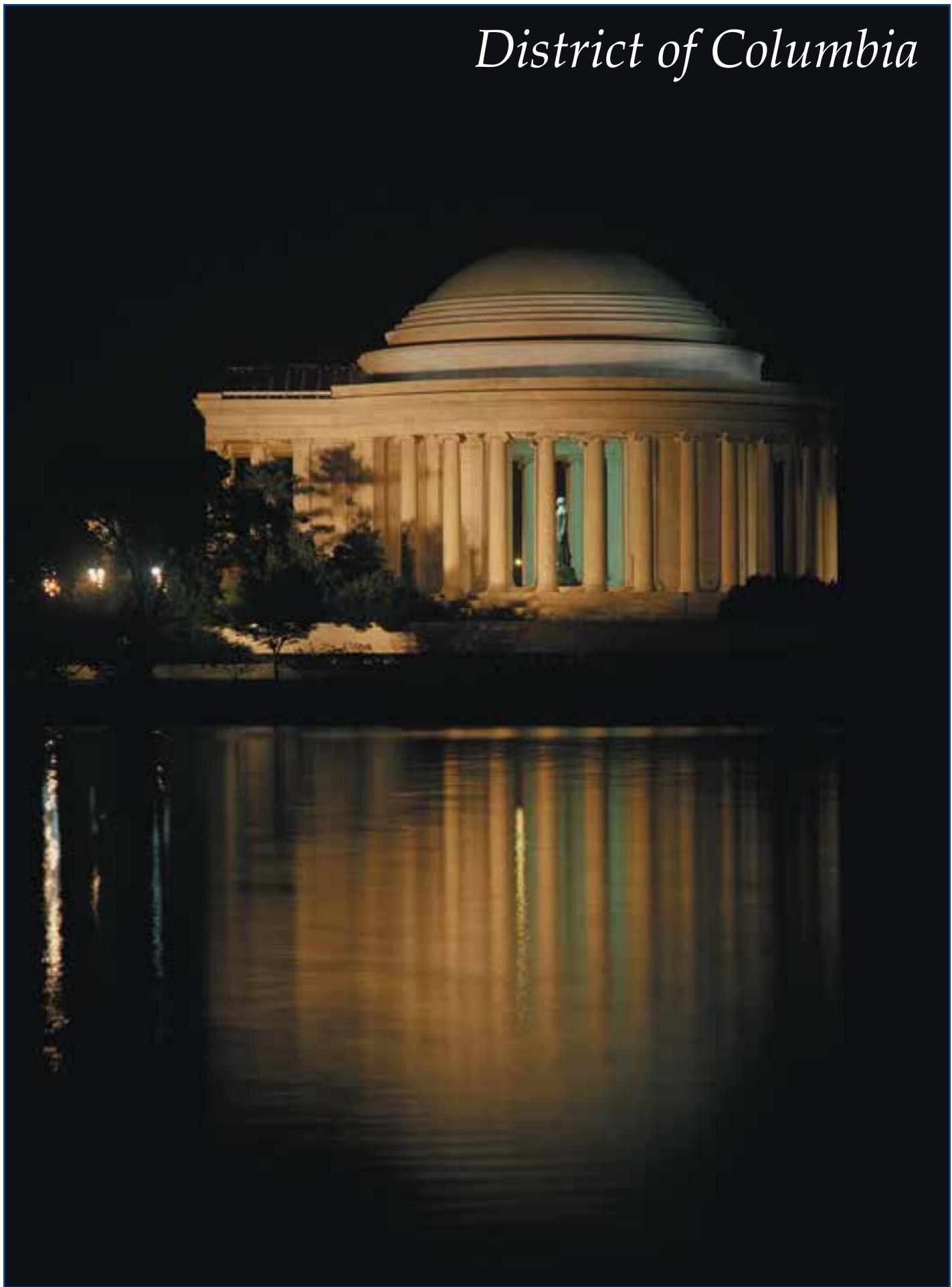
There is no current or proposed legislation that would affect the Medicaid rate calculation in Delaware.

Delaware

DELAWARE COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	66.50	93.00	96.00	109.00	120.00	120.00	144.00	138.50	138.00			
Average Daily Census	91.98	95.33	91.65	124.82	115.59	113.49	156.35	143.74	137.16			
Occupancy	85.4%	85.9%	86.5%	92.2%	92.0%	91.1%	93.6%	94.3%	92.6%			
Payor Mix Statistics												
Medicare	9.2%	8.4%	8.7%	15.6%	15.7%	17.4%	21.1%	22.0%	23.2%			
Medicaid	36.5%	42.1%	52.2%	60.9%	64.5%	63.9%	67.5%	69.4%	72.2%			
Other	15.0%	12.5%	10.9%	43.6%	25.2%	17.5%	84.8%	78.8%	67.5%			
Avg. Length of Stay Statistics (Days)												
Medicare	31.45	28.74	27.22	37.07	34.03	33.49	41.29	39.83	40.11			
Medicaid	245.68	259.43	270.94	395.04	358.65	451.84	782.80	721.80	726.32			
Other	113.62	95.09	65.31	221.86	217.12	123.85	406.97	281.76	239.78			
Revenue (PPD)												
Inpatient	\$204.46	\$229.07	\$258.17	\$250.10	\$262.28	\$288.35	\$279.18	\$283.54	\$308.65			
Ancillary	\$43.01	\$42.37	\$42.54	\$50.76	\$54.26	\$71.53	\$75.75	\$89.85	\$107.54			
TOTAL	\$250.99	\$270.96	\$298.99	\$305.15	\$321.11	\$365.29	\$407.99	\$410.71	\$448.06			
Expenses (PPD)												
Employee Benefits	\$23.27	\$20.52	\$23.10	\$35.13	\$33.14	\$35.69	\$48.77	\$44.54	\$43.10			
Administrative and General	\$30.97	\$36.45	\$36.85	\$37.55	\$43.10	\$48.06	\$52.90	\$49.80	\$58.75			
Plant Operations	\$10.50	\$10.02	\$11.23	\$12.73	\$11.54	\$12.58	\$29.26	\$16.33	\$17.53			
Laundry & Linens	\$1.98	\$1.86	\$1.78	\$2.61	\$2.78	\$3.10	\$3.49	\$3.54	\$4.08			
Housekeeping	\$5.02	\$5.23	\$5.40	\$7.17	\$7.28	\$6.85	\$11.36	\$8.64	\$8.55			
Dietary	\$17.18	\$16.87	\$17.08	\$21.60	\$19.44	\$19.65	\$33.02	\$26.30	\$25.90			
Nursing & Medical Related	\$90.18	\$97.04	\$98.39	\$101.44	\$110.34	\$107.80	\$121.85	\$123.14	\$122.45			
Ancillary and Pharmacy	\$24.55	\$23.26	\$23.49	\$28.99	\$32.18	\$35.98	\$40.45	\$43.53	\$47.57			
Social Services	\$1.05	\$1.40	\$1.55	\$2.27	\$2.21	\$2.19	\$2.55	\$3.03	\$3.32			

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*	19
Licensed Nursing Beds*	2,770
Beds per 1,000 Aged 65 >**	34.02
Beds per 1,000 Aged 75 >**	80.68
Occupancy Percentage - 2013***	90.94%

*Source: The District of Columbia Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.
- 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 2014 is \$5,473.93 per licensed bed annually.

MEDICAID RATE CALCULATION SYSTEM

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

COST CENTERS

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

- The Routine and Support cost component includes costs associated with dietary (excluding raw food), laundry and linen, housekeeping, plant operations and related clerical support, volunteer services, administrative and general salaries, professional services (non-healthcare related), non-capital related insurance, travel and entertainment, general and administrative costs, and non-capital related interest expenses.
- The Nursing and Resident Care cost component includes costs associated with raw food, nursing and physician services and their related clerical support services, nonprescription drugs and pharmacy consultant services, medical supplies, laboratory services, radiology services, social services, resident activities, oxygen therapy, utilization and medical reviews, and physical, speech and occupational therapy (only expenses for Medicaid residents).
- The Capital cost component includes cost associated with equipment rental, depreciation and amortization, interest on capital debt, real estate taxes and capital related insurance, property insurance, and other capital-related expenses.

INFLATION AND REBASING

D.C. has not finalized a rebase of Medicaid rates, inflated allowable costs or calculated any relevant rate ceilings since January 1, 2006. Rates effective January 1, 2006, were calculated utilizing 2000 cost report data inflated to April 1, 2003. However, during fiscal year 2009, the District received approval from the Centers of Medicare and Medicaid Services (CMS) to amend its rate setting system. The District is required to rebase Medicaid rates every three years. Based on this legislation, the District is in the process of finalizing rebased rates effective October 1, 2008, utilizing 2007 cost report data. The amendment also provides for an inflation adjustment for the period of October 1, 2008, to September 30, 2009, that would be based on CMS' Prospective Payment System Skilled Nursing Facility Input Price Index.

Given this delay, the District issued a temporary inflation adjustment that includes a 3.4% inflation adjustment and a 3.0% adjustment to simulate the affects of the rebasing. This adjustment was made in late 2010. In addition, the District reimbursed nursing facilities through lump sum payments to reflect the revenue nursing facilities should have received from October 1, 2008, to September 30, 2011, if rebased rates were finalized. Since this has occurred, the state has calculated interim rates that reflect that costs have been rebased with 2007 cost report data. These rates were calculated utilizing reimbursement methodology that was utilized to calculate prior year rates, which is detailed in the Rate Methodology section of this overview. However, these rates have yet to finalized. Once the rebased rates have been finalized, the District has indicated that it will retroactively adjust Medicaid rates to October 1, 2008.

Based on regulations, the District was required to rebase rates on October 1, 2011, utilizing 2010 cost report data. As with the 2008 rebasing, the District has yet to finalize these rebased rates. Interim rates issued by the District are rates for the period within October 1, 2011, to April 1, 2013. However, these rates are based on 2007 cost report data and will eventually need to be updated to reflect the base year of 2010. This reflects that the

District of Columbia

District has not yet completed auditing 2010 cost reports. These rates were calculated utilizing the same methodology that was used to determine rates prior to October 1, 2008; however, costs were inflated to a total 5.6% to bring them up to 2011 levels. In addition, effective January 1, 2011, the District has removed the requirement for any inflation adjustments. Therefore, with the exception of the inflation adjustment utilized to calculate initial interim rebased rates (effective October 1, 2011), no additional inflation was applied to rates effective (April 1, 2012, May 1, 2012, April 1, 2013) after that date. Also, effective May 1, 2012, the District adjusted allowable costs to remove any therapy expenses that were reimbursed by Medicare.

Based on the above described circumstances, the District has reimbursed nursing facilities through lump sum payments to reflect the revenue nursing facilities should have received since October 1, 2011, if rebased rates were finalized. Once the rebased rates have been finalized, the District has indicated that it will retroactively adjust Medicaid rates to October 1, 2011.

The facility-specific Nursing and Resident Care cost component rates are recalculated every six months to adjust for the nursing facility's case mix index (CMI). The rate year in D.C. is from October 1 to September 30. Medicaid rates for D.C. nursing facilities are adjusted semiannually for changes in case mix of Medicaid residents. However, several nursing facilities in the District are contesting case mix adjusted rates since the District has provided no documentation of how case mix adjusted rates were calculated.

Based on the District's regulations, the District is required to rebase rates again on October 1, 2014. Initial indications are that this rebasing will occur and will utilize 2013 cost report data. However, given that the state has still not finalized rates for the period of October 1, 2008, to April 1, 2013, and is yet to determine interim rates for October 1, 2013, it is likely that a significant amount of time will pass before this occurs.

RATE METHODOLOGY

In a rebasing year, the total facility-specific Medicaid rate is calculated as the sum of the Routine and Support (subject to a ceiling), Nursing and Resident Care (subject to a ceiling and adjusted semiannually for case mix) and Capital cost component per diem rates, plus any relevant incentive add-ons. For the purpose of calculating the Routine and Support and Nursing and Resident Care cost component rates, nursing facilities are classified into three peer groups as follows:

- Peer Group One: All freestanding nursing facilities (not including facilities owned and operated by the D.C. government).
- Peer Group Two: All hospital-based nursing facilities.
- Peer Group Three: All freestanding nursing facilities owned and operated by the D.C. government.

The facility-specific Routine and Support cost component per diem rate is determined by dividing total allowable inflated routine and support base year costs by total resident days adjusted for the occupancy requirement, if applicable. The per diem costs for all applicable nursing facilities are arrayed by peer

group and the day-weighted median cost for each peer group is determined. The day-weighted median is the point in the array at which half of the resident days have equal to or higher per diem costs and half have equal to or lower per diem costs. In 2006, the Routine and Support cost component rate ceiling equated to 139.3% of the day-weighted median for each peer group. Based on conversation with District rate-setting professionals, the above referenced percentages were utilized to determine October 1, 2008, and October 1, 2011, rebased rates.

The Routine and Support cost component per diem rate is the lower of the calculated facility-specific per diem or the adjusted cost ceiling relative to each nursing facility's peer group. A nursing facility is entitled to an incentive add-on if the facility's per diem cost is less than the applicable rate ceiling. The incentive equates to 25% of the difference between the facility-specific per diem rate and the rate ceiling.

D.C. uses the Resource Utilization Group (RUG) III resident classification system to categorize residents and to determine the Nursing and Resident Care cost component rate. The facility-specific Nursing and Resident Care cost component per diem costs are case mix neutralized before being arrayed into the applicable peer groups. This process begins by dividing each facility's allowable inflated nursing and resident care costs by the total facility CMI (the arithmetic mean of the individual resident CMIs for all residents, regardless of payor mix) to establish case mix neutral costs. The case mix neutral costs are then divided by total resident days (adjusted for the occupancy requirement, if applicable) to determine each facility's case mix neutralized per diem cost. These facility-specific per diem costs are then arrayed into the applicable peer groups and the median and day-weighted median costs are determined for each peer group.

In 2006, the Nursing and Resident Care cost component rate ceilings for peer groups one and three equated to 163.0% of the day-weighted median case mix neutralized cost per diem for each peer group. In 2006, the Nursing and Resident Care cost component rate ceiling for peer group two equated to 163.0% of the median case mix neutralized cost per diem. Based on conversation with District rate-setting professionals, the above referenced percentages utilized to determine October 1, 2008, and October 1, 2011, rebased rates.

The facility-specific Nursing and Resident Care cost component per diem rate (prior to case mix adjustment) is the lower of the calculated facility-specific case mix neutral per diem or the adjusted cost ceiling relative to the nursing facility's peer group. After the unadjusted facility-specific Nursing and Resident Care cost component per diem rate is determined, nursing facilities are entitled to an incentive add-on if the facility's per diem cost is below the cost applicable rate ceiling. This incentive equates to 40% of the difference between the facility-specific per diem rate and the adjusted ceiling.

The facility-specific Nursing and Resident Care cost component per diem is then adjusted for case mix. This is determined by multiplying the lesser of the nursing facility's case mix neutralized per diem cost (adjusted for the incentive add-on, if applicable) or the rate ceiling, by the nursing facility's Medicaid CMI. The

Medicaid CMI equates to the arithmetic mean of the individual resident CMIs for all residents that utilize Medicaid as their payor source. Capital costs are reimbursed as direct pass-through costs and are not subject to a rate ceiling. A nursing facility's Capital cost component rate is determined by dividing total allowable capital-related base year costs, adjusted for inflation (does not apply to depreciation, amortization and interest on capital related expenditures), by total resident days (adjusted for the occupancy requirement, if applicable). Nursing facilities may also be eligible for an additional per diem amount (\$380) if any of their residents require and receive ventilator care.

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 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 median or median cost per diem multiplied by the peer group's district-wide Medicaid average CMI. The Capital cost component per diem is established by dividing the lower of capital-related reported costs (as determined from the provider's

submitted pro forma cost report) or capital costs set forth in a written finding by the State Health Planning and Development Agency in its approval of the CON (if available) by the number of total resident days.

The interim facility-specific rate for each new provider remains in effect until one full year of the provider's operational costs has been audited. A new provider may also receive an add-on payment for each resident that qualifies and receives ventilator care. D.C. may collect any overpayment or pay any difference as a result of the difference between the audited final rate and the interim rate paid to a new provider. 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. The depreciation basis will be subject to the limitation of the re-evaluation of assets mandated by Title 18 of the Social Security Act. Allowable interest expense will be limited by the Medicare principles of reimbursement. 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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	64.50	60.00	77.00	180.00	164.00	180.00	225.50	230.00	230.00	
Average Daily Census	124.43	101.60	152.63	172.65	180.14	174.37	212.95	221.61	213.41	
Occupancy	83.0%	83.4%	88.0%	93.6%	90.2%	92.3%	95.6%	93.8%	92.9%	
Payor Mix Statistics										
Medicare	5.8%	4.0%	3.9%	8.0%	5.6%	6.6%	10.1%	7.6%	10.1%	
Medicaid	84.0%	56.1%	66.6%	85.3%	95.1%	88.3%	89.7%	95.5%	93.9%	
Other	46.5%	79.9%	79.4%	89.2%	92.4%	89.9%	93.5%	94.4%	93.4%	
Avg. Length of Stay Statistics (Days)										
Medicare	38.07	30.27	35.29	48.25	40.23	42.24	73.76	47.85	58.43	
Medicaid	432.60	395.24	418.56	660.31	625.35	565.41	723.48	1343.34	987.89	
Other	144.58	403.05	230.36	375.86	714.29	730.90	652.42	908.14	840.19	
Revenue (PPD)										
Inpatient	\$247.89	\$261.57	\$254.86	\$297.29	\$322.86	\$281.87	\$361.68	\$359.00	\$356.78	
Ancillary	\$23.97	\$22.88	\$24.60	\$30.91	\$25.78	\$28.81	\$32.76	\$39.07	\$40.28	
TOTAL	\$275.98	\$294.30	\$288.47	\$326.71	\$348.64	\$307.48	\$387.84	\$402.57	\$399.67	
Expenses (PPD)										
Employee Benefits	\$16.48	\$10.55	\$11.84	\$23.24	\$18.04	\$14.02	\$26.62	\$23.82	\$28.95	
Administrative and General	\$53.10	\$39.17	\$48.15	\$66.56	\$57.14	\$61.75	\$79.17	\$69.47	\$82.30	
Plant Operations	\$15.14	\$15.25	\$13.86	\$18.88	\$17.49	\$16.55	\$28.67	\$29.81	\$30.50	
Laundry & Linens	\$1.76	\$1.99	\$1.98	\$2.64	\$2.57	\$2.95	\$3.69	\$3.03	\$3.58	
Housekeeping	\$8.49	\$6.58	\$6.59	\$11.24	\$8.88	\$10.07	\$17.36	\$13.82	\$18.08	
Dietary	\$19.05	\$18.04	\$18.68	\$21.85	\$20.38	\$20.80	\$35.09	\$36.25	\$31.66	
Nursing & Medical Related	\$88.29	\$87.67	\$96.89	\$97.92	\$106.59	\$99.92	\$116.95	\$123.30	\$134.24	
Ancillary and Pharmacy	\$15.93	\$14.63	\$13.91	\$20.60	\$18.93	\$16.74	\$22.27	\$20.04	\$20.01	
Social Services	\$3.24	\$3.10	\$3.19	\$5.27	\$4.49	\$4.27	\$7.76	\$9.29	\$7.84	

Comments: The above data may be moderately skewed, given that the average sample size over the three-year period is approximately 11 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*	681
Licensed Nursing Beds*	83,428
Beds per 1,000 Aged 65 >**	21.87
Beds per 1,000 Aged 75 >**	49.25
Occupancy Percentage - 2013***	87.63%

*Source: Florida Health Finder

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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. This action was taken because the Legislature found that the continued growth in the Medicaid budget for nursing home care constrained the ability of the state to meet the needs of its elderly residents through the use of less restrictive and less institutional methods of long-term care. Exemptions to the moratorium are as follows:

- Nursing home beds within a continuing care retirement community (CCRC);
- Additional nursing home beds in a facility located in a county having up to 50,000 residents, if the expansion does not result in an addition that is more than the greater of 10 beds or 10.0% of the facility's licensed capacity; or beds for comprehensive rehabilitation.
- A county that has no existing nursing home beds.

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 eliminates the moratorium on issuance of CONs for additional nursing facility beds effective July 1, 2014. While a version of this bill still needs to be approved by the Florida Senate, representatives of the Florida Health Care Association indicated that this legislation is anticipated to be approved in the near future.

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

- The legislation will provide 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.
- It will create 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 will also result in the state resuming the calculation of nursing home bed need, which has been suspended since July 1, 2001. This will also include establishing a positive CON application factor for an applicant in a subdistrict where bed need has been determined to exist.

BED NEED METHODOLOGY

As previously mentioned, 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 has not published need for nursing home beds since that date. However, with the end of the moratorium on July 1, 2014, the state will again consider the construction of new nursing home beds and will resume the calculation of nursing home bed need. There is no firm date when the next bed need calculation will be completed; however, professionals from the Florida Health Care Association anticipate that it could occur by October 2014. The frequency of bed need determination is also unclear. Below is a summary of the bed need methodology that was previously in place for the consideration of CONs for new nursing homes in Florida. Based on a review of House Bill 287, some alteration of this methodology will be utilized to determine bed need in the future.

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

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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 94%. However, per House Bill 287, this percentage will be reduced to 92% when bed need is next calculated. 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.

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 January 1, 2014, the fee is \$26.05 per non-Medicare day for nursing facilities with less than 53,000 Medicaid patient days and \$2.94 for nursing facilities with greater than 53,000 Medicaid patient days. The prior fees (effective July 1, 2013) were \$23.78 for nursing homes with less than 53,000 Medicaid patient days and \$3.52 for nursing facilities with greater than 53,000 Medicaid patient days. The rates effective January 1, 2014, were increased to make up for a projected under collection for the first six months of the year. The state also established a uniformity-based waiver. 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:

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

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

All nursing facilities in the state are also reimbursed a Supplemental Rate add-on, which is based on funding remaining after the state has fully funded the Medicaid reimbursement system. The current add-on equates to \$8.6934 per day.

MEDICAID RATE CALCULATION SYSTEM

Florida AHCA uses a prospective, cost-based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. 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 will continue to be used to determine facility-specific nursing home Medicaid 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 costs based on historical costs for depreciation and interest or using the fair rental value (FRV) system.

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 for six-month periods (rate semesters) beginning in January 1 and July 1 of each year, based on the latest cost reports received by October 31 and April 30, respectively. Florida rebased nursing facility Medicaid rates effective July 1, 2012. However, Florida is not required by law to rebase rates.

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 using the change in the Florida Construction Cost

Inflation (FCCI) Index, based on the Global Insight CPI All Urban All Item Regional Index for the South Region. Non-FRV system property costs are not inflated from the cost report period to the effective rate period.

After facility-specific Medicaid rates have been determined, Florida adjusts these rates downward to account for budget shortfalls. The Medicaid Trend Adjustment is the percentage by which each nursing facility's calculated Medicaid rate is reduced to determine its final rate. Effective March 1, 2009, the state applied a significant rate reduction to previously calculated Medicaid rates. This rate reduction was completed by increasing the Medicaid Trend Adjustment from 6.5% (effective January 1, 2009) to 14.1% (effective March 1, 2009). The adjustment was based on the state's budget appropriations. However, effective April 1, 2009, the state recalculated Medicaid rates based on the additional revenue that the state generated from the NFQAF. Based on this additional revenue, the Medicaid Trend Adjustment was reduced to approximately 0.9%. The Medicaid Trend Adjustments for fiscal years 2010 and 2011 were also 0.9%.

Prior to the rate reduction and subsequent rate correction, Florida had imposed a rate freeze. Specifically, the average rate for the current rate period cannot exceed the average for the previous period. This rate freeze was applied to fiscal year 2010 and 2011 rates. Even with the additional revenue generated from the increase in the NFQAF, the state was required to reduce funding for Medicaid nursing home reimbursement by approximately \$187 million effective July 1, 2011, which represents a 6.5% average rate reduction to fiscal year 2011 rates. This was implemented by increasing the Medicaid Trend Adjustment to 7.3%. The state will partially offset this rate reduction by decreasing the minimum staff levels for direct care staff (non-RNs) from 3.9 to 3.6 hours per resident per day. Effective July 1, 2012, Florida was able to "buy back" a portion of the previous rate reductions by increasing the NFQAF for the majority of facilities in the state. However, the fiscal year budget reduced funding for nursing facilities by approximately \$32.5 million (1.25%). This resulted in a Medicaid Trend Adjustment of approximately 5.9% effective July 1, 2012, and 5.8% effective January 1, 2013.

The funding created from the increase in the NFQAF and increases in facility costs, offset this reduction. Medicaid rates effective July 1, 2012, increased 2.8% from January 1, 2012, to July 1, 2012, and Medicaid rates effective January 1, 2013, increased 0.5% from July 1, 2012, to January 1, 2013.

In fiscal year 2014 (effective July 1, 2013), the state was again able to buy back a portion of previous rate reductions based on the calculation of the maximum NFQAF allowed under federal law. This resulted in a 1.5% increase in Medicaid rates from January 1, 2013, to July 1, 2013, and a 0.4% increase from July 1, 2013, to January 1, 2014. In addition, the approximate Medicaid Trend Adjustment for both periods (4.3%) was less than previous adjustments.

RATE METHODOLOGY

For the purpose of determining nursing facilities, non-property rates and rate ceilings, nursing facilities are categorized into

six classes based on geographic location (northern, central or southern counties) and then facility size (0 – 100 beds and 101 plus beds). Separate reimbursement ceilings are established by class for the Direct Patient Care, Indirect Patient Care and Operating cost components.

For all three components, facility-specific per diem costs for all classes are determined by dividing allowable inflated costs by total Medicaid patient days. Effective January 1, 2002, a "Gross Up Factor" was added to each nursing facility's Direct Patient Care component rate to account for additional funding required to maintain the state's minimum staffing levels for RNs, LPNs and CNAs. The state updated the CNA portion of this adjustment on January 1, 2003, and January 1, 2007, respectively. On January 1, 2003, the CNA minimum staffing requirement was increased to 2.6 hours per patient day and on January 1, 2007, it was increased to 2.9 hours per patient day. The minimum staffing level for RNs and LPNs has remained at 1.0 hour per patient day. As previously mentioned, the state will partially offset this rate reduction by decreasing the minimum staff levels for direct care staff (non-RNs) from 3.9 to 3.6 hours per resident per day.

All applicable per diem costs for all cost components and classes are arrayed and cost component medians for each class are determined. Statewide median costs per cost component are determined as well. Both the statewide and class component medians are utilized to calculate ratios of class to state costs. These ratios are utilized to adjust facility-specific per diem costs and to determine the class rate ceilings per component.

The first step in this process is to calculate ratios for each of the four class medians per component to the statewide per diem cost per component. The facility-specific per diem costs per component are divided by the applicable ratio and arrayed by class and component. The lower and upper 10% of the per diems are excluded from the array. Based on the remaining data, the median per diem cost and standard deviation per class and component are determined. The component rate ceilings are calculated utilizing this data. For the Operating cost component, the rate ceiling is the sum of the median plus one standard deviation. For the Direct Patient Care and Indirect Patient Care cost components, the rate ceiling is the sum of the median plus 1.75 standard deviations. However, the cost based ceilings for the Central class are the simple averages of the Northern and Southern classes.

In non-rebasing years, there are additional rate limitations established for each class of each cost component. These include provider target rates and target rate class ceilings. In a non-rebasing year, a nursing facility's Operating and Indirect Patient Care cost component rates equate to the lesser of the facility-specific per diem cost, the applicable class ceiling, the provider target rates, or the target rate class ceiling. A nursing facility's Direct Patient Care cost rate is the lesser of the facility-specific per diem cost or the class rate ceiling.

Target rates and target rate class ceilings are mechanisms to control the rate of increase in provider-specific rates and the rate of increase in the cost ceilings for Operating and Indirect Patient Care. Provider target rates are facility-specific rates that are initially calculated in the rate semester preceding the last rebasing

rate semester by inflating the facility-specific rate calculated in the rebasing semester by a target inflation multiplier. The target inflation multiplier equates to 2.0 multiplied by FNHCII. Going forward, the provider target rate is calculated by multiplying the provider target rate for the previous rate semester by the target inflation multiplier. In addition, effective July 1, 2007, the provider target rate will not fall below 75% of the cost-based class ceiling.

The target rate class ceilings for the Operating and Indirect Care cost components are class-specific. Similar to the provider target rate, the target rate class ceiling is initially determined by multiplying the class rate ceiling in the rebasing year by a target inflation multiplier. The target inflation multiplier for the target rate class ceiling equates to 1.4 multiplied by FHNCII. In addition, effective July 1, 2007, the target rate class ceiling will not fall below 90% of the cost-based class ceiling.

Each rate semester after the initial calculation, the prior rate semester's target-based class ceiling is inflated forward using the target inflation factor to become the current rate semester's target-based class ceiling.

Nursing facilities owned on or before July 18, 1984, or leased on or before August 31, 1984, are reimbursed for property costs based on historical costs for depreciation and interest. Facilities existing as of October 1, 1985, have the option of being reimbursed based on the FRV system if the FRV system rate is higher. All facilities built since this time are reimbursed utilizing the FRV system. Facilities reimbursed under the old method will continue under this method until the facility's FRV system payment exceeds depreciation and interest payments. On this occurrence, the facility will begin reimbursement under the FRV system. The FRV system is the sum of the property tax (excluding sales tax on lease payments), insurance per diem and allocated home office property costs, plus the per diem cost determined through the FRV system.

Under the old system, total allowable property expenses are divided by total Medicaid days to determine the per diem property costs. Property costs are subject to the statewide ceilings (but not target limitations), which was the ceiling computed as of July 1, 1985, for facilities being reimbursed under the old method. This ceiling is frozen at \$13.65 per resident day.

The FRV system rate is based on the most recent acquisition costs prior to enrolling in the Medicaid program. The costs (subject to depreciation) are indexed forward utilizing the FCCI Index, subject to a ceiling. The ceiling per-bed cost was established at \$28,500.00 and is indexed forward every six months based upon the most recently published six-month full increase in the FCCI Index and is used to limit new construction costs in the future. The ceiling cost per bed effective January 1, 2014, is \$51,248. For calculation of the FRV system rate, these acquisition costs are allocated as debt (80% of the acquisition cost) and equity (20% of the acquisition costs).

The debt portion of the acquisitions costs is amortized assuming a 20-year mortgage utilizing the lesser of the following: the owner's actual interest rate; the prime rate as of the date of the provider's loan commitment plus 2% for a variable-rate mortgage

or plus 3% for a fixed mortgage; or 15%. The calculated annual debt payments for the mortgage are divided by the equivalent of 90% of the subject's total available patient days to determine the portion of the FRV system rate derived from debt. However, for newly constructed facilities, the per diem rate for the first year of operation is based on 75% instead of 90% of total available patient days. The portion of the acquisition costs attributed to equity is multiplied by the current return on equity factor and is then divided by the equivalent of 90% of the subject's total available patient days. The Return on Equity Factor is determined based on Centers for Medicaid and Medicare Services (CMS) standards, utilizing rates of interest on special issues of public debt to the Federal Insurance Trust Fund for each of the months during a nursing facility's reporting period.

The property tax, property insurance and allocated home office property cost per diem expenses are calculated utilizing the most recent cost report data available. Un-inflated allowable property tax and property insurance expenses are divided by total patient days to calculate the respective per diem costs for each category. These per diem costs are added to per diem costs calculated for the capital and equity portions of the facility's acquisitions costs to calculate the FRV system rate. For facilities being reimbursed under the FRV system, the property component has no target limitations or ceilings, but instead applies a per-bed standard limitation. The per-bed standard limitation sets a maximum amount that each facility's property asset indexing can grow. This indexing is further limited by the Medicaid occupancy and age of the facility.

Providers are entitled to an incentive add-on called the Medicaid Adjustment Rate (MAR). The MAR is included in Direct Patient Care and Indirect Patient Care cost components of the provider's total reimbursement rate. To be eligible for this add-on, nursing facilities must have been given a standard or superior quality of care license rating and have costs below the class ceiling.

Facilities with 90% or greater Medicaid utilization must have their MAR equal their weighted base rate. The weighted base rate is determined by multiplying a nursing facility's base rate (total Medicaid rate calculated before the MAR adjustment) by the Medicaid adjustment weight, which is set at 0.045. The product of this calculation is then multiplied by the percentage of standard and superior (without differentiation) licensure rating days to total licensure rating days.

The MAR for Facilities between 50% and 90% Medicaid utilization is determined by multiplying their weighted base rate by the Medicaid adjustment. The Medicaid adjustment is calculated by dividing the product of the nursing facility's actual Medicaid utilization minus the minimum allowable Medicaid utilization rate (50%), by the difference between the maximum (90%) and minimum Medicaid utilization rates. The product of this calculation is multiplied by 100 to determine a nursing facility's Medicaid adjustment. Facilities with 50% or less Medicaid utilization receive no MAR.

A nursing facility's Medicaid reimbursement rate is calculated as the sum of the following: the lower of the facility-specific per diem cost, provider target rate, the target rate ceiling, or the

applicable class rate ceiling for the Operating and Indirect Patient Care cost components; the lower of the facility-specific per diem cost or the applicable class rate ceiling for the Direct Patient Care cost component; the lower of the property cost per diem or the applicable statewide property cost per diem (for facilities not reimbursed under the FRV system), or the calculated FRV system rate (for facilities reimbursed under the FRV system) and the MAR, NFQAF-Medicaid Share, and Supplemental Rate add-ons.

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.

MINIMUM OCCUPANCY STANDARD

The capital and equity portions of the facility-specific FRV system per diem rate are determined assuming that the applicable nursing facility is 90% occupied.

OTHER RATE PROVISIONS

For new providers with no cost history in a newly constructed facility, an existing facility entering the program, an existing provider in a newly constructed replacement facility, or a new provider with no cost history resulting from a change in ownership in which the prior provider participated in the Medicaid program, the interim Operating, Direct Patient Care and Indirect Patient Care per diems are the lesser of the class reimbursement component ceilings; the Direct Patient Care and Indirect Patient Care cost per diems (based on budgeted costs); or the new provider target. The new provider target for a new provider with no cost history, a newly constructed facility, or an existing provider entering the program, is calculated as the average Operating, Direct Patient Care and Indirect Patient Care per diems in the district in which the facility is located plus 50% of the difference between the average district per diem and the facility class ceiling.

Existing providers in a newly constructed replacement facility will receive the greater of the budgeted operating and patient care cost per diems or their current operating and patient care per diems that were in effect prior to the operation of their replacement facility, not to exceed the facility class ceilings. The property cost per diem for newly constructed facilities or replacement facilities is the lesser of the budgeted FRV system rate; or the applicable FRV system rate based on the cost per bed standard that was in effect six months prior to the date the facility was first placed into service as a nursing facility. New providers will have budgeted rates settled based on cost reporting periods of at least six months, but not more than 18 months.

Effective July 1, 2007, new providers can be paid the previous owner's operating and patient care rates plus 50% of the difference between these rates and the effective class ceiling. The property component rate is calculated utilizing the FRV system.

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

As previously mentioned, the state implemented its Medicaid managed care reimbursement system for nursing facilities. The overall impact of this new system has yet to be determined. In addition, as previously mentioned, effective July 1, 2014, the state will eliminate the moratorium on the approval of CONs for the construction of new nursing home beds. This could result in the construction of as many as 3,500 new nursing home beds in Florida from July 1, 2014, to June 30, 2017.

Florida

FLORIDA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	99.50	100.00	103.00	120.00	120.00	120.00	120.00	120.00	120.00	2011	2012	2013
Average Daily Census	91.47	94.78	94.22	109.93	110.47	110.47	123.79	117.90	122.99	2011	2012	2013
Occupancy	84.7%	85.9%	85.0%	90.7%	91.2%	90.6%	93.7%	94.2%	94.3%	2011	2012	2013
Payor Mix Statistics												
Medicare	12.0%	11.8%	11.5%	18.0%	17.4%	16.5%	26.1%	25.1%	24.7%	2011	2012	2013
Medicaid	48.0%	48.4%	47.4%	60.6%	61.4%	61.4%	71.9%	72.0%	72.5%	2011	2012	2013
Other	11.8%	11.5%	12.4%	18.0%	18.1%	17.9%	29.0%	27.4%	29.0%	2011	2012	2013
Avg. Length of Stay Statistics (Days)												
Medicare	30.34	30.18	30.93	36.83	36.71	37.94	45.50	47.36	47.30	2011	2012	2013
Medicaid	223.41	241.22	231.40	309.88	320.22	309.71	484.71	485.78	464.30	2011	2012	2013
Other	38.56	38.23	38.15	62.64	65.05	64.25	127.03	120.09	135.74	2011	2012	2013
Revenue (PPD)												
Inpatient	\$214.75	\$215.29	\$220.64	\$238.97	\$235.20	\$239.18	\$275.61	\$266.48	\$276.34	2011	2012	2013
Ancillary	\$55.31	\$57.59	\$56.60	\$77.40	\$83.61	\$85.12	\$107.28	\$115.89	\$123.70	2011	2012	2013
TOTAL	\$283.18	\$286.30	\$290.89	\$328.46	\$326.80	\$335.14	\$385.62	\$382.41	\$398.96	2011	2012	2013
Expenses (PPD)												
Employee Benefits	\$15.08	\$13.56	\$12.73	\$19.59	\$17.91	\$18.40	\$28.72	\$28.46	\$27.52	2011	2012	2013
Administrative and General	\$44.43	\$46.27	\$48.62	\$52.08	\$54.43	\$56.38	\$61.71	\$61.18	\$65.49	2011	2012	2013
Plant Operations	\$9.43	\$9.36	\$9.12	\$10.81	\$10.95	\$10.71	\$13.64	\$13.76	\$13.19	2011	2012	2013
Laundry & Linens	\$1.93	\$1.99	\$1.76	\$2.57	\$2.68	\$2.56	\$3.21	\$3.30	\$3.20	2011	2012	2013
Housekeeping	\$4.81	\$4.66	\$5.05	\$5.86	\$5.74	\$6.17	\$7.20	\$7.31	\$7.57	2011	2012	2013
Dietary	\$14.53	\$14.35	\$14.51	\$16.84	\$16.52	\$16.61	\$20.32	\$20.56	\$20.26	2011	2012	2013
Nursing & Medical Related	\$82.54	\$80.62	\$79.45	\$89.45	\$89.27	\$89.99	\$99.93	\$100.68	\$101.90	2011	2012	2013
Ancillary and Pharmacy	\$27.32	\$27.27	\$26.11	\$37.61	\$36.77	\$36.49	\$50.50	\$51.34	\$50.11	2011	2012	2013
Social Services	\$2.72	\$2.96	\$2.73	\$4.15	\$4.55	\$4.51	\$6.23	\$6.33	\$6.38	2011	2012	2013

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*	369
Licensed Nursing Beds*	39,546
Beds per 1,000 Aged 65 >**	31.31
Beds per 1,000 Aged 75 >**	81.60
Occupancy Percentage - 2013***	85.45%

*Source: Georgia Division of Health Planning

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$2,650,282.
- Purchasing or leasing major medical equipment that exceeds the threshold amount for equipment acquisition of \$1,126,874.
- 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, 2013, 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 Rebasing 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.

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. The state recently rebased rates on February 1, 2012, and July 1, 2012, utilizing fiscal year 2009 and 2010 cost report data, respectively. Prior to this rebasing, given budgetary issues, Georgia has not rebased nursing facility Medicaid rates since July 1, 2007. Fiscal year 2008 per diem rates were based on cost report data for the fiscal year ending June 30, 2006. In addition, standards effective July 1, 2009 and 2010 were not recalculated based on changes in rates due to subsequent determination of additional allowable cost, disallowable or previously allowable cost, or any change in the net per diem in any cost center.

In recent years, Georgia has inflated Medicaid per diem rates forward using a growth allowance. The current growth allowance associated with the allowed per diem for each of the four non-property and related cost centers is 1.19% for rates established for July 1, 2010, through June 30, 2011. This was also the growth allowance that was used for the previous two fiscal years. The growth allowance is associated with the cost report data and determined based on appropriations from the state as determined in the annual budget. No growth allowance was applied to fiscal year 2012 rates.

Georgia also adjusts nursing facility Medicaid rates quarterly for case mix utilizing the RUG III, 34 grouper system. The RUG III system utilizes the MDS 2.0 assessment tool when assessing residents for acuity. Further details of how the state adjusts rates for case mix are included in the Rate Methodology section. Per CMS guidelines, nursing facilities are now required to utilize the MDS 3.0 assessment tool. This assessment tool only correlates to the RUG IV system. Due to anomalies in the RUG scores from converting data from MDS 2.0 to 3.0, the state did not issue case mix adjusted rates for the period of April 1, 2011, to June 30, 2011.

However the state has since rectified this problem and has been adjusting Medicaid rates for case mix as scheduled by state regulations. Prior to adjusting the Routine and Support Services cost component rate by the facility-specific Medicaid CMI, the facility-specific Medicaid CMI is adjusted to reflect that the base period CMI scores are derived using MDS 2.0 and RUG III grouper while the quarterly CMI scores are determined using the MDS 3.0 and the RUG IV grouper. Because the CMI weights under the two groupers are not the same, the CMIs that were determined utilizing RUGs IV are adjusted to correlate to quarterly CMI scores determined using RUG III. This adjustment will no longer be required the next time the state rebases since the updated cost report data will be fore periods after the implementation of RUG IV/MDS 3.0.

Until February 1, 2012, Medicaid rates were effectively frozen since January 1, 2011. Although rates were rebased on February 1, 2012, and July 1, 2012, no growth allowance/inflation adjustment was utilized for the calculation of these rates. Rates were not rebased or inflated on July 1, 2013, which essentially freezes rates at July 1, 2012, levels. However, these rates will still be adjusted for case mix.

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. Standards effective July 1, 2009 and 2010 were not recalculated based on rate changes due to additional allowable costs or disallowances of previously allowable costs in any cost center. 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, and July 1, 2012.

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. Since current Medicaid rates are based on 2006 cost report data, the base year CMI was determined using the MDS 2.0 assessment tool. Given this factor, the state has adjusted the base year CMIs to correlate to current CMI data derived from the MDS 3.0 assessment tool. 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. Property reimbursement under the FRV system will replace the previous methodology over a three-year period. For fiscal years 2010 through 2012, the FRV rate was to be held harmless to a nursing facility's Property and Related cost component rate effective June 30, 2009. The rate effective July 1, 2010, could not exceed the June 30, 2010, rate by more than 250%. Effective July 1, 2012, the FRV system completely replaced rates determined utilizing the Dodge Index.

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.
- 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, 2010, was \$144.66. The average rate was not available for rates effective July 1, 2011, but the average rate effective July 1, 2012, was \$157.22.

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.

Nursing facilities are reimbursed on a full-time equal basis, up to \$738 for each individual who has completed a state-approved training and competency program for nurse aides. At the facility's request, interim payments of \$0.25 per Medicaid patient day will be made quarterly to the facility to cover the cost of providing nurse aide testing and training.

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

According to rate setting officials, the state is considering significant changes to the rate calculation methodology. This includes converting to the RUG IV system for the adjustment of rates for case mix and developing a new quality of care incentive program. No formal plans for changes to the methodology have been determined and the likelihood of any changes to the methodology is currently unclear.

GEORGIA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	78.00	78.00	78.25	100.00	100.00	100.00	135.50	130.00	133.75			
Average Daily Census	69.89	69.59	70.55	92.89	91.77	92.38	122.04	116.01	118.32			
Occupancy	83.5%	84.6%	84.3%	89.8%	89.4%	89.9%	93.7%	93.3%	93.3%			
Payor Mix Statistics												
Medicare	6.8%	6.8%	6.3%	9.8%	9.7%	9.7%	15.0%	14.6%	14.0%			
Medicaid	64.2%	65.8%	65.2%	73.5%	74.1%	74.4%	78.6%	79.4%	80.1%			
Other	14.8%	15.0%	13.9%	27.0%	33.7%	28.4%	90.4%	91.1%	90.2%			
Avg. Length of Stay Statistics (Days)												
Medicare	33.31	32.12	31.63	44.10	43.50	41.84	64.92	63.05	60.89			
Medicaid	335.33	310.08	318.42	485.68	490.39	520.85	810.94	723.01	764.40			
Other	86.23	88.14	100.97	173.35	163.29	183.98	390.85	295.36	306.80			
Revenue (PPD)												
Inpatient	\$151.51	\$163.20	\$165.13	\$177.27	\$186.34	\$185.97	\$204.94	\$212.16	\$209.42			
Ancillary	\$23.37	\$23.91	\$26.18	\$35.51	\$35.29	\$37.53	\$55.93	\$60.11	\$61.90			
TOTAL	\$184.86	\$192.46	\$198.67	\$215.77	\$228.85	\$224.44	\$255.87	\$269.04	\$258.74			
Expenses (PPD)												
Employee Benefits	\$10.84	\$11.40	\$12.24	\$14.14	\$14.95	\$14.93	\$17.74	\$17.99	\$18.22			
Administrative and General	\$29.77	\$33.54	\$33.65	\$34.46	\$38.67	\$39.08	\$39.55	\$43.88	\$45.19			
Plant Operations	\$7.58	\$7.73	\$7.78	\$8.77	\$8.86	\$9.10	\$10.53	\$10.62	\$10.74			
Laundry & Linens	\$2.04	\$2.09	\$2.02	\$2.53	\$2.61	\$2.62	\$3.18	\$3.17	\$3.25			
Housekeeping	\$4.56	\$4.62	\$4.67	\$5.73	\$5.76	\$5.77	\$7.16	\$7.19	\$7.31			
Dietary	\$13.49	\$13.52	\$13.79	\$14.70	\$14.74	\$15.13	\$16.33	\$16.45	\$17.02			
Nursing & Medical Related	\$56.07	\$58.08	\$58.88	\$65.11	\$66.94	\$69.31	\$76.08	\$77.80	\$80.64			
Ancillary and Pharmacy	\$14.61	\$14.38	\$14.52	\$19.53	\$20.04	\$21.03	\$29.43	\$29.47	\$29.44			
Social Services	\$2.22	\$1.81	\$1.96	\$3.16	\$3.00	\$2.98	\$3.89	\$4.08	\$4.21			

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*	50
Licensed Nursing Beds*	4,060
Beds per 1,000 Aged 65 >**	17.75
Beds per 1,000 Aged 75 >**	40.03
Occupancy Percentage - 2013***	80.79%

*Source: Hawaii Center on Disability Studies

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 patient days from total Medicaid patient days 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, HMAA, 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. In past years 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 or inflation of costs since July 1, 2013. 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.

According to representatives of the Healthcare Association of Hawaii, their member facilities have communicated that their rates remained relatively flat in recent years. 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.

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, it 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 managed care plans have not provided any significant details on how they are determining nursing facility rates, 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-payer 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-payer 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 (4.0%). 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 0.72%.

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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	43.50	63.75	78.00	95.00	93.50	94.00	120.00	117.50	120.00			
Average Daily Census	80.97	74.82	74.95	98.66	93.66	92.42	126.92	111.87	124.22			
Occupancy	89.5%	88.2%	89.5%	91.8%	91.7%	92.0%	94.9%	93.8%	94.7%			
Payor Mix Statistics												
Medicare	3.5%	3.8%	2.8%	7.6%	7.0%	5.9%	10.8%	10.2%	10.2%			
Medicaid	44.5%	53.5%	52.0%	59.3%	68.9%	67.0%	76.0%	73.6%	76.6%			
Other	16.6%	17.2%	17.9%	33.2%	25.2%	29.2%	55.5%	38.9%	44.4%			
Avg. Length of Stay Statistics (Days)												
Medicare	32.07	31.84	31.03	37.88	44.43	43.55	52.54	56.20	56.71			
Medicaid	399.09	356.79	361.66	543.31	441.40	487.08	757.58	605.59	686.89			
Other	70.17	65.50	55.56	125.46	118.28	87.63	207.25	259.87	145.41			
Revenue (PPD)												
Inpatient	\$280.95	\$307.42	\$296.93	\$321.46	\$335.80	\$326.36	\$346.41	\$370.35	\$373.77			
Ancillary	\$25.08	\$21.87	\$25.37	\$75.01	\$65.20	\$54.98	\$96.92	\$84.42	\$77.60			
TOTAL	\$314.83	\$336.89	\$322.71	\$393.02	\$401.42	\$397.92	\$453.45	\$444.43	\$448.73			
Expenses (PPD)												
Employee Benefits	\$26.94	\$27.51	\$30.83	\$34.72	\$33.25	\$34.80	\$52.53	\$42.60	\$42.80			
Administrative and General	\$43.06	\$50.05	\$55.95	\$50.48	\$62.70	\$69.60	\$63.89	\$73.57	\$75.01			
Plant Operations	\$13.96	\$13.95	\$14.80	\$17.28	\$17.02	\$17.22	\$21.18	\$19.92	\$20.26			
Laundry & Linens	\$2.94	\$2.86	\$3.10	\$3.76	\$3.69	\$3.61	\$5.45	\$6.40	\$5.72			
Housekeeping	\$5.06	\$5.76	\$6.16	\$6.50	\$7.54	\$7.65	\$8.52	\$8.87	\$8.90			
Dietary	\$19.95	\$20.03	\$21.01	\$21.83	\$23.00	\$23.46	\$25.15	\$28.02	\$26.65			
Nursing & Medical Related	\$85.15	\$88.89	\$95.10	\$103.82	\$104.51	\$108.81	\$112.12	\$110.16	\$121.42			
Ancillary and Pharmacy	\$16.45	\$12.91	\$13.90	\$29.15	\$32.36	\$28.75	\$38.69	\$43.46	\$43.49			
Social Services	\$2.06	\$2.02	\$2.21	\$3.12	\$2.84	\$2.79	\$3.47	\$3.66	\$3.47			

Comments: The above data may be moderately skewed, given that the average sample size over the three-year period is approximately 20 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*	79
Licensed Nursing Beds*	5,977
Beds per 1,000 Aged 65 >**	25.81
Beds per 1,000 Aged 75 >**	63.83
Occupancy Percentage - 2013***	67.70%

*Source: Idaho Department of Health and Welfare

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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.

This supplemental payment substantially offsets the state's rate reduction in fiscal year 2012 and in subsequent years. For fiscal year 2012, the state has allocated \$42 million in supplemental Medicaid payments funded as a result of the QAF. For fiscal years 2013 and 2014, this amount increased to \$57 million and \$66.5 million, respectively. In fiscal year 2015 this amount decreased slightly to \$64.7 million. According to state rate setting professionals, this amount of funding did not significantly change in fiscal year 2016. Based on data provided by the state rate setting consultant (Myers and Stauffer), the most current average per diem reimbursement for the supplemental payment is \$76.91 for privately owned nursing facilities.

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, 2009, to December 31, 2009, was used to calculate Medicaid rates effective July 1, 2010. However,

rates were not rebased again until October 1, 2012.

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.

As previously mentioned, 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%. The cost limit for 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 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 (1.149554% for the current year) 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.

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. The system is operated by Blue Cross Blue Shield of Idaho (BCBS of Idaho) and currently includes 33 of the state's 44 counties. The program will be expanded to 42 counties on January 1, 2016. Given the rural nature of the remaining counties (Franklin and Lemhi counties), it is unclear if this program will be established within these areas.

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. The overall impact of this program on nursing facility reimbursement is still yet to be determined.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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

Idaho

IDAHO COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	60.00	60.00	58.00	80.00	77.00	74.00	116.00	117.00	114.50			
Average Daily Census	46.37	45.12	45.19	64.55	67.94	61.78	83.31	83.16	82.57			
Occupancy	65.7%	67.0%	66.7%	75.9%	74.3%	75.0%	81.3%	82.8%	82.7%			
Payor Mix Statistics												
Medicare	7.3%	6.8%	7.3%	12.5%	12.1%	11.4%	17.3%	19.7%	18.4%			
Medicaid	49.4%	53.3%	51.1%	60.7%	60.9%	61.7%	71.9%	68.8%	69.8%			
Other	17.6%	17.5%	18.4%	22.2%	23.8%	23.2%	34.6%	30.9%	34.2%			
Avg. Length of Stay Statistics (Days)												
Medicare	32.19	28.99	28.50	37.33	34.02	33.74	44.49	39.55	42.02			
Medicaid	276.86	285.86	251.69	345.37	350.30	341.43	450.46	478.21	446.40			
Other	50.02	54.87	55.45	78.33	82.30	89.13	144.19	142.14	160.69			
Revenue (PPD)												
Inpatient	\$193.87	\$202.37	\$206.52	\$211.78	\$232.91	\$243.86	\$240.56	\$267.96	\$287.98			
Ancillary	\$34.37	\$38.47	\$33.62	\$56.18	\$67.36	\$57.97	\$86.53	\$95.40	\$88.29			
TOTAL	\$241.02	\$264.14	\$268.15	\$287.32	\$316.21	\$332.88	\$326.25	\$353.28	\$365.97			
Expenses (PPD)												
Employee Benefits	\$18.64	\$17.09	\$20.64	\$27.93	\$25.50	\$24.36	\$35.03	\$33.39	\$31.07			
Administrative and General	\$39.37	\$47.87	\$48.14	\$53.55	\$57.39	\$57.59	\$62.42	\$64.97	\$68.97			
Plant Operations	\$7.69	\$7.76	\$8.37	\$9.27	\$9.22	\$10.53	\$11.87	\$11.95	\$12.64			
Laundry & Linens	\$2.05	\$2.14	\$2.04	\$2.59	\$2.88	\$2.89	\$3.14	\$3.53	\$3.88			
Housekeeping	\$4.19	\$4.04	\$4.11	\$4.86	\$4.74	\$5.00	\$5.75	\$5.60	\$6.13			
Dietary	\$15.12	\$15.39	\$15.65	\$16.73	\$17.22	\$17.25	\$18.20	\$19.42	\$19.93			
Nursing & Medical Related	\$66.54	\$67.62	\$68.14	\$80.35	\$88.03	\$84.70	\$90.70	\$99.16	\$99.46			
Ancillary and Pharmacy	\$18.30	\$19.33	\$20.99	\$28.38	\$30.61	\$29.89	\$41.57	\$41.78	\$42.78			
Social Services	\$1.88	\$1.95	\$2.45	\$2.39	\$2.54	\$2.95	\$3.17	\$3.66	\$4.08			

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 (OHCRR) 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*	787
Licensed Nursing Beds*	102,383
Beds per 1,000 Aged 65 >**	56.47
Beds per 1,000 Aged 75 >**	130.92
Occupancy Percentage - 2013***	76.27%

*Source: Illinois Health Facilities and Services Review Board

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$7,161,646.
- Any substantial change in a nursing facility's bed capacity.
- 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 \$7,161,646.

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, 2014.

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 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. Projected bed need is calculated for 2015 utilizing population data derived from the 2010 census. The following table summarizes the most recent bed need data:

LONG-TERM CARE BED INVENTORY UPDATES 2015			
Planning Area	Calculated Bed Need 2015	Existing Beds	Additional Beds Needed or (Excess Beds) in 2015
HSA 1	5,445	6,072	-627
HSA 2	7,251	7,905	-654
HSA 3	6,355	7,099	-744
HSA 4	7,012	8,230	-1,218
HSA 5	6,292	7,279	-987
HSA 6	14,686	16,163	-1,477
HSA 7	26,779	28,230	-1,451
HSA 8	8,103	8,764	-661
HSA 9	4,325	4,658	-333
HSA 10	1,799	2,014	-215
HSA 11	4,673	5,089	-416
Totals	92,720	101,503	-8,783

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. Prior to January 1, 2007, the state utilized an annual inspection of care and patient assessment to establish Nursing and Direct Care cost component rates. 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 will be 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 January 1, 2015.

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. Two of the state's three rate components were partially rebased. The Nursing and Direct Care cost component rate was derived from two factors: established regional per-minute wage rates and statewide standard minutes of service for care professionals. For rates effective January 1, 2009, the state inflated allowable support costs derived from either 2003 or 2004 cost reports to January 1, 2006.

In August 2009, the governor approved House Bill 415, which dictated a quarterly recalculation of the statewide standard minutes of service for care professionals based on quarterly updated MDS data. Due to this new legislation, July 1, 2009, rates were based on MDS data as of March 31, 2009, and the state has updated these standards quarterly since that date. However, the regional wage rates were not inflated since 2001.

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 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). According to rate setting officials, these rates will remain frozen on January 1, 2015. Support cost component rates were frozen from July 1, 2012, to June 30, 2014. However, these rates were increased 8.17% effective July 1, 2014. Rate setting officials indicated that Support cost component rates will not change on January 1, 2015.

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 is projected to calculate rates on 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 unchanged since July 1, 2001. In addition, Capital cost component rates effective through the transition period equate to rates effective July 1, 2012, when the state last reduced Capital cost component rates. According to state rate setting officials, Capital cost components will remain unchanged effective January 1, 2015.

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), 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 effective January 1, 2015. 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, or patient need, 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 will be 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

Illinois

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 has indicated that it will inflate this per diem rate to \$85.25 effective January 1, 2015.

During the transition period (January 1, 2014, to December 31, 2014), a nursing facility's Nursing and Direct Care cost component rates are 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.

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.

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.

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

With the exception of the above mentioned changes on January 1, 2015, there are no planned or proposed changes to the state rate calculation methodology.

Illinois

ILLINOIS COST REPORT STATISTICS											
	Lower Quartile Values			Median Values			Upper Quartile Values				
	2011	2012	2013	2011	2012	2013	2011	2012	2013		
General Statistics											
Number of Beds	54.00	56.00	58.00	94.50	98.00	99.00	148.00	145.00	145.00		
Average Daily Census	69.19	68.89	67.13	94.73	94.04	91.72	135.46	134.81	131.27		
Occupancy	70.6%	71.1%	69.8%	81.7%	80.6%	79.6%	89.0%	88.6%	86.8%		
Payor Mix Statistics											
Medicare	8.6%	8.4%	8.1%	12.3%	12.0%	12.2%	18.9%	19.2%	18.5%		
Medicaid	41.2%	41.3%	39.2%	58.7%	58.1%	57.1%	76.0%	72.9%	73.0%		
Other	15.0%	16.0%	16.6%	29.8%	29.9%	30.8%	54.2%	47.8%	50.6%		
Avg. Length of Stay Statistics (Days)											
Medicare	34.82	35.13	34.90	42.10	44.21	43.77	54.09	58.26	58.58		
Medicaid	159.19	162.54	150.14	271.57	263.23	265.79	457.79	446.55	433.23		
Other	100.60	97.72	92.94	196.04	177.10	171.63	355.00	326.18	323.22		
Revenue (PPD)											
Inpatient	\$139.06	\$151.14	\$153.11	\$168.03	\$175.22	\$185.10	\$218.80	\$221.95	\$232.13		
Ancillary	\$20.69	\$19.90	\$23.00	\$41.57	\$40.78	\$44.66	\$71.05	\$75.91	\$78.21		
TOTAL	\$166.18	\$176.59	\$179.73	\$207.37	\$212.17	\$223.68	\$274.41	\$281.35	\$294.07		
Expenses (PPD)											
Employee Benefits	\$11.17	\$11.67	\$11.99	\$14.91	\$15.27	\$15.65	\$20.88	\$21.29	\$21.66		
Administrative and General	\$23.98	\$29.65	\$29.78	\$31.92	\$36.69	\$37.23	\$42.86	\$46.72	\$46.29		
Plant Operations	\$7.38	\$6.94	\$7.32	\$8.82	\$8.51	\$8.90	\$11.47	\$10.79	\$11.57		
Laundry & Linens	\$1.72	\$1.71	\$1.72	\$2.26	\$2.27	\$2.34	\$2.96	\$2.99	\$3.08		
Housekeeping	\$4.24	\$4.20	\$4.37	\$4.94	\$5.07	\$5.19	\$6.28	\$6.12	\$6.32		
Dietary	\$12.35	\$12.53	\$13.01	\$14.65	\$14.77	\$15.25	\$17.57	\$17.79	\$18.66		
Nursing & Medical Related	\$50.55	\$52.10	\$54.24	\$60.50	\$61.24	\$63.30	\$76.27	\$76.80	\$78.83		
Ancillary and Pharmacy	\$15.36	\$15.23	\$15.74	\$22.67	\$23.56	\$24.74	\$34.15	\$34.78	\$36.17		
Social Services	\$3.06	\$3.09	\$3.45	\$4.58	\$4.58	\$5.04	\$7.13	\$6.69	\$7.25		

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*	541
Licensed Nursing Beds*	52,594
Beds per 1,000 Aged 65 >**	54.76
Beds per 1,000 Aged 75 >**	128.90
Occupancy Percentage - 2013***	76.56%

*Source: Indiana State Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

CERTIFICATE OF NEED

Indiana does 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 the moratorium conditions in 2011 and extended it to July 1, 2016. Specifically, the state cannot approve the certification or conversion of nursing facility beds for participation in the Medicaid program unless the statewide nursing facility occupancy percentage is greater than 95%. 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. Nursing facility beds for which construction began after June 30, 2011, may not be certified for participation with the Medicaid program before July 1, 2016.

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.

The Indiana legislature is currently in the process of considering legislation that would extend the overall moratorium. However, the likelihood of this occurring is currently unknown.

BED NEED METHODOLOGY

Indiana has not utilized a bed need methodology since 2004.

QUALITY ASSESSMENT FEE

The quality assessment fee (QAF) in Indiana was recently extended through June 30, 2017. Effective October 1, 2012, the current QAF is \$16.00 per non-Medicare patient day (with fewer than 70,000 patient days) or \$4.00 (with 70,000 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 6.0% of total revenue, which is the maximum allowable QAF by the Centers for Medicare and Medicaid (CMS).

The previous 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 were applied to partially offset the implementation of a 5.0% total Medicaid rate reduction effective July 1, 2011. It is currently unclear if the state will alter the QAFs in fiscal year 2015 (effective July 1, 2014).

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.

In the past, including the current rate year, a nursing facility's rate year began on the first day of the second calendar quarter after the facility's fiscal year end. However, all nursing facilities in the state were converted to a July 1 to June 30 rate year effective July 1, 2008.

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. October 1, 2013, rates represent the last rates that have been issued by the state. This reflects that the state is currently waiting for the Centers for Medicare and Medicaid (CMS) to approve a State Plan Amendment that would reduce the rate reduction from 5% to 3% effective January 1, 2014. This change would also be incorporated into fiscal year 2015 rates (effective July 1, 2014), which will also be rebased rates.

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.

Indiana utilizes the Resource Utilization Group (RUG) III system to adjust facility-specific Direct Care cost component rates quarterly for changes in CMI for the facility's Medicaid residents. The state utilizes 37 RUG categories, including RUG classifications for unclassifiable residents and delinquent residents. 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 April 1, 2012, is \$64.81.

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 October 1, 2013, is \$38.38. 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 are 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 statewide Administrative cost component rate effective October 1, 2013, is \$19.19.

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 for nursing facilities as of October 1, 2013, is \$0.63.

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 October 1, 2013, is \$106,444. After then 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 October 1, 2013, is 5.044%.

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 October 1, 2013, is \$15.62.

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 care score is determined based on the latest published data available as of the end of each state fiscal year, and the Nursing Home Report Card add-on is determined as follows:

- Nursing home report card score < 82 = \$14.30 per diem add-on.
- Nursing home report card score with 83 – 265 = the per diem add-on equates to $\$14.30 - [(nursing\ home\ report\ care\ score - 82) \times \$0.0777]$.
- Nursing home report care score > 266 = no add-on.

Facilities lacking a report card score published as of the recently completed state fiscal year may receive an add-on equal to \$2.00.

Effective October 1, 2011, the maximum allowable Quality of Care add-on increased from \$5.75 to \$14.30, and the multiplication factor increased from \$0.03125 to \$0.0777. Each facility with

Indiana

acceptable report card scores will receive a proportion of this new maximum amount based on its score.

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 - Nursing Facility Total Quality Score) x 0.216667)
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 Scores	
Report Card Score	Quality Points Awarded
0 - 82	75
83 - 265	Proportional quality points awarded as follows: 75 - ((facility report card score - 82) x 0.407609))
266 and above	0

Effective October 1, 2013, the median Nursing Facility Quality add-on in the state was \$9.10.

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.

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.

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 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 73.05% in fiscal year 2014. 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 2013 (July 1, 2012, to June 30, 2013) there were an estimated 267 nursing homes in Indiana that participated in the program.

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 2013, the average UPL payment to county hospitals was \$106.52 per Medicaid day, with an average annual payment of \$1,743,838. 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 \$586,186 per facility.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

Indiana is currently considering converting from the RUG III system to the RUG IV system for the purpose of adjusting Direct Care cost component rates for acuity. The state is also proposing to eliminate the SCU add-on, since it anticipates that converting to the RUG IV system will result in higher expenditures. As of the date of this overview, the likelihood of these changes occurring is unclear. However, representatives of Leading Age Indiana indicated that they do not anticipate that these changes will be considered until fiscal year 2016.

Indiana

INDIANA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	67.00	66.50	70.00	97.00	93.00	96.00	126.00	121.00	124.75			
Average Daily Census	63.91	60.05	60.38	83.19	81.59	82.42	113.67	109.29	108.07			
Occupancy	73.9%	72.1%	70.9%	82.1%	80.6%	78.9%	89.0%	87.7%	86.4%			
Payor Mix Statistics												
Medicare	9.5%	9.6%	9.4%	12.7%	12.7%	12.8%	18.2%	18.0%	17.9%			
Medicaid	54.1%	54.8%	30.6%	63.4%	64.9%	60.9%	70.0%	71.6%	69.4%			
Other	25.2%	21.0%	24.5%	80.8%	70.7%	75.2%	87.8%	86.6%	88.1%			
Avg. Length of Stay Statistics (Days)												
Medicare	39.51	36.66	36.73	46.51	44.80	45.84	59.73	58.65	61.24			
Medicaid	279.37	341.74	302.35	460.91	515.61	552.06	726.35	752.80	904.65			
Other	145.39	133.50	127.39	253.38	224.45	207.44	450.22	408.49	339.66			
Revenue (PPD)												
Inpatient	\$163.99	\$179.62	\$197.85	\$193.34	\$207.89	\$228.18	\$217.34	\$237.34	\$259.44			
Ancillary	\$40.08	\$45.16	\$46.70	\$58.89	\$61.87	\$67.44	\$81.03	\$82.65	\$93.17			
TOTAL	\$215.57	\$233.99	\$261.19	\$254.74	\$272.72	\$299.77	\$288.02	\$317.81	\$341.95			
Expenses (PPD)												
Employee Benefits	\$14.08	\$14.22	\$14.21	\$19.09	\$19.88	\$19.44	\$23.04	\$22.66	\$22.43			
Administrative and General	\$22.28	\$22.48	\$28.15	\$28.70	\$34.13	\$35.01	\$38.83	\$43.81	\$44.94			
Plant Operations	\$8.22	\$8.24	\$8.93	\$9.64	\$9.65	\$10.40	\$11.64	\$11.60	\$12.53			
Laundry & Linens	\$2.00	\$2.06	\$1.77	\$2.50	\$2.52	\$2.46	\$3.06	\$3.04	\$3.05			
Housekeeping	\$3.70	\$3.52	\$3.60	\$4.42	\$4.39	\$4.49	\$5.67	\$5.66	\$5.54			
Dietary	\$13.08	\$12.95	\$13.44	\$14.85	\$14.44	\$14.80	\$17.43	\$16.78	\$17.39			
Nursing & Medical Related	\$59.59	\$60.90	\$63.98	\$66.79	\$67.32	\$69.81	\$75.16	\$73.77	\$76.96			
Ancillary and Pharmacy	\$21.22	\$23.00	\$24.88	\$29.84	\$30.68	\$31.87	\$39.72	\$39.31	\$40.30			
Social Services	\$1.97	\$2.17	\$2.38	\$3.65	\$3.78	\$3.82	\$5.92	\$6.16	\$6.45			

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*	442
Licensed Nursing Beds*	31,167
Beds per 1,000 Aged 65 >**	62.00
Beds per 1,000 Aged 75 >**	133.25
Occupancy Percentage - 2013***	80.78%

*Source: Iowa Department of Inspections and Appeals

**Source: The Nielsen Company - 2015 Population

***Source: 2012 Medicare Cost Reports

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 February 2016, projects unmet demand in 2021 for long-term care beds in 65 counties and a total unmet demand for 6,983 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 \$1.38 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.

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. Cost report data from 2008 was used to calculate the Medicaid rates for fiscal years 2010 and 2011. The state rebased rates for fiscal year 2012, effective July 1, 2011, utilizing 2010 cost report data. This data was also utilized to determine fiscal year 2013 rates.

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%.

The state is currently in the process of issuing fiscal year 2016 rates (effective July 1, 2015). The majority of facilities have received their new rates; however, a limited percentage of facilities are still in the process of having their cost report data audited. 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.

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 replacements was reduced from \$1.6 million to \$200,000 to be used for payment effective July 1, 2007, through the time at which the funding is expended. This funding was expended by November 1, 2009, and all additional payments were suspended until additional funding is available. In fiscal year 2012, \$285,000 was allocated for these add-ons (to be carried over until exhausted) and an additional \$250,000 was allocated for fiscal year 2013 (also with carryover provisions). The state allocated \$150,000 for these add-ons in fiscal year 2014 and \$500,000 to be used in fiscal year 2015.

Effective July 1, 2002, nursing facilities have been eligible to receive additional reimbursements based upon 12 accountability measures. This additional reimbursement program is known as the state's nursing facility Accountability Measures Program. The state has approved legislation to alter this program. Upon implementing these changes, the state will refer to this additional reimbursement as the nursing facility Pay for Performance Program. The new nursing facility Accountability Measures Program implements a system of prerequisites that facilities must meet in order to be considered for the add-on payment. The program is based on a 100-point system. Points are measured (awarded) around four domains, which are indicators of:

- Quality of care (59 possible points);
- Quality of life (25 possible points);
- Access for certain resident populations (eight possible points); and
- Efficiency (eight possible points).

Nursing facilities will receive a retroactive per patient day add-on payment based on the number of points achieved. To be eligible for this add-on, nursing facilities must achieve a score of at least 51 points. For any score of 51 or greater, a nursing facility will receive an add-on that equates to a percentage of the combined statewide medians for the Direct Care and Non-Direct Care components as follows:

Score	% Add-On	Estimated Add-On (Per Day)
0-50	0%	\$0.00
51-60	1%	\$1.25
61-70	2%	\$2.50
71-80	3%	\$3.75
81-90	4%	\$5.00
91-100	5%	\$6.25

The state plan amendment also recommended that any performance-based payments be used to support Direct Care staff through increased wages, enhanced benefits and expanded training opportunities.

The calculation of any add-on will be determined utilizing the most current cost report data. Given budget limitations, the state suspended Pay for Performance Program payments for fiscal years 2010 through 2014. In addition, it is currently unclear if this program will be funded in the future.

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.

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

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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. Previously, payment for bed hold days was reimbursed at 42% of the nursing facility's rate. Nursing facilities were paid to hold the bed for a period not to exceed 10 days in any calendar month and not to exceed 18 days in a calendar year.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

Effective April 1, 2016, Iowa will convert to Medicaid Managed Care Reimbursement System known as the Iowa Health Link Program. Under this program, nursing facilities will be guaranteed their fee-for-service rates (calculated utilizing the above described system) for two years. After this period, the managed care organizations will have the authority to negotiate rates with the nursing facilities.

IOWA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	50.00	49.00	49.00	64.00	62.00	63.50	87.00	85.25	86.25			
Average Daily Census	39.80	39.06	38.79	55.86	53.31	53.44	74.33	71.62	71.64			
Occupancy	74.1%	72.8%	72.3%	82.8%	81.3%	81.1%	90.0%	89.9%	89.5%			
Payor Mix Statistics												
Medicare	3.8%	3.7%	3.9%	5.8%	5.7%	5.9%	8.2%	8.2%	8.6%			
Medicaid	35.1%	36.4%	36.0%	44.9%	47.5%	46.8%	55.6%	56.8%	58.6%			
Other	39.3%	36.0%	33.0%	51.4%	45.9%	47.0%	63.5%	58.4%	58.6%			
Avg. Length of Stay Statistics (Days)												
Medicare	27.19	28.24	28.59	39.78	39.25	38.78	54.88	55.16	52.49			
Medicaid	381.25	373.24	387.31	548.13	528.63	577.32	803.20	836.33	922.01			
Other	167.43	148.59	149.21	259.12	260.44	233.81	416.90	420.60	385.53			
Revenue (PPD)												
Inpatient	\$144.41	\$149.04	\$154.98	\$159.07	\$164.20	\$170.60	\$178.19	\$184.49	\$190.11			
Ancillary	\$11.43	\$11.21	\$13.95	\$19.33	\$19.46	\$23.43	\$28.97	\$32.55	\$34.66			
TOTAL	\$157.33	\$162.76	\$171.07	\$180.45	\$184.21	\$193.50	\$205.40	\$215.05	\$223.81			
Expenses (PPD)												
Employee Benefits	\$7.08	\$6.98	\$7.03	\$12.33	\$11.76	\$11.72	\$16.74	\$16.41	\$16.32			
Administrative and General	\$17.98	\$18.23	\$18.73	\$23.30	\$24.35	\$26.11	\$28.92	\$29.91	\$31.44			
Plant Operations	\$8.18	\$7.98	\$8.29	\$9.79	\$9.66	\$9.80	\$11.76	\$11.44	\$11.89			
Laundry & Linens	\$2.03	\$2.12	\$2.09	\$2.67	\$2.74	\$2.79	\$3.32	\$3.40	\$3.53			
Housekeeping	\$3.72	\$3.60	\$3.79	\$4.50	\$4.57	\$4.71	\$5.36	\$5.65	\$5.67			
Dietary	\$15.30	\$15.51	\$15.55	\$17.47	\$17.84	\$17.97	\$20.12	\$20.24	\$21.20			
Nursing & Medical Related	\$60.86	\$62.94	\$64.48	\$68.65	\$69.54	\$72.24	\$77.75	\$81.15	\$84.04			
Ancillary and Pharmacy	\$6.78	\$7.07	\$8.00	\$10.21	\$10.86	\$11.36	\$14.82	\$16.04	\$17.38			
Social Services	\$1.00	\$1.01	\$0.98	\$1.70	\$1.72	\$1.73	\$2.85	\$3.13	\$2.87			

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*	345
Licensed Nursing Beds*	24,253
Beds per 1,000 Aged 65 >**	57.49
Beds per 1,000 Aged 75 >**	128.10
Occupancy Percentage - 2013***	82.34%

*Source: Kansas Department on Aging

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$1,950. Effective July 1, 2013, the NFPA is currently \$325 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. The remaining facilities in the state are assessed a fee of \$1,950 per licensed bed. Prior to July 1, 2013, these rates were \$250 and \$1,500, respectively.

Effective July 1, 2013, Kansas began reimbursing 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 2015) inpatient days utilized to determine reimbursement of the NFPA will be derived from 2013 cost reports. The state's minimum occupancy requirement is not applied to this calculation. Prior to this change, nursing facilities will be reimbursed for the Medicaid share of their NFPA fees quarterly and not as part of the Medicaid rate.

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.

In fiscal year 2009, the state implemented a change as to how the state rebases nursing facility rates. This change was approved as part of House Bill No. 2144. Based on the requirements of House Bill No. 2144, Medicaid rates now utilize average data derived from the three most recent cost reports. Cost report data for 2005, 2006 and 2007 was used to calculate Medicaid rates effective July 1, 2008. During the 2009 session, legislation was passed that suspended the provisions of House Bill 2144 for fiscal year

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2010. Cost report data for 2005, 2006 and 2007 was again used to calculate Medicaid rates effective July 1, 2009.

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.

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. Effective July 1, 2010, the upper payment limit for the Direct Health Care cost component was increased from 120% to 130%. The upper payment limits for the cost components are as follows:

Upper Payment Limits - Fiscal Year 2015		
Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	\$31.86
Indirect Health Care	115% of the Median Cost	\$47.53
Direct Health Care	130% of the Median Cost	\$103.42
Real/Personal Property Fee	105% of the Median Cost	\$9.39

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 quarterly 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.

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 five 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, 2010, the state increased the incentive factor add-ons by 150%. However, effective July 1, 2012, the state removed the Kansas Cultural Change/Person-Centered Care Incentive Program (PEAK) incentive add-on from the original incentive program. This incentive is now reimbursed as a separate add-on. In order to fund the expansion of the PEAK incentive, the remaining five add-ons for the original incentive program were reduced on average by approximately 20.0%. However, excluding the PEAK incentive, the total maximum add-on from the existing program only decreased from \$6.13 to \$5.90. The table below summarizes the incentive factor outcomes and per diem add-ons effective July 1, 2014:

Outcome Measures	Incentive
1) CMI adjusted staffing ratio \geq 75th percentile (4.97) or	\$2.25
2) CMI adjusted staffing < 75th percentile but improved \geq 10%	\$0.20
3) Staff turnover rate \leq 75th percentile (42%) or	\$2.25
4) Staff turnover rate $>$ 75th percentile but reduced \geq 10%	\$0.20
5) Medicaid occupancy $>$ 60%	\$1.00
Total Incentive Per Diem Add-on	\$5.90

The PEAK incentive program includes five 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:

Peak Nursing Home Incentive Program			
Incentive	Eligibility	Per Diem Add-on	Duration
Level 0 - The Foundation	Home completed the Kansas Culture Change Instrument (KCCI) evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and works. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for resapplication.	\$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 must be selected for a random site visit. The home must participate in the random site visit within 12 months of incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels I & 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 the first level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core competencies. Incentive is granted 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 confirmation of the completion of the 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 considered minimum achievement in the following high score on the KCCI evaluation tool. Demonstration of success in one or more of the following: 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 confirmation of 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.	\$3.00	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 monitoring activities suggested by KDADS (see KDADS monitoring activities). Monitoring activities should be documented.	\$4.00	Available beginning July 1 following confirmation of the renewal of the sustained person-centered care award. Incentive is granted for two fiscal years. Renewable bi-annually.

The projected average Medicaid rate (\$159.03) effective July 1, 2014, is approximately 2.9% greater than the average rate (\$154.57), effective July 1, 2013. The average rates effective July 1, 2012, and July 1, 2011, were \$150.47 and \$149.10, 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

KANSAS COST REPORT STATISTICS												
	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
General Statistics												
Number of Beds	50.00	47.75	47.00	60.00	60.00	60.00	90.25	90.00	90.00			
Average Daily Census	41.61	41.28	40.70	54.03	53.67	52.81	76.10	74.27	73.17			
Occupancy	76.2%	77.1%	76.5%	85.2%	85.4%	85.0%	91.4%	90.1%	91.7%			
Payor Mix Statistics												
Medicare	5.4%	5.7%	5.8%	8.8%	8.7%	9.4%	13.4%	13.4%	12.6%			
Medicaid	45.8%	45.8%	44.8%	55.4%	53.9%	54.0%	63.3%	64.2%	64.8%			
Other	27.9%	27.5%	27.3%	37.1%	40.1%	39.0%	51.9%	60.4%	60.3%			
Avg. Length of Stay Statistics (Days)												
Medicare	31.72	32.10	30.56	43.91	44.22	44.84	66.53	66.71	63.60			
Medicaid	296.88	309.44	294.13	462.65	433.46	425.00	657.67	649.14	630.44			
Other	129.50	133.78	127.18	202.03	214.20	224.56	321.98	361.00	414.44			
Revenue (PPD)												
Inpatient	\$144.74	\$146.36	\$147.18	\$167.60	\$166.52	\$169.93	\$192.11	\$196.29	\$199.97			
Ancillary	\$18.06	\$22.64	\$22.51	\$33.15	\$35.19	\$38.19	\$55.80	\$57.80	\$62.65			
TOTAL	\$171.92	\$174.81	\$174.37	\$202.79	\$206.75	\$210.38	\$265.74	\$272.89	\$265.65			
Expenses (PPD)												
Employee Benefits	\$11.84	\$12.97	\$12.38	\$14.94	\$16.63	\$16.42	\$19.31	\$21.17	\$20.38			
Administrative and General	\$23.30	\$22.21	\$23.50	\$28.65	\$27.43	\$29.35	\$35.06	\$34.10	\$35.41			
Plant Operations	\$8.38	\$8.41	\$9.05	\$10.03	\$10.12	\$10.94	\$13.22	\$13.42	\$14.00			
Laundry & Linens	\$1.62	\$1.54	\$1.61	\$2.14	\$2.18	\$2.26	\$2.91	\$3.00	\$2.90			
Housekeeping	\$3.82	\$4.03	\$4.07	\$4.78	\$5.09	\$5.22	\$6.29	\$6.73	\$6.50			
Dietary	\$14.32	\$15.02	\$15.01	\$17.48	\$17.56	\$18.23	\$21.64	\$21.74	\$22.67			
Nursing & Medical Related	\$58.50	\$60.52	\$60.43	\$66.10	\$69.42	\$69.81	\$77.88	\$81.31	\$82.37			
Ancillary and Pharmacy	\$10.94	\$13.00	\$13.15	\$18.21	\$20.34	\$19.69	\$26.77	\$28.92	\$27.26			
Social Services	\$2.00	\$2.16	\$1.97	\$3.59	\$3.64	\$3.32	\$5.31	\$5.19	\$5.32			

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*	310
Licensed Nursing Beds*	27,467
Beds per 1,000 Aged 65 >**	41.13
Beds per 1,000 Aged 75 >**	101.09
Occupancy Percentage - 2013***	87.66%

*Source: Kentucky Cabinet of Health and Family Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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; however, the state will only allow these transactions if the nursing facilities are located within the same county and if the transferring nursing facility has at least 250 beds.
- Any capital expenditure (including major medical equipment) exceeding \$2,913,541 (effective September 17, 2014).

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.

The state of Kentucky is currently soliciting suggestions from the public regarding the modernization of its CON process. However, according to the state's policy advisor, the majority of comments being provided by the public do not relate to nursing facilities.

In addition, the policy advisor indicated that there are currently no proposed changes to the CON program, and any changes to the program would require legislative action. Lastly, the policy advisor indicated that given the state's limited Medicaid budget, it is unlikely the state would consider limited restrictions on the development of nursing facility beds in the state. Therefore, no change in the current policy related to nursing facilities is imminent, and CONs for new nursing facility construction will likely not be issued in the foreseeable future.

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 July 11, 2013), there is a surplus of nursing facility beds in every county within the state, with a statewide surplus of 16,044 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 fewer than 60 beds, \$12.85 per non-Medicare resident day for non-hospital based nursing facilities with fewer 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. 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

Kentucky

is adjusted quarterly for each individual facility's case mix index (CMI). Effective January 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 weights 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. Effective July 1, 2014, non-capital rates were only increased 0.1%. 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 recently 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%.

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. However, the state has recently 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, 2014, for both rural and urban facilities are as follows:

Category	Rural	Urban
Case Mix Adjusted Labor Cost Component	\$69.35	\$81.84
Case Mix Adjusted Non-Labor Cost Component	\$9.07	\$10.71
Non-Case Mix Adjusted Labor Cost Component	\$16.12	\$18.45
Non-Case Mix Adjusted Non-Labor Cost Component	\$36.27	\$41.48
Non-Capital Facility Related	\$5.67	\$5.67
Price Per Day of Service	\$136.48	\$158.15

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 \$55,892 per bed effective July 1, 2013. 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 \$9.64 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.

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

KENTUCKY COST REPORT STATISTICS											
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values				
	2011	2012	2013	2011	2012	2013	2011	2012	2013		
	Number of Beds	62.25	65.00	65.00	95.00	97.50	94.00	120.00	120.00	120.00	
	Average Daily Census	67.40	71.46	64.89	89.86	90.61	86.67	112.04	110.82	110.39	
Occupancy	86.1%	84.7%	84.0%	91.9%	90.8%	90.3%	95.2%	94.6%	94.4%		
Payor Mix Statistics											
Medicare	9.6%	9.4%	9.2%	12.7%	12.1%	12.2%	16.4%	16.6%	15.5%		
Medicaid	55.7%	57.6%	60.8%	68.2%	69.6%	71.8%	75.2%	75.1%	77.5%		
Other	13.1%	12.1%	10.9%	22.4%	19.3%	16.9%	42.5%	34.2%	30.5%		
Avg. Length of Stay Statistics (Days)											
Medicare	36.16	32.36	31.59	45.19	41.14	43.42	57.69	55.97	57.29		
Medicaid	346.58	374.89	365.82	494.55	561.71	555.70	808.23	835.45	786.67		
Other	89.39	95.89	80.27	174.86	152.60	129.82	317.42	300.35	228.02		
Revenue (PPD)											
Inpatient	\$170.10	\$173.06	\$180.93	\$184.25	\$187.62	\$199.52	\$212.68	\$211.79	\$225.53		
Ancillary	\$42.07	\$44.22	\$46.01	\$54.36	\$56.84	\$63.62	\$69.37	\$71.59	\$93.75		
TOTAL	\$217.64	\$223.59	\$230.72	\$243.48	\$248.16	\$267.48	\$278.11	\$278.58	\$316.67		
Expenses (PPD)											
Employee Benefits	\$14.23	\$14.33	\$14.49	\$17.55	\$17.96	\$17.95	\$21.84	\$22.47	\$22.73		
Administrative and General	\$27.31	\$28.10	\$31.77	\$36.71	\$36.00	\$39.78	\$46.64	\$43.68	\$45.51		
Plant Operations	\$7.72	\$8.09	\$8.38	\$8.91	\$9.74	\$9.90	\$11.15	\$12.53	\$11.75		
Laundry & Linens	\$1.90	\$1.94	\$1.90	\$2.34	\$2.40	\$2.45	\$2.86	\$2.86	\$3.13		
Housekeeping	\$4.17	\$4.28	\$4.50	\$5.11	\$5.27	\$5.17	\$6.14	\$6.33	\$6.23		
Dietary	\$13.50	\$14.05	\$14.10	\$14.95	\$15.50	\$15.75	\$16.96	\$18.32	\$17.77		
Nursing & Medical Related	\$60.96	\$62.81	\$64.79	\$67.09	\$67.84	\$70.71	\$77.77	\$76.66	\$79.62		
Ancillary and Pharmacy	\$20.41	\$22.03	\$21.66	\$26.48	\$26.64	\$27.32	\$34.25	\$34.26	\$34.07		
Social Services	\$1.47	\$1.58	\$1.63	\$2.51	\$2.91	\$2.73	\$3.76	\$4.25	\$4.26		

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*	280
Licensed Nursing Beds*	34,987
Beds per 1,000 Aged 65 >**	54.03
Beds per 1,000 Aged 75 >**	131.59
Occupancy Percentage - 2013***	73.75%

*Source: Centers for Medicare & Medicaid Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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, 2016. 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 that is referred to as a provider fee. It is assessed as a \$10.00 charge per patient day (effective May 1, 2013). The overall revenues generated from the provider fee are budgeted not to exceed 6.0% of total net revenues. The current provider fee is set at the maximum (6.0%). 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, 2013, utilizing 2011 cost report data. This represents the seventh straight year in which Louisiana has rebased rates. 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 addition to the above, in November 2014 Louisiana residents will vote on a constitutional amendment (Act 439) that would provide additional protection for nursing facility rates. This act would require 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 would 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 would not be allowed to be any greater than cuts to other Medicaid programs.

The act would also create Louisiana Medical Assistance Trust Fund, which would collect all revenues generated from provider fees. In addition, the state treasurer would set up separate accounts within the fund for each healthcare provider group that paid provider fees. The majority of these funds will only be allowed to be distributed to the specific provider group that paid the fees. This essentially ensures that the matching revenue generated from nursing facility provider fees cannot be used to fund other Medicaid programs. The likelihood of this legislation being approved by Louisiana voters is currently unclear.

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 \$18.96 effective July 1, 2013.

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 \$45.60 effective July 1, 2013.

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, 2013, is \$181.68 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, 2013, is \$6,776. 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, insurance 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 \$10.00 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 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 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

Louisiana

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 the provider fee add-on (\$10.00 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).

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.

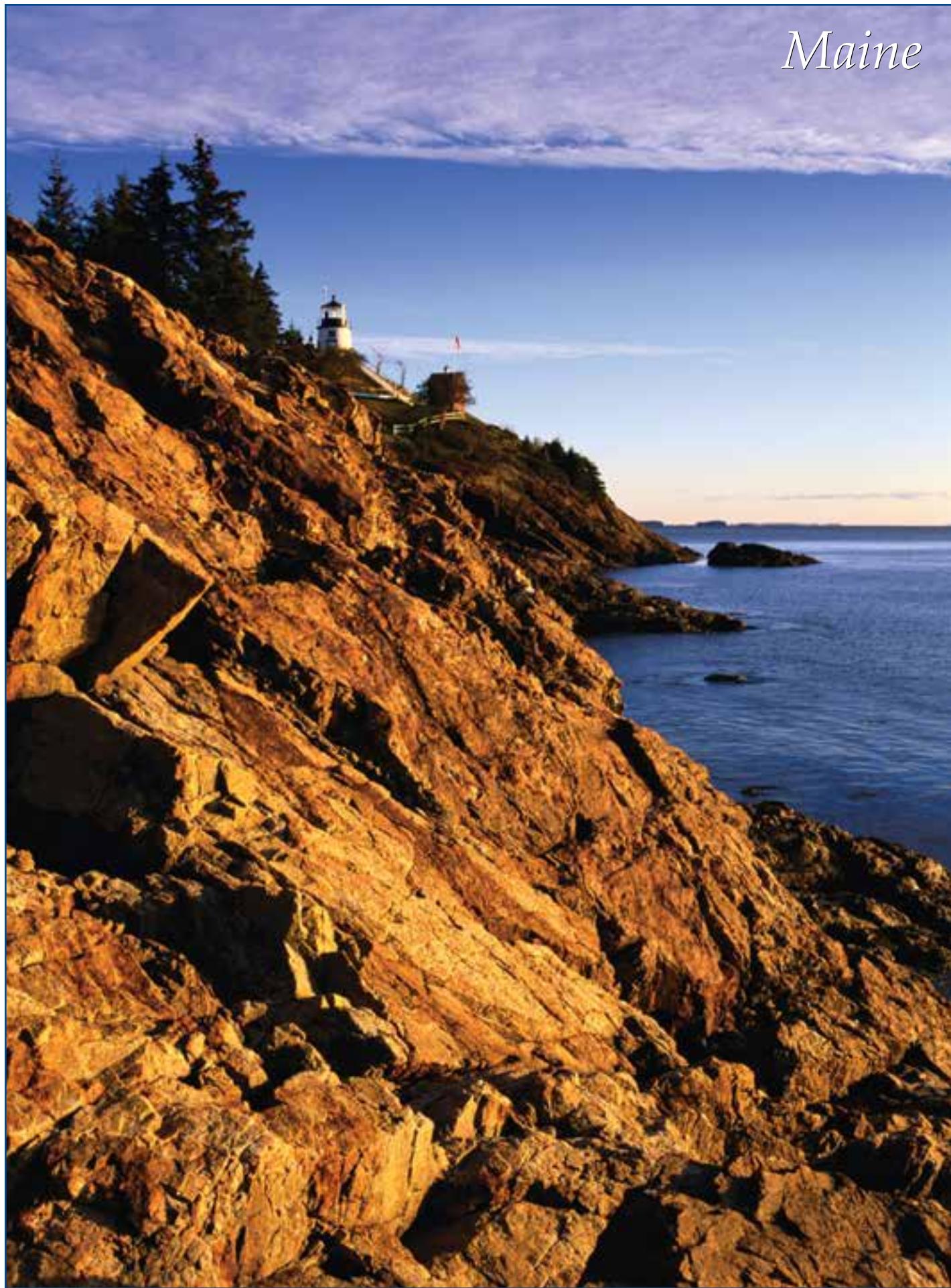
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of Act 439, 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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	101.25	104.00	101.00	123.50	125.50	124.00	145.00	151.00	150.00			
Average Daily Census	72.37	77.38	72.61	93.96	99.70	96.53	120.18	120.73	120.43			
Occupancy	65.3%	66.2%	65.5%	75.6%	77.9%	76.0%	87.1%	88.8%	87.7%			
Payor Mix Statistics												
Medicare	8.2%	8.3%	8.1%	10.2%	10.6%	10.3%	13.0%	13.1%	13.1%			
Medicaid	67.6%	67.3%	68.9%	74.5%	73.9%	74.5%	80.2%	79.5%	79.0%			
Other	10.0%	10.4%	10.5%	14.8%	15.4%	15.0%	21.3%	20.7%	21.0%			
Avg. Length of Stay Statistics (Days)												
Medicare	50.79	42.53	44.57	61.95	61.93	63.94	76.53	87.87	83.94			
Medicaid	348.03	351.02	384.28	611.45	573.07	563.31	1,161.96	1,147.14	1,043.96			
Other	124.89	107.84	97.85	201.00	180.67	152.83	316.15	326.13	296.94			
Revenue (PPD)												
Inpatient	\$142.24	\$146.77	\$150.89	\$151.82	\$157.47	\$165.61	\$168.61	\$177.94	\$191.16			
Ancillary	\$23.27	\$25.92	\$26.26	\$34.47	\$40.12	\$39.33	\$52.72	\$59.62	\$56.56			
TOTAL	\$173.68	\$185.81	\$189.60	\$191.57	\$203.93	\$210.84	\$221.06	\$226.37	\$237.01			
Expenses (PPD)												
Employee Benefits	\$7.21	\$7.34	\$4.97	\$10.10	\$10.51	\$10.62	\$12.31	\$12.23	\$12.69			
Administrative and General	\$29.28	\$30.08	\$31.57	\$34.13	\$35.20	\$36.47	\$39.47	\$39.49	\$43.82			
Plant Operations	\$7.70	\$7.59	\$7.68	\$8.90	\$8.92	\$8.99	\$10.31	\$10.69	\$10.92			
Laundry & Linens	\$1.68	\$1.73	\$1.69	\$2.03	\$2.05	\$2.03	\$2.44	\$2.61	\$2.59			
Housekeeping	\$3.83	\$3.96	\$4.04	\$4.57	\$4.65	\$4.79	\$5.43	\$5.66	\$5.74			
Dietary	\$12.11	\$12.43	\$12.77	\$13.42	\$13.43	\$13.68	\$14.43	\$14.83	\$15.21			
Nursing & Medical Related	\$53.25	\$55.41	\$56.02	\$57.21	\$59.19	\$59.98	\$62.82	\$66.34	\$67.47			
Ancillary and Pharmacy	\$15.69	\$17.23	\$16.22	\$21.41	\$22.46	\$20.95	\$26.72	\$28.33	\$26.40			
Social Services	\$1.10	\$1.17	\$1.19	\$1.54	\$1.63	\$1.68	\$2.18	\$2.24	\$2.37			

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*	103
Licensed Nursing Beds*	6,840
Beds per 1,000 Aged 65 >**	28.20
Beds per 1,000 Aged 75 >**	66.50
Occupancy Percentage - 2013***	92.34%

*Source: Maine Licensing and Regulatory Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$3,379,550, including the acquisition of medical equipment, effective January 1, 2014.
- 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 \$3,168,328 or more and annual operating expenses of \$1,056,109 or more for the third year after the service is offered, effective January 1, 2014.

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 (USDL) 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 USDL 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.

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.

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.

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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	40.50	40.00	40.00	60.00	62.00	58.00	82.50	80.00	83.00			
Average Daily Census	56.15	54.99	51.01	74.96	68.71	66.01	102.33	101.10	102.52			
Occupancy	89.2%	88.5%	88.8%	92.4%	92.5%	92.8%	94.6%	94.7%	94.8%			
Payor Mix Statistics												
Medicare	7.6%	8.4%	8.5%	12.0%	12.1%	13.3%	16.6%	18.0%	17.0%			
Medicaid	40.9%	42.2%	42.6%	52.3%	55.0%	52.0%	65.8%	65.6%	65.6%			
Other	17.0%	17.1%	16.3%	33.8%	27.2%	30.0%	50.1%	49.4%	48.9%			
Avg. Length of Stay Statistics (Days)												
Medicare	19.43	20.23	19.27	23.78	25.09	24.61	31.65	31.80	32.71			
Medicaid	187.90	244.75	237.53	306.98	365.06	368.19	420.75	463.75	489.75			
Other	73.15	50.25	60.34	195.77	161.35	130.26	406.37	346.76	282.00			
Revenue (PPD)												
Inpatient	\$215.51	\$236.17	\$235.56	\$261.06	\$275.38	\$287.62	\$291.64	\$306.31	\$324.02			
Ancillary	\$37.17	\$45.40	\$44.81	\$61.40	\$60.31	\$65.70	\$80.67	\$93.15	\$107.10			
TOTAL	\$270.25	\$283.92	\$295.78	\$322.40	\$340.65	\$353.88	\$368.18	\$393.14	\$413.80			
Expenses (PPD)												
Employee Benefits	\$16.27	\$18.58	\$17.28	\$22.15	\$23.89	\$22.81	\$27.57	\$31.78	\$29.64			
Administrative and General	\$28.63	\$29.55	\$28.80	\$38.46	\$41.65	\$39.37	\$47.41	\$56.05	\$51.63			
Plant Operations	\$9.23	\$9.23	\$9.29	\$10.82	\$11.19	\$12.01	\$12.66	\$13.75	\$14.12			
Laundry & Linens	\$2.01	\$2.12	\$2.10	\$2.56	\$2.62	\$2.76	\$3.07	\$3.35	\$3.49			
Housekeeping	\$4.29	\$4.33	\$4.73	\$5.29	\$5.82	\$5.75	\$6.69	\$7.09	\$7.33			
Dietary	\$14.97	\$15.88	\$16.71	\$17.76	\$18.97	\$19.40	\$20.15	\$21.52	\$22.75			
Nursing & Medical Related	\$69.40	\$74.44	\$79.04	\$83.06	\$87.73	\$90.82	\$95.13	\$97.64	\$101.23			
Ancillary and Pharmacy	\$14.34	\$16.96	\$17.97	\$21.26	\$25.38	\$25.16	\$32.02	\$38.18	\$35.25			
Social Services	\$1.88	\$1.91	\$2.05	\$2.29	\$2.53	\$2.64	\$2.77	\$3.87	\$4.34			

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

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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*	230
Licensed Nursing Beds*	28,011
Beds per 1,000 Aged 65 >**	33.31
Beds per 1,000 Aged 75 >**	80.79
Occupancy Percentage - 2013***	88.65%

*Source: Maryland Health Care Commission

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$5,650,000 (effective March 18, 2014) 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 base year used in the current calculation is 2009, and the projected bed need is as of 2016. It is unclear when MHCC next plans to update the bed need methodology.

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 (2006) 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. Net bed need is

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then adjusted for the potential number of alternative adult care placements and the geographic differences between residence and place of care to derive adjusted net bed need.

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 state currently reimburses nursing facilities for the QAF as part of the Capital cost component. The QAF portion of the Capital

component is calculated by dividing a facility's QAF expense from the prior year's cost report by total non-Medicare days. This per diem is then included in the Capital cost component rate.

MEDICAID RATE CALCULATION SYSTEM

Maryland currently uses a retrospective, cost-based, non-RUG, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The state establishes interim per diem rates effective the first day of the state rate period (July 1) using cost report data from the previous calendar year. However, a nursing facility's final per diem rate is not determined until the state has audited the cost report data. There is no specific time frame in which cost settlement must be completed.

Upon completion of the final rate, the state determines the difference in total reimbursement that the nursing facility would have received if the facility had been reimbursed the final rate instead of the interim rate during the cost settlement period. Typically, nursing facilities with interim per diem rates greater than the final per diem rate are given the option to reimburse the state either through a one-time payment or a negotiated payment plan. The state is also required to reimburse nursing facilities for the variance in total payment if the interim rate is less than the final rate.

Effective January 1, 2015, the state will convert to a prospective, RUG-based, case mix adjusted rate setting methodology. Details of the system are still being determined and the state is yet to publish any specific regulations regarding the new system. However, it is anticipated that the system will be phased in over a two-year period. The state will also be required to submit a State Plan Amendment to the Centers for Medicare and Medicaid (CMS) for approval of the new system. State rate setting officials have indicated that the state anticipates submitting the amendment to CMS by the end of 2014. More details about the proposed new reimbursement system will be included in the Proposed Changes to Medicaid Rate Calculation section of this overview. The following sections of this overview will detail the state's current rate calculation methodology.

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 includes expenses accrued for property taxes, property insurance, mortgage interest (including bond interest), lease costs, depreciation and reimbursement for the QAF.
- The Nursing Services cost component includes all nursing service expenses related to patient care.

INFLATION AND REBASING

Nursing facility rates and ceilings are typically rebased annually using cost report data reported the previous calendar year. The rate year for Maryland is from July 1 to June 30. All cost components are adjusted by an inflation factor to determine interim rates. Except for the Capital cost component, the state uses internal data and the Consumer Price Index to inflate all cost components. State Highway Administration data and Marshall & Swift assumptions are used to inflate the Capital cost component.

The state has not rebased rates since fiscal year 2009, which were based on 2007 cost report data. Previously, the fiscal year 2009 rates were revised effective November 1, 2008, in accordance with the department's revised appropriations for nursing services for fiscal year 2009. With the exception of the cost containment reduction, the state froze each nursing facility's current Medicaid rate (effective November 1, 2008) through fiscal year 2010.

Rates for fiscal year 2011 are based on fiscal year 2007 cost report data indexed forward to December 2008. This did not represent a significant change for fiscal year 2010 rates. The state had previously indicated plans to rebase rates in fiscal year 2012, using 2010 cost report data. However, this rebase did not occur.

The state has increased Medicaid rates (excluding QAF fees) by an average of 1.5% in fiscal year 2012. This was accomplished by reducing the cost containment reduction for Administrative and Routine, Other Patient Care and Capital cost component rates from 4.158% to 1.623%. The state did not rebase rates in fiscal year 2013 but implemented a 1.0% rate increase. This was accomplished by eliminating the cost containment reduction. The state did not rebase rates on July 1, 2013, but implemented an average 1.725% rate increase. This was accomplished by increasing net payments for Administrative and Routine, Other Patient Care and Capital cost centers by 3.2%. Rates effective from July 1, 2014, will remain frozen at rates effective June 30, 2014, until the state begins the implementation of its prospective payment system (PPS) for nursing facility Medicaid reimbursement on January 1, 2015. The state is anticipated to increase nursing facility rates 2.0% on January 1, 2015 for the first six months of the phase-in to ease the transition to the new Medicaid reimbursement system.

RATE METHODOLOGY

A maximum allowable reimbursement level is determined for each component. With the exception of the Capital cost, the maximum allowable amount is determined as a percentage of the median cost for all nursing facilities in the state. The reimbursement for mortgage interest and a capital rental return for the Capital cost is calculated as an amount per bed for land, building and equipment subject to a Medicaid appraisal. According to state officials, approximately a third of all nursing facilities are reappraised every year. The maximum allowable reimbursement for the Administrative and Routine, Other Patient Care or Therapy Service components is calculated for three geographic regions (Baltimore Metropolitan, Washington Metropolitan and Non-Metropolitan). Effective July 1, 2012, for the purpose of determining the maximum allowable reimbursement for the Administrative and Routine cost and Other Patient Care

components, the city of Baltimore is separated from the Baltimore Metropolitan Area (Ann Arundel, Baltimore, Carroll and Howard counties).

In recent years, Maryland has adjusted nursing facility rates by a cost containment reduction that reflects the budget shortfalls in the state. This reduction factor is applied to nursing facilities' unadjusted rates to determine a facility's final rate. For rates effective from November 1, 2008, a cost containment reduction was applied to the Administrative and Routine, Other Patient Care and Capital cost centers equaling 4.816% of the interim and final per diem payments. This cost containment reduction was increased from the 1.3% reduction that was applied to nursing facility rates from July 1, 2008, to October 31, 2008. For the period of August 1, 2009, to November 30, 2009, the cost containment reduction was increased to 8.681%. For rates effective December 1, 2009, through June 30, 2010, the cost containment reduction was 7.796%.

For rates effective July 1, 2010, the Administrative and Routine, Other Patient Care and Capital cost centers are reduced by a cost containment reduction of 4.158%. However, the reduction of this factor from the previous level results in a 2% average increase in reimbursement. As previously mentioned, the cost containment reduction was reduced to 1.623% in fiscal year 2012, which resulted in an average rate increase of 1.5%. The state increased rates approximately 1.0% in fiscal year 2013, which was partially accomplished by eliminating the cost containment reduction.

The payment for the Administrative and Routine cost center is calculated as the provider's indexed cost plus an efficiency payment. This cost center, for rates effective July 1, 2012, is reimbursed up to a mandated ceiling equal to 112% of the median per resident day cost (last determined on November 1, 2008). This represents the last time the state has updated the cost ceilings. The following are the most recent cost ceilings and maximum allowable payments that were effective July 1, 2012:

Region	Administrative and Routine Cost Center		
	FY 2012 Rate Ceiling	FY 2012* Max. Payment July 1, 2011 - June 30, 2012	FY 2013 Max. Payment July 1, 2012 - June 30, 2013
Baltimore City	\$80.34	\$79.04	\$83.91
Baltimore Metro	\$80.34	\$79.04	\$80.65
Washington	\$86.70	\$85.29	\$86.70
Non-Metro	\$73.51	\$72.32	\$73.51

Source: Maryland Department of Health and Mental Hygiene

*These rates reflect the cost containment reduction.

To encourage efficiency, efficiency reward payments are available equal to 40% of the difference between the provider's cost and the ceiling. To minimize excessive efficiency payments, the efficiency payment is capped at 10% of the ceiling.

The payment for the Other Patient Care cost center is calculated as the provider's indexed cost plus an efficiency payment. This cost center, for rates effective July 1, 2011, is reimbursed up to a mandated ceiling equal to 118% of the median per resident day cost (last determined on November 1, 2008). Effective July 1,

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2012, ceiling will be increased to 120% of the median cost. This represents the last time the state has updated the cost ceilings. The following are the most recent cost ceilings and maximum allowable payments that were effective July 1, 2012:

Region	Other Patient Care Cost Center		
	FY 2012 Rate Ceiling	FY 2012* Max. Payment July 1, 2011 - June 30, 2012	FY 2013 Max. Payment July 1, 2012 - June 30, 2013
Baltimore City	\$16.69	\$16.87	\$17.15
Baltimore	\$16.69	\$16.90	\$17.18
Washington	\$16.79	\$16.79	\$17.07
Non-Metro	\$16.01	\$16.02	\$16.28

Source: Maryland Department of Health and Mental Hygiene

*These rates reflect the cost containment reduction.

Efficiency reward payments are available equal to 25.0% of the difference between the provider's cost and the ceiling, with a maximum efficiency payment of 5.0% of the ceiling.

The Capital cost component is based on fair rental rates, an equipment allowance and payment of fixed costs. The Capital payment is the sum of the net capital value rental per diem and fixed cost per diem.

As mentioned, to calculate the net capital value rental per diem, the total appraised value for land, building and nonmovable equipment is divided by the number of beds to arrive at a per-bed value. Each nursing home is appraised every three years, and appraised values are inflated from the date in which they were calculated to December 31 of the rate setting year.

According to state officials, although the state has continued to appraise nursing facilities, the portion of Capital component rates determined by the appraised values has been frozen since fiscal year 2009. Therefore, no inflation to appraised values has occurred since fiscal year 2009. The following table displays the inflation factors for fiscal year 2009 used to increase the appraised values calculated in the last three years of appraisals:

Capital Cost Center		
March-06	March-07	March-08
Land	0.9281	0.9117
Building	1.1841	1.1297
Equipment	1.1706	1.1100

Source: Maryland Department of Health and Mental Hygiene

The per-bed value is compared against a cost ceiling determined by DHMH using the most current Marshall & Swift cost data available. The maximum allowable per-bed value effective July 1, 2008, for a nursing facility is \$74,352. The lesser of the facility Medicaid appraisal or the per-bed ceiling is added to the equipment allowance determined by the DHMH each year. The equipment allowance effective July 1, 2008, is \$6,651.15 per bed. The sum of the per-bed value and the equipment allowance is multiplied by the number of beds. Allowable debt is subtracted to derive net equity, which is then multiplied by the rental rate to arrive at the annual rental rate. The allowable rental rate effective November 1, 2008, is 7.57%. To arrive at the per diem net capital

value rental, divide the adjusted value estimate by the facility's total patient days (subject to the occupancy standard). However, in fiscal year 2013, the allowable rental rate will be increased to 9.42% for nursing facilities located in the city of Baltimore. To calculate the fixed cost per diem, sum taxes, insurance costs and allowable interest are added, and then divided by days (subject to the occupancy standard) to arrive at the per diem for fixed costs. This estimate is derived from the most recent cost report data and is added to the net capital value per diem to set the interim total reimbursement for the Capital cost component.

Based upon the discretion of the DHMH, the rental rate may be increased up to two percentage points in order to stimulate the addition of licensed beds to existing supply for facilities in a county or a group of counties.

Nursing service interim medical assistance reimbursements are calculated from resident-specific standard per diem rates, the medical assistance days of each resident type, and the frequencies of reimbursable procedures used by each resident type. Nursing facilities' per-day reimbursement rates are based on each individual resident's level of care. Levels of care payments are established based on activities of daily living (ADL) dependency. There are presently four main levels of care (Light Care, Moderate Care, Heavy Care and Heavy Special Care). In addition, to the level of care per day reimbursement rates, nursing facilities may also be reimbursed additional amounts for patients that require one of 13 categories of ancillary care.

An annual wage survey is conducted, during a two-week pay period, to collect wage and hours for five category groupings (DON, RN, LPN, NA and CMA). The wage at the 75th percentile is selected for hours in five nursing regions (Baltimore, Washington, Non-Metro, central and western Maryland). A regional fringe benefit factor is calculated from cost report data and is multiplied by the predetermined wage costs to estimate the adjusted wage costs per region.

A periodic work measurement study is then conducted to establish the amount of direct care hours and personnel mix required to provide a specific level of care and any additional ancillary services. For years in which a work measurement study is not conducted, the time and personnel mix for each level of care is recalibrated using wage survey data for those years. The work measurement study provides an estimate of hours of direct patient care by employee categories, which are converted into personnel weights by level of care (including ancillary). These weights are then multiplied by the adjusted wage cost to determine the weighted average wage cost of nursing facility care. Fiscal year 2009 Nursing Services cost component rates are based on the wage survey completed in October 2007. The rates based on the 2007 wage survey have been utilized for every fiscal year since 2009.

The weighted average wage costs are then inflated based on incentive adjustments for providing care to higher acuity patients. Levels of care incentive adjustments for higher acuity patients are as follows: 2.0% for moderate care, 3.0% for heavy care and 4.0% for heavy special care and all ancillary care. Lastly, a standard per diem supply cost is added to the wages costs to

determine the facility's total Nursing Services cost. Based on the above methodology, the maximum allowable reimbursement for nursing services by region is as follows:

Fiscal Year 2015 Nursing Service Rates			
Patient Classification	Balt.	Wash.	Non-Metro
Light Care	82.74	80.55	81.27
Moderate Care	104.82	102.74	102.92
Heavy Care	108.59	106.81	106.61
Heavy Special Care	140.02	136.58	137.03
Decubitus Care - Medicare	15.95	15.00	15.00
Decubitus Care - Medicaid	16.78	15.83	15.83
Negative Pressure Wound Therapy	116.41	116.41	116.41
Turning and Positioning	9.15	9.29	9.12
Tube Feeding - Medicare	37.04	34.85	34.85
Tube Feeding - Medicaid	41.57	38.38	39.38
Communicable Disease Care	110.84	108.26	107.70
Central Intravenous Line	56.51	53.41	51.49
Peripheral Intravenous Care	19.96	18.81	18.58
Aerosal Oxygen Therapy	4.17	3.93	3.88
Suctioning	46.19	43.59	42.55
Class A Support Service	23.13	23.13	23.12
Class B Support Service	92.14	92.14	92.14
Ventilator Care	501.62	484.11	478.32

Source: Maryland Department of Health and Mental Hygiene

Fiscal Year 2015 Nursing Service Rates (cont...)		
Patient Classification	Cent. MD	West. MD
Light Care	82.23	76.18
Moderate Care	104.93	97.57
Heavy Care	109.09	101.65
Heavy Special Care	139.35	129.28
Decubitus Care - Medicare	15.07	13.41
Decubitus Care - Medicaid	15.90	14.24
Negative Pressure Wound Therapy	116.41	116.41
Turning and Positioning	9.56	9.20
Tube Feeding - Medicare	35.01	31.15
Tube Feeding - Medicaid	39.54	35.68
Communicable Disease Care	110.04	100.62
Central Intravenous Line	52.99	45.99
Peripheral Intravenous Care	18.82	16.60
Aerosal Oxygen Therapy	3.93	3.46
Suctioning	43.43	38.01
Class A Support Service	23.13	23.13
Class B Support Service	92.14	92.14
Ventilator Care	483.46	448.00

Source: Maryland Department of Health and Mental Hygiene

Effective July 1, 2012, the state eliminated the Communicable Disease Care add-on and implemented a rate add-on for residents who require Intensive Tracheotomy Care.

For providers with nursing service costs less than reimbursement rates, an allowable profit is calculated as 60.0% of the difference between the amount of the reimbursements and the amount of the costs. Profits may not exceed the provider's maximum reimbursement multiplied by 3.0% (effective November 1, 2008).

The statewide average Medicaid nursing home rate for fiscal year 2013 was approximately \$235.35 per day. This is a 2.7% increase from the weighted average rate for fiscal year 2012 (\$229.12). Given that Medicaid rates were projected to increase 1.725% in fiscal year 2014, the projected average rate effective July 1, 2013, is \$239.41.

Additionally, the July 1, 2011, average Medicaid rate was \$218.00, the August 1, 2009, average Medicaid rate was \$212.53, the November 1, 2008, rate was \$217.02, the fiscal year 2008 rate was \$200.93 and the fiscal year 2007 was \$193.21.

MINIMUM OCCUPANCY STANDARDS

In Maryland, the minimum occupancy standard applied to Administrative and Routine, Other Patient Care and Capital cost centers equates to the statewide average occupancy plus 1.5% effective July 1, 2012. Prior to this change, the minimum occupancy standard equated to the statewide average occupancy plus 2.0%. There is no occupancy requirement for the Nursing Services component.

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 \$1.97 to \$3.94 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 \$0.47 to \$0.94. Maryland reimburses eligible nursing facilities for these incentive programs via lump sum payments.

When a change of ownership occurs, the new owner shall have a new interim per diem rate established within 90 days after the date of the change of ownership. The new interim per diem rate is applicable retroactively to the date of the change of ownership. The new provider is reimbursed at the interim per diem rates that existed before the change of ownership, until the new interim per diem rates are established.

The maximum debt basis for a nursing facility that changes ownership is limited to the Medicaid appraisal, which will determine the maximum debt basis for both the seller and buyer. Upon transfer of ownership, a new Medicaid appraisal is not completed, but Maryland will allow the owner to utilize their current interest rate to determine allowable interest expense up to the maximum debt basis. However, the interest rate must be in line with current market rates. For the transfer of ownership of leased facilities, Maryland establishes an input-debt estimate, which is determined to equate to 85.0% of the facility's Medicaid appraisal.

The Medicaid per diem rate for a new provider is based on a projected budget for the period from the beginning of its operation as a provider to the end of its first fiscal year, along with a monthly amortization schedule for its mortgage debt. The

Maryland

DHMH uses the existing Nursing Services standard rates and establishes interim per diem rates for each remaining cost center based on the projected budget, the debt amortization schedule and other available data.

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

As previously mentioned, effective January 1, 2015, the state will convert to a prospective, RUG-based, case mix adjusted Medicaid rate calculation. Although the rate methodology has not yet been finalized, it is anticipated that the calculation will consist of the following:

- The state will utilize the RUG IV, 48-RUG Grouper to adjust facilities' rates for case mix.
- The non-capital portion of the rate calculation will be price-based and the calculation of new rates will consist of periodic rebasing.
- Capital rates will be determined utilizing a fair rental value system.
- The system will be phased in over a proposed 12-month period, with nursing facilities receiving a reimbursement rate that is a blend of the rates calculated utilizing the old and new system.

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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	83.50	91.00	90.75	119.00	120.00	120.00	151.25	153.00	155.00			
Average Daily Census	80.79	85.98	83.70	111.80	115.49	114.49	138.43	137.97	144.05			
Occupancy	85.5%	84.2%	84.1%	89.9%	89.3%	89.4%	93.3%	93.3%	93.5%			
Payor Mix Statistics												
Medicare	9.8%	10.7%	10.7%	15.3%	15.5%	15.4%	20.5%	20.0%	20.6%			
Medicaid	53.8%	51.3%	50.8%	63.0%	63.1%	62.9%	73.6%	71.2%	71.9%			
Other	14.9%	15.8%	14.9%	57.5%	55.6%	45.3%	85.2%	84.1%	83.9%			
Avg. Length of Stay Statistics (Days)												
Medicare	28.43	29.87	30.00	33.36	34.86	34.87	41.88	42.14	41.53			
Medicaid	328.15	320.79	301.63	733.56	491.07	410.57	1049.11	798.97	703.43			
Other	81.03	85.05	71.27	197.18	180.11	163.54	406.24	358.11	335.50			
Revenue (PPD)												
Inpatient	\$241.31	\$248.55	\$251.62	\$268.14	\$275.52	\$283.15	\$297.84	\$302.22	\$316.82			
Ancillary	\$34.82	\$41.94	\$42.92	\$50.99	\$58.70	\$64.95	\$72.40	\$81.00	\$89.46			
TOTAL	\$281.43	\$303.06	\$302.33	\$323.77	\$335.86	\$352.26	\$369.28	\$383.10	\$403.55			
Expenses (PPD)												
Employee Benefits	\$20.55	\$21.34	\$20.30	\$25.40	\$24.70	\$24.24	\$35.78	\$33.26	\$31.42			
Administrative and General	\$45.86	\$48.19	\$51.07	\$56.43	\$59.30	\$59.33	\$68.39	\$70.77	\$71.85			
Plant Operations	\$10.56	\$10.22	\$9.90	\$12.79	\$12.40	\$12.69	\$16.90	\$16.10	\$16.09			
Laundry & Linens	\$2.41	\$2.74	\$2.67	\$3.26	\$3.50	\$3.50	\$4.33	\$4.49	\$4.74			
Housekeeping	\$5.83	\$5.81	\$5.73	\$7.25	\$7.05	\$6.87	\$8.93	\$8.51	\$8.79			
Dietary	\$16.76	\$16.56	\$16.21	\$19.09	\$18.40	\$18.75	\$24.45	\$22.91	\$23.84			
Nursing & Medical Related	\$87.41	\$90.45	\$88.78	\$99.97	\$100.22	\$100.24	\$112.61	\$111.68	\$112.57			
Ancillary and Pharmacy	\$23.37	\$26.60	\$26.03	\$30.51	\$34.09	\$34.67	\$42.16	\$41.95	\$43.62			
Social Services	\$2.16	\$2.32	\$2.34	\$3.26	\$3.84	\$3.77	\$4.93	\$4.85	\$5.02			

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*	420
Licensed Nursing Beds*	48,365
Beds per 1,000 Aged 65 >**	46.46
Beds per 1,000 Aged 75 >**	105.02
Occupancy Percentage - 2013***	88.78%

*Source: Massachusetts Health and Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$1,901,869 (effective October 1, 2015).

Existing homes can add up to 12 beds once during the life of a facility without a DON if spending thresholds are not exceeded. State officials believe that Massachusetts currently has a surplus of nursing home beds. The state has a moratorium on applications for new nursing facility beds that was established in 1990. The state extended the expiration date of this moratorium to May 2016. The DON is still in the process of updating the statewide bed need methodology. Therefore, the state has indicated that it will not consider applications

for new nursing facility beds until May 2016. This effectively extends the moratorium until that date.

BED NEED METHODOLOGY

Massachusetts' bed need methodology is determined by the DON department. The methodology applies 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 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. If this calculation results in a positive number, there is need for additional nursing facility beds in the state. If this calculation results in a negative number, there is a surplus of nursing facility beds within the state.

The calculation for 2015 results in a surplus of 10,772 beds. Based on the projected surplus of nursing facility beds in Massachusetts, the DON department issued a moratorium on new nursing facility construction until May 2016. This moratorium excludes the construction of replacement nursing facility beds. If any additional need occurs, the DON department will revisit the projections to address additional need.

Although the DON has not finalized a new statewide bed need methodology, the department did issue a memorandum on April 15, 2015, that indicates that the DON projects that the state will possess a surplus of 7,000 beds in 2020.

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 current Nursing Facility User Fees effective July 1, 2010, are 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

The user fees in the previous chart represent a decrease from the prior user fees (effective September 1, 2009). The user fees effective September 1, 2009, were \$19.17 for Class I facilities and \$1.92 for Class II and III facilities. The user fees effective April 1, 2009, were \$11.59 for Class I facilities and \$1.16 for Class II and III facilities.

Massachusetts

Nursing facilities (Class IV facilities) that meet the following three criteria are exempt from paying the user fee:

- Nursing facilities with less than 100 licensed beds.
- Nursing facilities that were constructed prior to July 30, 1965.
- Nursing facilities that are not participating in either Medicare or Medicaid.

Nursing facilities that are located in Essex, Middlesex and Suffolk counties, and meet the first two criteria but participate in the Medicaid program are also exempt from paying the user fee.

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 have been frozen since

July 1, 2007.

In years in which the state increases Medicaid rates, nursing facility allowable costs are inflated from the midpoint of the cost report period to the midpoint of the rate period utilizing an inflation rate determined by the state. When determining the rate, the state considers three Massachusetts Consumer Price Indices provided by Global Insight as follows: a pessimistic index, a baseline index and an optimistic index. The state typically utilizes the lower of the indices. For rates effective for the July 2007 fiscal year, calendar year 2005 costs were inflated by 6.49% to bring costs forward for 30 months. 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.

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.

RATE METHODOLOGY

The following is the rate methodology detailed in the state law that was utilized the last time the state calculated new rates (October 1, 2014).

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 the rate add-on for the Nursing Facility User Fee.

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, 2014) for these residents as follows:

Resident Categories		
Payment Group	Management Minute Range	Standard Payment
H	0 - 30	\$14.45
J and K	30.1 - 110	\$39.54
L and M	110.1 - 170	\$68.38
N and P	170.1 - 225	\$96.34
R and S	225.1 - 270	\$117.67
T	270.1 and above	\$146.39

The standard payments for each of these categories are determined based on an analysis of per diem nursing costs for all applicable facilities. The facility-specific per diem costs are determined by dividing the facility's inflated allowable nursing

costs by total resident days (adjusted for the minimum occupancy requirement, if necessary). The facility-specific per diem costs are arrayed and a median is determined. The median is then divided by the average number of management minutes required for nursing facility residents in Massachusetts for the same period as the cost report data. This amount is then multiplied by the median number of required management minutes per category to determine the standard payment. The standard payments are determined annually, based on the inflated base year nursing costs.

Massachusetts establishes one statewide Other Operating cost component standard per diem rate for all nursing facilities. The Other Operating cost component standard per diem rate is a price comprised of two cost subcomponents, the Other Operating cost subcomponent and the Administrative and General cost subcomponent. The overall Other Operating cost component per diem rate is calculated as follows:

- Step 1 – calculate the median per diem cost for the Other Operating cost subcomponent of the rate through an array of all applicable nursing facilities' Other Operating per diem costs (adjusted for the minimum occupancy requirement, if necessary).
- Step 2 – determine the lower of the facility-specific General and Administrative per diem cost (adjusted for the minimum occupancy requirement, if necessary) or 85.0% of the median per diem cost for all applicable nursing facilities.
- Step 3 – add the lesser of the facility-specific General and Administrative per diem cost or 85.0% of the facility-wide General and Administrative cost subcomponent median to the facility-specific Other Operating cost subcomponent median.
- Step 4 – array the result of Step 3 for every applicable nursing facility and determine the median. The standard Other Operating cost component rate equates to the median. The current standard statewide Other Operating cost component rate (effective October 1, 2014) is \$76.96, which was frozen at the rate calculated on October 1, 2014. This rate represents a 7.0% increase from the prior rate effective July 1, 2007.

As previously noted, a nursing facility's Capital cost component rate is determined based upon when the licensed beds became operational and the facility's capital payment as of August 31, 2007. If a nursing facility's beds were licensed after February 1, 1998, the facility's Capital cost component rate is 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 – Forward	\$28.06

The Capital cost component rate for nursing facilities that were licensed prior to February 1, 1998, is 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 is 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 will allow depreciation on the building, improvements and equipment based on the determined allowable basis for fixed assets. Depreciation will be calculated utilizing the straight-line method of determining depreciation, assuming maximum use life standards established by the state.

The financing contribution will be calculated by multiplying the allowable basis of fixed assets, less accumulated depreciation, by 7.625%. Allowable rent and leasehold expenses are 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 are 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 was less than \$17.29, the facility's Capital cost component per diem rate will be the greater of its prior year's rate or the payment determined (effective July 1, 2007) 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 is greater than or equal to \$17.29, the facility's Capital cost component rate will equal its previous rate. The Medicaid reimbursement rate paid to nursing facilities includes a rate add-on for the Nursing Facility User Fee that nursing facilities pay to the state. Effective October 1, 2015, the user fee add-on by facility class is presented in the table below:

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	\$16.12
Class II	Nonprofit continuing care retirement facilities	\$1.62
Class III	Nonprofit nursing facilities that had greater than 68,000 Medicaid resident days	\$1.82

Massachusetts

Effective September 1, 2011, the User Fee add-on for all nursing facilities was increased to equate the actual Nursing Facility User Fee that a nursing facility is assessed. For Class I facilities this resulted in a \$2.94 ($\$18.41 - \$15.47 = \2.94) increase, and for Class II and III facilities it resulted in a \$0.29 ($\$1.84 - \$1.55 = \0.29) increase. In addition, nursing facility rates for remainder of the fiscal year (until June 30, 2012) were retroactively reimbursed for revenue they would have received if the state had implemented the increased add-on effective July 1, 2011. This was accomplished by the inclusion of a temporary add-on as follows:

Class I:	\$0.26
Class II:	\$2.91
Class III:	\$2.91
Class IV:	\$3.20

This temporary add-on was eliminated in fiscal year 2013. This most impacted Class IV nursing facilities, which are not assessed a Nursing Facility User Fee and, subsequently, do not receive a User Fee add-on.

For rates effective July 1, 2012, to December 31, 2012, nursing facilities were reimbursed at the rates that were effective prior to September 1, 2011, which do not include the increased User Fee add-on. This results in a slight temporary rate reduction. However, the state reimbursed nursing facilities the full Nursing Facility User Fee for the period between January 1, 2013, and June 30, 2013. This change was not implemented until February 1, 2013. Given this factor, for the period between February 1, 2013, and February 28, 2013, the state reimbursed nursing facilities their full user fees as an add-on as well as an annualization add-on that accounted for the revenue lost while they were waiting for the state to approve the continuation of the increased add-on. This add-on was \$3.39 for Class I nursing facilities and \$0.34 for Class II and III nursing facilities.

From July 1, 2013, to September 30, 2013, the state eliminated the additional reimbursement from the Nursing Facility User Fee and facilities were reimbursed the add-ons that were effective prior to September 1, 2013. From October 1, 2013, to June 30, 2014, nursing facilities were reimbursed the full user fees as add-ons as well as the following annualization adjustments : Class I - \$0.98 and Class II and III - \$0.10.

Effective July 1, 2014, the state eliminated the additional reimbursement for the Nursing Facility User Fee, and facilities are once again reimbursed the add-ons effective prior to September 1, 2011, as follows: Class I - \$15.47 and Class II and III - \$1.55. This results in a \$20 million reduction in reimbursement.

Effective October 1, 2014, the state increased the add-ons to the following amounts: Class I Nursing Facilities - \$16.52 and Class II & III Nursing Facilities - \$1.65. However, the state reduced these add-ons to the current amounts (Class I Nursing Facilities - \$15.47 and Class II & III Nursing Facilities - \$1.55) effective January 1, 2015. As displayed in the above table, effective October 1, 2015, the User Fee add-ons were increased moderately (Class I Nursing Facilities - \$16.12 and Class II & III Nursing Facilities - \$1.62). In addition, to reflect that the increase in funding for the User Fee add-on is applicable for the state's fiscal year (July 1, 2015, to June

20, 2016), annualization add-on is applied to nursing facility rates to reflect the three months that passed (July 1, 2015, to September 30, 2015) in which nursing facilities did not receive the increased User Fee add-on. This add-on is effective October 1, 2015, and equates to \$0.22 per diem for Class I facilities and \$0.02 per diem for Class II & III facilities.

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 will average approximately \$0.22 per day. This add-on was determined utilizing 2007 nursing facility direct care salaries. Funding for this add-on is \$2.5 million. The first step in calculating this add-on is to determine a nursing facility's percentage of total direct care expenses in the state. Once that facility-specific percentage is determined, it is multiplied by \$2.5 million to determine the nursing facility's specific add-on.

Effective September 1, 2009, Massachusetts implemented a "pay for performance" incentive program. Due to budgetary constraints, this program was not implemented until fiscal year 2012. The focus of the program is to encourage nursing facilities to implement a consistent staff assignment model of care. In this model of care, Certified Nursing Assistants (CNAs) are consistently assigned to the same residents on each unit on most shifts (85.0%).

Funding for the program was approximately \$2.8 million in fiscal year 2012. Funding for the program was reduced to \$1.4 million in fiscal year 2013 but restored to \$2.8 million in fiscal year 2014. This level of funding was maintained in fiscal year 2015 and will be maintained in fiscal year 2016. Nursing facilities are eligible to receive a lump sum supplemental payment if they meet the thresholds for the program.

These thresholds include, but are not limited to, the following:

- The nursing facility must not have an immediate jeopardy designation by the Massachusetts Department of Health or the Centers for Medicare and Medicaid (CMS);
- The nursing facility must not be designated by CMS as a Special Focus Nursing Facility;
- Nursing facilities must be participating in the Massachusetts Medicaid program; and
- Nursing facilities must meet the criteria for clinical measures and any other requirements to be established by the MassHealth agency.

Based on estimates provided by the Massachusetts Senior Care Association, approximately over 350 nursing facilities will be qualified for the program in fiscal year 2016.

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 all three cost components. The resident-specific Nursing cost component rate will be determined based on an assessment of the resident upon admission.

A facility that experiences a change of ownership will receive the appropriate standard Nursing and Other Operating cost component rates. The Capital cost component will be based on the facility's initial date of license. If the facility was licensed after February 1, 1998, the facility will receive the applicable standard rate. If a facility was licensed prior to February 1, 1998, the facility's rate will be determined using the previously mentioned methodology. However, the allowable basis of fixed assets will be determined as follows:

- The allowable basis of land is the lower of the acquisition cost or the seller's allowable basis.
- The allowable basis of the building will be the lesser of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June 30, 1976, and from 1993 forward.
- The allowable basis of improvements will be the lesser of the acquisition cost or the seller's allowable basis, reduced by the

amount of actual depreciation allowed in the Medicaid rates.

- The allowable basis of equipment will be the lesser of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

Upon transfer, the seller's building improvements will become part of the owner's allowable basis of the building.

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.

MASSACHUSETTS COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	82.00	82.00	82.00	117.50	120.00	120.00	141.00	141.50	142.00			
Average Daily Census	76.06	76.99	75.82	104.44	105.39	106.21	125.18	126.37	124.87			
Occupancy	87.6%	87.0%	85.8%	91.6%	91.1%	91.1%	94.2%	94.4%	94.2%			
Payor Mix Statistics												
Medicare	8.0%	7.9%	7.4%	12.2%	11.8%	11.3%	16.8%	16.2%	15.8%			
Medicaid	52.1%	49.7%	48.0%	64.7%	61.6%	61.0%	73.7%	71.7%	71.1%			
Other	14.2%	17.2%	18.1%	22.4%	25.0%	26.5%	35.2%	40.0%	40.5%			
Avg. Length of Stay Statistics (Days)												
Medicare	28.41	28.08	26.36	37.36	35.47	34.53	48.99	48.11	50.56			
Medicaid	289.69	281.73	271.67	432.70	424.51	407.81	688.01	654.17	642.71			
Other	63.65	61.61	65.72	114.42	106.85	116.81	223.83	224.55	223.32			
Revenue (PPD)												
Inpatient	\$264.99	\$263.21	\$266.93	\$299.79	\$308.32	\$315.80	\$345.64	\$355.61	\$367.97			
Ancillary	\$35.08	\$35.00	\$34.98	\$53.64	\$57.71	\$56.56	\$75.66	\$79.95	\$82.78			
TOTAL	\$314.47	\$314.62	\$313.03	\$364.94	\$374.60	\$377.73	\$415.80	\$435.10	\$447.20			
Expenses (PPD)												
Employee Benefits	\$20.71	\$20.24	\$19.87	\$24.39	\$23.79	\$23.33	\$29.55	\$29.32	\$28.44			
Administrative and General	\$45.54	\$46.05	\$46.83	\$54.16	\$54.12	\$54.52	\$60.64	\$61.40	\$62.80			
Plant Operations	\$10.21	\$9.91	\$10.29	\$12.16	\$11.63	\$12.10	\$14.67	\$14.30	\$14.61			
Laundry & Linens	\$2.61	\$2.60	\$2.64	\$3.10	\$3.10	\$3.17	\$3.77	\$3.85	\$4.07			
Housekeeping	\$4.54	\$4.57	\$4.62	\$5.43	\$5.55	\$5.72	\$6.87	\$6.99	\$7.03			
Dietary	\$15.51	\$15.74	\$16.03	\$17.72	\$17.79	\$18.29	\$20.56	\$20.81	\$21.38			
Nursing & Medical Related	\$87.54	\$88.66	\$88.42	\$95.98	\$96.69	\$97.95	\$105.52	\$107.27	\$108.34			
Ancillary and Pharmacy	\$19.00	\$18.91	\$17.98	\$25.51	\$26.57	\$26.59	\$34.66	\$36.27	\$36.08			
Social Services	\$2.48	\$2.57	\$2.58	\$3.25	\$3.38	\$3.40	\$5.05	\$5.42	\$4.90			

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 Community Health, Bureau of 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*	445
Licensed Nursing Beds*	46,865
Beds per 1,000 Aged 65 >**	30.24
Beds per 1,000 Aged 75 >**	71.34
Occupancy Percentage - 2013***	83.66%

*Source: Michigan Bureau of Health Care Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$3,197,500, effective January 1, 2015. 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 86 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 86 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 project proposes to replace an equal or lesser number of beds currently licensed to the facility. However, the existing facility may relocate no more than 50.0% of its beds to another nursing facility. In addition, the nursing home that is transferring the beds and the nursing home that is receiving the beds must be 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 equity contribution 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

Michigan

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 on August 1, 2013, utilizing a base year of 2010.

As of August 1, 2013, six of the 86 planning districts have a need for additional beds. However, four of these planning areas have a projected bed need of 10 or less beds. Overall, the calculation results in a total surplus of 3,654 beds 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. The current per diem amounts effective October 1, 2014, are as follows: \$2.00 per non-Medicare day for nursing facilities with under 40 beds; \$16.00 per non-Medicare day for nursing facilities with greater than 51,000 Medicaid days; and \$23.82 per non-Medicare day for all other nursing facilities.

The QAAP for nursing facilities with under 40 beds and nursing facilities with greater than 51,000 Medicaid days did not change from the prior period (effective October 1, 2013). However, the rate (\$23.82) for all other facilities effective October 1, 2014, is \$0.12 greater than rate (\$23.70) effective October 1, 2013. As of the effective date of this overview, the state is still in the process of determining the QAAPs that will be effective October 1, 2015.

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, 2015, utilizing 2014 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 and 2016 Medicaid 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, 2015, the current asset limit was increased from \$71,000 to \$75,000 per bed. The current asset limit floor is 30% of the current asset limit (\$22,500 as of October 1, 2015).

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.

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 2016.

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.

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, 2015) for holding a bed for hospital leave is \$112.01 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.

On April 3, 2014, the state agreed to a Memorandum of Understanding (MOU) with the Centers for Medicare & Medicaid Services (CMS) on April 3rd, which solidified the implementation of a managed care Integrated Care Organization pilot demonstration for dual eligible beneficiaries. The pilot program was effective March 1, 2015, and is used in four regions of the state as follows: the Michigan Upper Peninsula; Southwestern Michigan (containing seven counties); Macomb County and Wayne County. The impact of this project is still to be determined.

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

Michigan Cost Report Statistics												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	80.00	81.25	80.00	106.00	107.50	104.00	138.50	140.75	140.00			
Average Daily Census Occupancy	71.21	75.13	73.87	94.41	96.81	94.67	120.10	125.12	120.59			
	78.5%	80.2%	80.7%	86.2%	86.9%	86.8%	91.7%	92.2%	92.0%			
Payor Mix Statistics												
Medicare	9.8%	9.6%	9.2%	13.2%	13.1%	13.2%	18.9%	18.3%	19.8%			
Medicaid	54.3%	57.7%	55.1%	67.6%	69.0%	69.0%	75.7%	77.0%	76.6%			
Other	15.5%	14.2%	13.4%	23.3%	21.8%	22.8%	68.4%	63.0%	67.3%			
Avg. Length of Stay Statistics (Days)												
Medicare	31.01	30.97	30.23	36.38	37.26	37.82	49.14	47.62	47.75			
Medicaid	223.17	251.87	265.63	344.90	401.69	419.14	567.60	558.52	637.84			
Other	53.36	54.00	53.13	93.80	92.61	86.79	171.04	163.37	162.52			
Revenue (PPD)												
Inpatient	\$218.37	\$219.74	\$228.79	\$242.75	\$246.82	\$251.05	\$276.28	\$296.62	\$308.89			
Ancillary	\$39.18	\$46.65	\$46.70	\$60.77	\$66.28	\$71.65	\$88.81	\$102.06	\$108.03			
TOTAL	\$268.27	\$273.91	\$285.64	\$301.35	\$318.49	\$328.91	\$355.39	\$379.75	\$395.01			
Expenses (PPD)												
Employee Benefits	\$15.83	\$16.09	\$17.31	\$22.06	\$22.83	\$23.63	\$31.62	\$31.65	\$32.36			
Administrative and General	\$42.33	\$42.15	\$44.37	\$50.07	\$48.83	\$50.99	\$56.48	\$56.63	\$56.63			
Plant Operations	\$9.56	\$9.55	\$10.06	\$11.53	\$11.49	\$11.97	\$15.00	\$15.39	\$15.68			
Laundry & Linens	\$2.82	\$2.82	\$2.78	\$3.83	\$3.79	\$3.69	\$4.54	\$4.50	\$4.51			
Housekeeping	\$4.96	\$5.08	\$5.06	\$6.28	\$6.35	\$6.40	\$7.76	\$7.66	\$7.82			
Dietary	\$16.24	\$16.50	\$16.89	\$18.72	\$18.88	\$19.56	\$21.62	\$22.07	\$22.23			
Nursing & Medical Related	\$76.50	\$77.40	\$78.68	\$91.08	\$91.06	\$91.69	\$103.56	\$104.56	\$107.28			
Ancillary and Pharmacy	\$19.75	\$19.58	\$20.57	\$26.49	\$27.61	\$28.18	\$36.13	\$38.25	\$37.93			
Social Services	\$2.31	\$2.32	\$2.39	\$3.34	\$3.49	\$3.57	\$5.05	\$4.85	\$5.14			

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*	375
Licensed Nursing Beds*	29,269
Beds per 1,000 Aged 65 >**	36.91
Beds per 1,000 Aged 75 >**	84.48
Occupancy Percentage - 2013***	89.82%

*Source: Minnesota Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$1,451,303 (effective October 1, 2013).

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 and are not assessed the provider bed tax/license fees. 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. According to representatives of the Minnesota Nursing Home Association (Care Providers of Minnesota), the state's provider fee is below the maximum allowable provider fee (6.0% of total revenue) allowed by the federal government.

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.

CURRENT MEDICAID RATE CALCULATION SYSTEM

Minnesota nursing facilities participating in the state's Medical Assistance (MA) program are currently reimbursed under a facility 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. From 1995 to October 1, 2006, nursing facilities were allowed to choose between the systems. As of October 1, 2006, it was mandated that the remaining facilities utilizing the cost-based property payment methodology convert to the APS.

The initial reimbursement rate under the contract system is the total per diem rate the facility was receiving under the cost-based system at the time the contract was signed with the Commissioner of Human Services. The APS, or contract-based system, was authorized by the legislature in 1995. The goal of the APS was to determine if a system based on contracts between individual facilities and the DHS could reduce nursing facility regulations and allow nursing facilities more fiscal flexibility, while promoting

positive resident satisfaction and healthcare outcomes. The old cost-based system (also known as Rule 50) was implemented in November 1985, with the reporting year running from October 1 to September 30, and a July 1 to June 30 rate year. Minnesota nursing facility rates are currently calculated utilizing an October 1 to September 30 rate year.

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 included operating costs that were divided into two subcategories, nursing costs and other care-related costs. Nursing costs, or case mix costs, included costs related to nursing wages, salaries, fringe benefits and payroll taxes, as well as nursing equipment and supplies. Nursing costs were subject to a spend-up limit, which limited the rate of increase in spending from one year to the next. These rates were also adjusted for case mix using established RUG weights. Other care-related costs included expenses related to social services, activities, therapies, applicable fringe benefits and payroll taxes, as well as food and dietary consultant costs. Other care-related costs were subject to a high-cost limit, which reduces the reimbursement rate for high-cost facilities.
- The Other Operating cost component included dietary services (excluding raw food and dietary consulting), laundry and linen, housekeeping, plant operations and maintenance, and general and administrative. Nursing facilities with other operating cost per diems below specified limits earned a progressive efficiency incentive.
- The Pass-Through cost component included costs paid by the state, including property taxes, special assessments, Public Employee Retirement Act (PERA) pension contributions, and preadmission screening fees. These costs were "passed through" in that they were not subject to the spend-up and high-cost limits.
- 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.

A nursing facility's property reimbursement rate was adjusted annually for inflation and to account for small construction or remodeling projects. The component was also adjusted upon the sale of a facility, completion of a major addition or replacement, or the completion of a moratorium exception project. The sum of these four components determined the total reimbursement rate in the cost-based system. This Medicaid rate, calculated for the year the contract is signed with the Commissioner of Human Services, also served as the initial reimbursement rate under APS.

INFLATION AND REBASING

With the exception of the property payment component, inflation adjustments for the cost-based and APS portions of the rate will be specifically determined based on appropriations from the state legislature. APS law provides for rate adjustments for facilities

under contract, based on inflation. This provision has been set aside for every rate year since 1999, for the operating portion of the rate, because the legislature has taken different actions. The state has not applied any inflation adjustments to non-property portions of APS rates since October 1, 2008. This includes fiscal year 2009 to 2014 rates. In addition, any inflation of non-property rates is suspended through September 30, 2017.

Effective October 1, 2008, nursing facilities received a 1% cost of living adjustment (COLA) increase over the prior year's rate. In addition, nursing facilities received a one-time temporary 1% COLA increase for rates effective October 1, 2008. In Minnesota, a COLA adjustment is an increase given when a facility agrees to a plan by which employee compensation is increased. In addition, 75% of the additional funding made available through the COLA adjustments must be used for increases in compensation-related costs for eligible employees. Also, two-thirds of 75% of the second COLA adjustment must be used to provide quarterly bonuses to all eligible employees. The state has not applied any COLA adjustment to rates since October 1, 2008.

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, inflation adjustments were 1.84% and 1.73%, respectively. However, property cost component rates were frozen at fiscal year 2011 levels in fiscal years 2012, 2013 and 2014 and will be frozen indefinitely. More details of why this will occur are included in the "Changes to the Medicaid System Based on 2007 Legislation" section.

OTHER RATE PROVISIONS

Nursing homes participating in the Medicaid program cannot charge higher rates to private residents than the rates set for similar Medicaid residents. Rate equalization does not apply to single-bed rooms. In addition, for the first 30 days of a new admission, nursing facilities can charge private pay residents up to 120.0% of the equivalent Medicaid rate for semiprivate accommodations.

CHANGES TO THE MEDICAID SYSTEM BASED ON 2007 LEGISLATION

Included in 2007 legislation were significant changes to the Medicaid reimbursement system. On October 1, 2008, DHS began to phase in a new method for determining operating payment rates based on cost report data. The new methodology determines both facility-specific and resident-specific rates. The new total rate will include an Operating rate component, an External fixed rate component and a Property Payment rate component.

COST CENTERS

- The Operating rate component will be a blend of the rates that would have been provided under the APS and cost-based system. For the cost-based portion of the Operating rate, the operating cost will equal the sum of direct care costs (nursing costs) and other care costs. The other care expenses include activities, other direct care, raw food, therapy and social service costs. An efficiency incentive is also established for the other care portion of the cost component.

- The External Fixed rate component includes reimbursement for the nursing facility license surcharge (quality assurance fee), licensure fees, scholarships, 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. Elements of the external fixed rate will be removed from the APS rate used to calculate the operating payment blend.
- The Property Payment rate component will continue to be based on the APS system until 2014, when it will be converted to a cost-based estimate or some other type of system.

INFLATION AND REBASING

The cost-based portion of the total Medicaid rate in the first year (effective October 1, 2008) of the new methodology was based on cost report data for the year October 1, 2006, to September 30, 2007. The APS rates are based on cost report data that was available when a nursing facility converted to the system.

Initially, Operating Cost payment rates were scheduled to be rebased on October 1, 2016, and every two years after that date. However, given budgetary issues, this rebasing was delayed. Rebasing will be calculated using cost report data for the year prior to the year the rebasing occurs. With the exception of the Property Payment Component, inflation adjustments for the cost-based and APS portions of the rate will be 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 since October 1, 2008, for several years. This includes fiscal year 2009 to 2013 rates. However, exclusive of APS rates, effective September 1, 2013, the state inflated operating rates from 3.75% to 6.35%. This reflects that some facilities received larger increases related to the quality score utilized to determine the state's quality add-on. Rates established on September 1, 2013, will remain frozen through September 30, 2015. In addition, the state intends to inflate operating rates from 2.4% to 4.4% effective October 1, 2015. The inflation percentage will also vary based on a nursing facility's quality score.

RATE METHODOLOGY

For the year beginning October 1, 2008, the operating rate will be equal to 13% of the cost-based rate and 87% of the APS rate. Originally, the blending was planned to occur along the following schedule, with rates being completely cost-based on October 1, 2015.

Effective October 1 of:	Cost-based Portion	APS Portion
2008	13%	87%
2009	14%	86%
2010	14%	86%
2011	31%	69%
2012	48%	52%
2013	65%	35%
2014	82%	18%
2015	100%	0%

Given budgetary issues, the state initially suspended the phase-in for fiscal years 2010 and 2011. However, the state has since indefinitely suspended the phase-in. Therefore, current nursing facility Medicaid rates still equate to 13% of the cost-based rate and 87% of the APS rate. The following is a summary of how the state will calculate cost-based rates in a rebasing year. However, given the above mentioned factors, nursing facility rates have remained relatively unchanged since October 1, 2008. In fiscal years 2010, 2011 and 2012 nursing facility rates experienced minor changes resulting from the inflation of the property rate, the recalculation of a portion of the external fixed rate and any case mix adjustments. Rates remained relatively unchanged in fiscal year 2013. However, as previously maintained, operating rates were inflated from 3.75% to 6.35% on September 1, 2013. In addition, operating rates effective October 1, 2015, will be inflated from 2.4% to 4.4%.

Property rates are essentially frozen indefinitely. This reflects that property rates will remain the same until cost-based rates equate to 82% of the phased-in rates. Given that cost-based rates currently only equate to 13% of total phased-in rates and that the phase-in is suspended indefinitely, cost-based rates will remain frozen for the foreseeable future.

One significant policy change did occur on January 1, 2012. Effective this date, the state converted from a RUG III system to the RUG IV, 48-Group model for the purpose of adjusting direct care costs for acuity.

The Direct Care 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 times total days or summing the total of each specific case mix class times the number of days in that class. For purposes of calculating the limit on the total direct care-related per diem, nursing facilities in Minnesota are categorized into one of two facility types and three peer groups. The two facility types are hospital-attached, or freestanding nursing facilities. The peer group categories are as follows:

Peer Group	Counties Included in Peer Group
Peer Group 1	Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright Counties
Peer Group 2	Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Wing, Fairbault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan or Wilkes Counties
Peer Group 3	All other counties

The Direct Care ceiling cost for nursing facilities must equate to 120% of the median cost for all nursing facilities within a facility's peer and facility group type. The Other Care related per diem will

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be the sum of the facility's other care costs divided by the facility's resident days. An Other Care cost ceiling will be determined for each of the three previously described peer groups. A facility's Other Care cost ceiling must equate to 105% of the median for its peer group. Nursing facilities are also eligible to receive an efficiency incentive if their Other Care costs per diem are below the cost ceiling of their peer group. In previous years, nursing facilities are also eligible to receive an efficiency incentive if their Other Care costs per diem are below the cost ceiling of their peer group. However, this incentive has been eliminated.

The final step in calculating the Operating rate component is to apply the Facility Average Case Mix Index RUG weights to the sum of the Direct Care and Other Care subcomponents to calculate facility-specific Medicaid rates for each RUG category. The case mix adjusted Operating rate component is added to the External Fixed and Property rate components to calculate the total Medicaid rate per RUG category.

For rates effective October 1, 2008, the state has established a minimum and maximum rate for the Operating rate component. The minimum rate equates to 101% of the facility's fiscal year 2008 rate. Representatives of the state have indicated that these standards will not be repealed in future rate years. The maximum rate equates to approximately 1.032% of the fiscal year 2008 rate. During the phase-in, for years beginning October 1, 2009, nursing facilities were held harmless to the October 1, 2008, rate at least until June 30, 2011. However, given that operating rates have been frozen since October 1, 2008, this provision is no longer relevant.

Under the new system, nursing facilities will receive a per diem reimbursement for the surcharge per diem that equates to \$8.86 as part of their external fixed rate. The portion of the external fixed rate related to the license fee equates to the fee divided by the actual resident days. The scholarship portion of the component is a 25-cent per diem that a facility is eligible to receive if it provides tuition and direct educational benefits to its employees. The portion of the component equated to long-term consultation is based on the facility's payments for this program. The state determines the amount for each county and the county appropriates it based on an equal amount per bed. The county will use this to fund programs that provide assistance to county residents when making long-term care decisions. The portion of the component attributed to development and education of resident and family advisory councils is \$5.00 divided by 365.

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 PCRA factor is a dollar value per bed (initially limited to \$2,080), which is subject to negotiation with the DHS. Effective June 30, 2009, the PCRA was frozen at \$2,080 per bed. The state eliminated this program effective October 31, 2011, but the PCRAs that were already included in facilities' rates will not be affected by the end of the program. Anyone who had a planned closure application approved prior to the termination of this program still had 18 months to act on it. However, the state recently reinstated the PCRA in fiscal year 2014, utilizing the previous methodology. Rates effective October 1, 2014, will also include PCRAs.

The portions of the external fixed rate component related to PERA, property insurance, real estate taxes, special assessments and payments in lieu of taxes will be 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. Nursing facilities that convert units into single-bed rooms will have their operating rate component increased by a factor calculated by multiplying 20% by the ratio of the number of new single-bed rooms. The ratio of the number of new single-bed rooms is calculated by dividing the number of new single-bed rooms by the total number of active beds. The state also provides a limited add-on for bed layway, which is based on the allocation of property costs over a fewer number of beds.

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. All proposals must contain facility-specific baseline data or at a minimum a detailed description of how the baseline data will be gathered. Improvement objectives must include specific and measurable levels of improvement. Nursing facilities can lose up to 20.0% of their project funding if these facilities fail to achieve these measurable outcomes, which are tied to state nursing home performance standards. Effective July 1, 2012, to June 30, 2013, \$2.4 million dollars of funding will be available for this program. From July 1, 2013, to June 30, 2014, the funding is anticipated to increase to \$3.1 million.

Effective September 30, 2013, the state provided nursing facilities with a quality add-on that can equate to up to 3.2% of a nursing facility's operating rate. The actual add-on amount will be facility-specific and will depend on how well each nursing facility performs in the following two quality measures: the Minnesota Resident Quality of Life and Satisfaction Survey and Minnesota Department of Health inspection results. These are the measures that are included in Nursing Home Report Cards that are published by the Minnesota Department of Human Services. Quality add-ons will be included in fiscal year 2015 rates as well.

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.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no planned or proposed changes to the state's rate setting methodology.

MINNESOTA COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	55.00	54.00	51.25	75.00	70.00	69.00	105.00	104.25	103.50	
Average Daily Census	49.11	47.33	46.33	71.20	67.91	65.76	99.88	99.84	97.27	
Occupancy	84.9%	84.4%	84.2%	90.4%	90.7%	90.4%	93.5%	94.4%	94.0%	
Payor Mix Statistics										
Medicare	6.2%	5.8%	5.8%	9.2%	8.6%	8.2%	12.8%	11.9%	11.9%	
Medicaid	45.2%	45.1%	44.3%	52.8%	53.5%	52.7%	62.3%	61.9%	59.7%	
Other	30.2%	31.3%	33.3%	39.5%	39.2%	40.7%	57.0%	54.2%	54.2%	
Avg. Length of Stay Statistics (Days)										
Medicare	26.27	25.90	25.60	33.82	34.39	34.00	42.15	47.86	48.22	
Medicaid	307.12	275.78	310.50	464.20	483.58	528.89	669.16	826.83	799.40	
Other	74.00	88.81	77.83	137.47	144.72	144.51	226.73	274.14	240.63	
Revenue (PPD)										
Inpatient	\$164.38	\$163.21	\$165.53	\$183.48	\$182.45	\$181.97	\$207.78	\$206.48	\$206.20	
Ancillary	\$25.98	\$26.79	\$29.26	\$42.24	\$41.88	\$44.31	\$64.97	\$60.76	\$63.64	
TOTAL	\$203.59	\$198.55	\$199.46	\$232.64	\$228.29	\$235.01	\$274.31	\$267.21	\$278.44	
Expenses (PPD)										
Employee Benefits	\$18.27	\$18.85	\$18.90	\$21.81	\$22.14	\$22.50	\$28.34	\$28.93	\$29.11	
Administrative and General	\$27.31	\$26.53	\$27.84	\$31.73	\$33.02	\$33.34	\$39.03	\$39.91	\$42.78	
Plant Operations	\$8.43	\$8.94	\$9.38	\$10.29	\$10.55	\$11.37	\$12.76	\$13.14	\$14.22	
Laundry & Linens	\$2.39	\$2.28	\$2.32	\$2.93	\$2.84	\$2.94	\$3.75	\$3.74	\$3.79	
Housekeeping	\$4.01	\$4.17	\$4.03	\$5.20	\$5.33	\$5.38	\$6.25	\$6.47	\$6.92	
Dietary	\$15.91	\$16.68	\$17.10	\$18.41	\$19.18	\$19.36	\$21.00	\$21.60	\$22.23	
Nursing & Medical Related	\$70.55	\$72.00	\$74.19	\$81.35	\$81.68	\$82.20	\$93.06	\$94.36	\$95.89	
Ancillary and Pharmacy	\$13.18	\$13.10	\$13.66	\$20.59	\$19.73	\$19.90	\$28.67	\$28.07	\$30.63	
Social Services	\$2.72	\$2.92	\$2.88	\$6.03	\$5.79	\$5.83	\$7.98	\$7.93	\$7.93	

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*	206
Licensed Nursing Beds*	19,076
Beds per 1,000 Aged 65 >**	43.97
Beds per 1,000 Aged 75 >**	106.21
Occupancy Percentage - 2013***	87.01%

*Source: Mississippi State Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$2,000,000.
- 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 2014 State Health Plan. The MDH

utilized 2015 and 2020 population projections prepared by the Center for Policy Research and Planning of the Institutions of Higher Learning 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 2014 State Health Plan estimates a need for 3,817 additional nursing facility beds in 2015 and 2020. 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. A nursing facility's assessment fee expense is included as an allowable cost in the Administrative and Operating cost component. Given this factor, although nursing facility rates were frozen between January 1, 2010, and December 31, 2013, nursing facility Administrative and Operating cost component rates and ceilings were increased to reflect the additional cost related to the increase in the NFAF.

MEDICAID RATE CALCULATION SYSTEM

Mississippi Medicaid utilizes a case mix adjusted, cost-based, facility-specific rate setting system to calculate Medicaid rates. The Mississippi case mix system utilizes the Mississippi Base Weights (M3PI) system, which contains 34 total groups and is patterned on the Resource Utilization Groups III (RUG III) classification system.

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, contracted expenses for registered nurses, licensed practical nurses 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, 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-

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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, utilities, provider fee expenses, auto lease, non-emergency transportation and miscellaneous expense.

- 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 the most recent cost report data available. The rate year is from January 1 to December 31. Rates effective January 1, 2010, were based on year ending June 30, 2008, 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, 2010, the trend factors were 3.78% of Direct Care and Care Related costs, and 3.51% for Administrative and Operating costs. However, given budget limitations, base rates effective January 1, 2010, were frozen through December 31, 2013. The state rebased rates on January 1, 2014, utilizing 2012 cost report data.

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 M3PI to classify nursing home residents to determine facility-specific average case mix indexes (CMIs). This classification system utilizes specific items from the Minimum Data Set (MDS) to assign residents to categories, which reflect a resident's functional status as well as resource utilization to meet resident care needs. All nursing facilities complete an MDS quarterly. The M3PI contains 34 total groups and is based on a descending hierarchical order ranging from most to least resource intense, which is based on the RUG III classification.

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 computing the average CMI for each facility to be used in adjusting the standard Direct Care rate, a quality incentive is considered. This incentive is only available to facilities whose case mix adjusted Direct Care and Care Related per diem costs are greater than or equal to 90.0% of the median for the cost report period used to compute the base rate. These incentives will increase the M3PI used to compute the average CMI score for the appropriate calendar quarter. The direct care quality incentive will increase the base weight by 2.0% for certain case mix categories, which reflect higher patient acuity.

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, 2014, is \$56,002. 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% per year (based on the weighted average age of the facility). The maximum allowable amount of depreciation is 30.0%. The total new construction value adjusted for depreciation is multiplied by the rental factor to determine the FRV. The rental factor is determined utilizing the Treasury Securities' Constant Maturities (10-year), as published by the Federal Reserve Statistical Release, using the average for the second calendar year preceding the beginning of the rate period. The minimum allowable rental factor is 9.5% (which includes a 2.0% risk premium) and the maximum allowable rental factor is 12.0%. 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 historical Medicaid rates in Mississippi are as follows: 2007 - \$157.56; 2008 - \$168.19; 2009 - \$177.62; 2010 - \$183.37; 2011 - \$185.62; 2012 - \$187.28; and 2013 - \$187.77. As of April 1, 2014, the average Medicaid rate is \$191.47, which represents a 2.0% increase from the prior year's rates.

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

In 2012, the Mississippi State Legislature passed House Bill 421, which required the Division of Medicaid (DOM) to develop a plan providing revisions to the current reimbursement methodology for nursing facility services. To accomplish this goal DOM established a workgroup that consisted of a combination of professionals from DOM and the state's healthcare associations. The workgroup was initially divided into three sub-groups that would consider the following issues:

- Acuity
- Cost
- Quality

The work group issued their recommendations on January 1, 2014, and the recommendations were incorporated into House Bill 1275. House Bill 1275 has been approved by both the Governor and State Legislature and will significantly alter the Mississippi

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Medicaid rate calculation effective January 1, 2015. Changes in the reimbursement methodology include the following:

Direct Care cost component:

- For the purpose of adjusting rates for CMI, the state will convert from the RUG III Classification system to the RUG IV system, and
- The state will eliminate the 2% access and quality incentive adjustment applied to specific RUG classifications.

FRV Calculation:

- The state will increase the value of a nursing facility bed to \$91,200;
- The state will increase the annual depreciation percentage amount from 1% to 1.75%;
- The state will increase the maximum depreciation from 30% to 50%; and
- The state will decrease the rental factor from 7.5% to 5.35% while maintaining the 2% risk premium.

Return on Equity Per Diem:

- The state will reduce the Return on Equity interest rate from 9.5% to 5.75%. This adjustment (as well as the adjustment to the above mentioned rental factor) reflects that interest rates are significantly lower than when this standard was established 20 years ago.

Ventilator-Dependent Residents:

- The state will provide an add-on to Medicaid rates for large and small nursing facilities that provide the necessary treatment and services for ventilator-dependent residents.

These changes will need to be approved by the Centers of Medicare and Medicaid (CMS) as part of a state plan amendment. As of the date of this overview, the state has not submitted a state plan amendment to CMS. However, representatives of the Mississippi Healthcare Association have indicated that there is no indication that these changes will not be made. Also, these professionals indicated that these changes would be budget neutral and will not result in a significant alteration to current Medicaid rates.

MISSISSIPPI COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	60.00	60.00	60.00	96.00	94.00	94.00	120.00	120.00	120.00			
Average Daily Census	56.79	56.64	55.67	80.72	79.02	77.26	107.83	106.94	106.04			
Occupancy	84.5%	84.9%	83.7%	90.3%	90.4%	89.8%	94.0%	94.2%	93.4%			
Payor Mix Statistics												
Medicare	12.2%	10.6%	11.1%	15.2%	13.7%	14.5%	19.8%	18.1%	19.3%			
Medicaid	70.0%	68.8%	68.2%	78.1%	77.0%	76.7%	82.1%	82.6%	81.5%			
Other	5.1%	5.9%	6.1%	8.7%	11.2%	10.5%	19.7%	21.4%	21.5%			
Avg. Length of Stay Statistics (Days)												
Medicare	46.02	47.81	45.33	59.79	61.72	59.51	84.88	87.21	82.76			
Medicaid	610.37	619.63	633.51	814.06	882.48	858.15	1,441.12	1,330.73	1285.05			
Other	96.00	100.27	90.54	190.00	161.68	156.40	410.88	298.93	308.49			
Revenue (PPD)												
Inpatient	\$180.32	\$179.61	\$190.38	\$200.08	\$195.77	\$210.81	\$216.62	\$215.58	\$224.44			
Ancillary	\$41.66	\$38.47	\$37.31	\$57.02	\$53.33	\$54.45	\$77.81	\$81.34	\$77.83			
TOTAL	\$223.14	\$222.86	\$234.29	\$257.92	\$246.67	\$259.08	\$289.82	\$291.53	\$298.21			
Expenses (PPD)												
Employee Benefits	\$11.16	\$12.00	\$13.02	\$16.04	\$16.10	\$16.48	\$20.22	\$19.65	\$19.61			
Administrative and General	\$39.39	\$39.71	\$39.85	\$42.59	\$43.88	\$44.34	\$46.59	\$46.69	\$49.62			
Plant Operations	\$8.38	\$8.42	\$8.60	\$10.02	\$9.75	\$9.98	\$11.41	\$11.30	\$11.74			
Laundry & Linens	\$2.47	\$2.58	\$2.32	\$2.99	\$3.06	\$3.04	\$3.80	\$3.55	\$3.50			
Housekeeping	\$4.23	\$4.32	\$4.53	\$4.99	\$4.87	\$5.09	\$5.91	\$6.15	\$6.32			
Dietary	\$14.09	\$14.35	\$14.52	\$15.52	\$15.69	\$15.89	\$17.09	\$17.35	\$17.68			
Nursing & Medical Related	\$66.57	\$65.85	\$66.24	\$71.83	\$71.93	\$72.47	\$80.22	\$79.25	\$80.57			
Ancillary and Pharmacy	\$23.22	\$21.62	\$22.24	\$29.21	\$27.40	\$27.56	\$35.94	\$33.71	\$34.49			
Social Services	\$1.64	\$1.59	\$1.66	\$2.29	\$2.43	\$2.38	\$4.29	\$4.11	\$4.27			

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

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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*	496
Licensed Nursing Beds*	54,370
Beds per 1,000 Aged 65 >**	57.46
Beds per 1,000 Aged 75 >**	133.68
Occupancy Percentage - 2013***	72.13%

*Source: Missouri Department of Health & Senior Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 June 15, 2015, the state determined that there will be an approximate surplus of 1,011 beds by the year 2020, with an anticipated bed need in 42 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.

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 were last rebased for the rates effective July 1, 2004. These rates

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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. According to Missouri rate setting officials, the state intends to increase nursing facility rates \$2.09 per Medicaid day effective January 1, 2016. However, the regulations for this rate increase have not been finalized by the state and this rate increase will also need to be approved by the Centers for Medicare and Medicaid (CMS) as part of a state plan amendment.

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

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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. The statewide average rate for fiscal year 2016 is \$153.68, which represents a 0.8% increase from the statewide average of \$152.42 effective fiscal year 2015. The previous weighted average rates are as follows: July 1, 2013 – \$151.56; July 1, 2012 – \$147.48; October 1, 2011 – \$140.70; January 1, 2010 – \$132.13; and July 1, 2009 – \$132.23.

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.

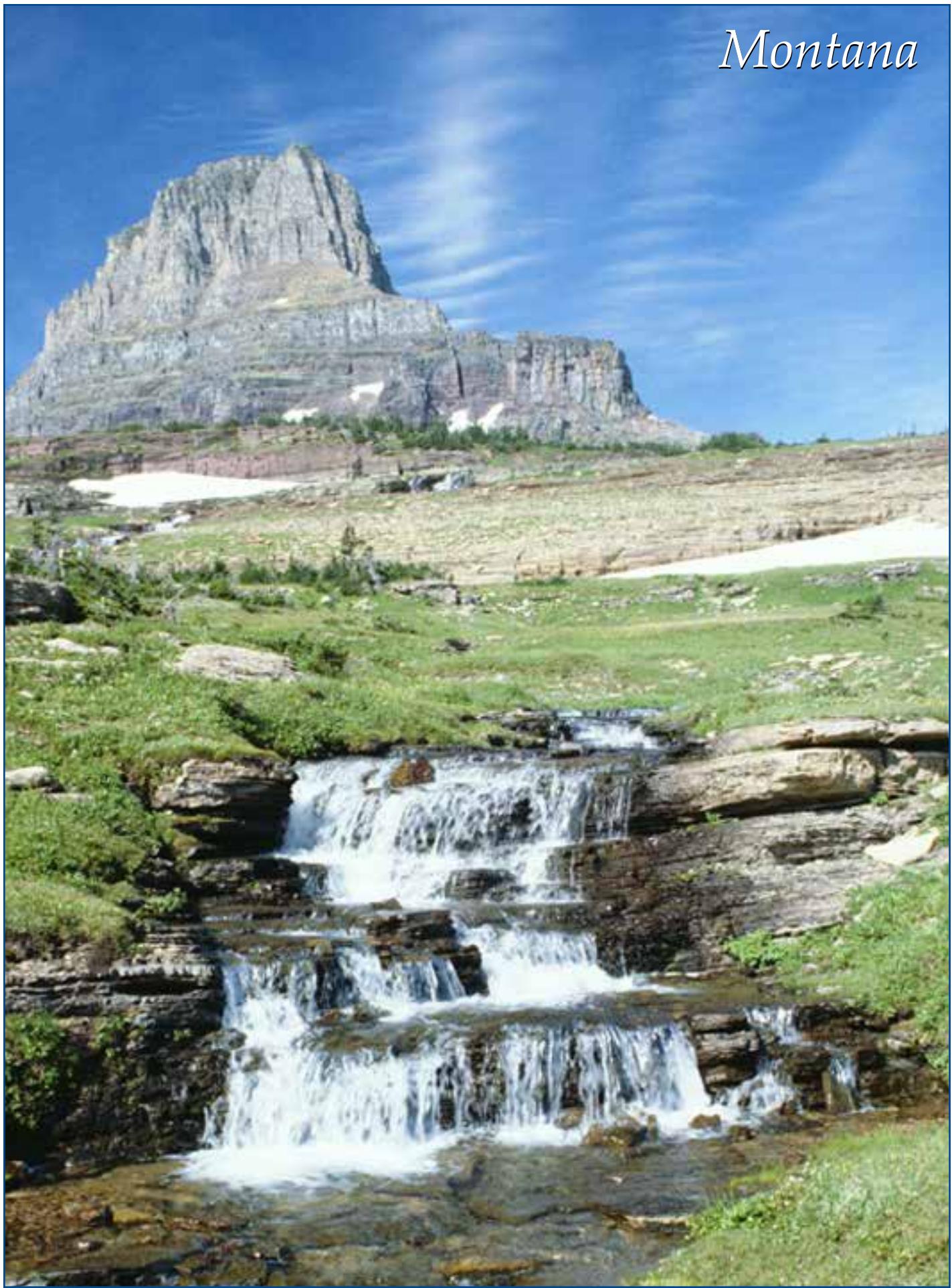
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this publication, 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				
	2011	2012	2013	2011	2012	2013	2011	2012	2013		
	Number of Beds	60.00	60.00	60.00	96.00	96.00	96.00	120.00	120.00	120.00	
	Average Daily Census	57.42	56.80	55.83	77.12	76.06	74.44	99.67	101.06	100.39	
Occupancy	64.2%	65.8%	65.3%	74.4%	75.5%	75.0%	85.8%	85.8%	86.1%		
Payor Mix Statistics											
Medicare	7.0%	6.2%	6.0%	9.7%	9.0%	8.8%	13.9%	12.9%	12.1%		
Medicaid	46.7%	47.7%	48.6%	57.4%	58.8%	57.9%	68.0%	69.0%	68.4%		
Other	22.9%	21.8%	23.1%	33.1%	32.9%	34.3%	50.4%	49.5%	49.8%		
Avg. Length of Stay Statistics (Days)											
Medicare	27.86	29.73	31.22	36.67	39.02	41.77	52.20	54.86	55.99		
Medicaid	190.47	217.48	218.31	264.74	288.50	300.45	371.92	403.21	420.08		
Other	97.08	92.15	99.30	156.43	152.25	155.17	276.60	258.80	241.01		
Revenue (PPD)											
Inpatient	\$139.92	\$145.04	\$147.75	\$158.97	\$160.01	\$166.33	\$180.45	\$190.34	\$196.35		
Ancillary	\$25.73	\$25.81	\$25.51	\$36.84	\$37.59	\$38.09	\$53.04	\$55.78	\$55.16		
TOTAL	\$170.48	\$175.78	\$180.08	\$197.97	\$202.50	\$203.96	\$233.34	\$243.70	\$248.62		
Expenses (PPD)											
Employee Benefits	\$9.04	\$9.01	\$9.02	\$11.55	\$11.67	\$12.20	\$15.90	\$16.24	\$16.82		
Administrative and General	\$28.97	\$31.40	\$31.39	\$33.09	\$35.55	\$35.87	\$38.65	\$41.12	\$41.45		
Plant Operations	\$7.91	\$7.86	\$8.38	\$9.39	\$9.04	\$9.69	\$11.40	\$11.07	\$11.42		
Laundry & Linens	\$1.90	\$1.87	\$1.88	\$2.43	\$2.38	\$2.44	\$3.01	\$2.94	\$3.03		
Housekeeping	\$3.95	\$3.95	\$4.02	\$4.68	\$4.73	\$4.91	\$5.64	\$5.69	\$5.84		
Dietary	\$12.65	\$12.93	\$13.13	\$14.59	\$14.61	\$14.82	\$16.86	\$16.55	\$17.01		
Nursing & Medical Related	\$46.97	\$48.10	\$49.06	\$55.39	\$55.59	\$57.21	\$65.13	\$64.94	\$65.97		
Ancillary and Pharmacy	\$14.92	\$14.39	\$14.12	\$20.68	\$19.63	\$19.54	\$28.66	\$27.90	\$27.09		
Social Services	\$1.27	\$1.33	\$1.36	\$1.93	\$1.99	\$2.03	\$3.09	\$2.99	\$3.12		

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*	84
Licensed Nursing Beds*	6,772
Beds per 1,000 Aged 65 >**	39.10
Beds per 1,000 Aged 75 >**	94.61
Occupancy Percentage - 2013***	66.32%

*Source: Montana Department of Public Health and Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 provision by a hospital of services for long-term 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 July 2010) resulted in the determination of moderate demand for additional nursing facility beds in 20 of 59 communities with an existing nursing facility. However, only three of these communities (Boulder, Sidney and Whitefish) have bed need for more than 10 beds. The Sidney area has the greatest amount of bed need (14 beds). According to state CON professionals, the state will update the bed need calculation in the near future.

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. Since state fiscal year (SFY) 2007, the NFBT has been \$8.30 per bed day.

Currently, \$2.80 of the fee per day is allocated to the general fund, which funds the nursing facility budget. The balance, or \$5.50 per day, is allocated to the nursing facility utilization fee account, a state special revenue fund that is required to fund the nursing facility budget at the level required.

Historically, the NFBT was \$4.50 in 2003 and 2004, \$5.30 in 2005 and \$7.05 in 2006.

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 add-ons 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.

According to representatives of the Montana Health Care Association (MHCA), the state is projected to increase nursing facility Medicaid rates 2.0% per year in the next bi-annual budget (SFYs 2014 and 2015).

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 SFY 2012, total program expenditures were \$171,106,008. The total estimated program expenditures for fiscal year 2013 are approximately \$170,207,317.

Each nursing facility receives the same Operating component rate, which is 80% of the statewide price for nursing services. For SFY 2013, that amount is \$126.58. The Direct Resident Care component of each facility's rate is 20% of the overall statewide price for nursing services. For SFY 2013, the portion of the statewide price attributed to the Direct Resident Care component was \$31.64.

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.

The following table summarizes the average statewide Medicaid reimbursement rates, as well as the ranges, for SFYs 2010, 2011, 2012 and 2013:

Statewide Figures for SFYs 2010, 2011, 2012 and 2013						
	SFY 2010	SFY 2011	SFY 2012	% Change	SFY 2013	% Change
Statewide Average Rate	\$161.90	\$163.87	\$161.75	-1.3%	\$162.66	0.6%
Maximum	\$168.34	\$167.77	\$166.31	-0.9%	\$167.66	0.8%
Minimum	\$156.62	\$158.95	\$156.54	-1.5%	\$157.46	0.6%

In addition to the per diem rate calculated above, facilities are eligible for a supplemental payment related to the state's wage initiative. The 2009 Montana Legislature approved funding for a wage initiative for direct care and ancillary workers in both nursing facilities and swing bed facilities in Montana for SFY 2010 that went into effect July 1, 2009. It was allocated in House Bill 645 as a one-time appropriation, but was extended for SFY 2011. The total expenditure was \$5,515,093 in SFY 2011 and was paid in two lump sum payments, the first in July 2010 and the second in January 2011. The total expenditures for SFY 2010 were \$5,729,357.

The allocations are facility specific. To receive the direct care and/or ancillary services workers' lump sum payment, a nursing facility must submit a request form to the department stating how the direct care and ancillary services workers' lump sum payment will be spent in the facility to comply with all statutory requirements. The state continued the wage initiative program through fiscal year 2013. However, funding for the wage initiative was reduced to \$3,862,986. Total funding for SFY 2013 increased slightly to \$3,981,106, and equates to an approximate \$3.81 per Medicaid day add-on. According to representatives of both Montana Department of Public Health and Human Services (MDPHHS) and MHCA, the WPT add-on will be maintained in SFYs 2014 and 2015 at similar funding and reimbursement levels provided in SFY 2013. Lump sum payments continue to be made on July 1 and January 1 of the current fiscal year.

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 a per diem increase of approximately \$2.00 per day to non-county facilities. However, changes in CMS regulations have enabled the state to receive increased funding through the program. This resulted in the average IGT reimbursement for non-county facilities being increased to approximately \$6.39 and \$8.58 per Medicaid day in fiscal years 2011 and 2012, respectively. These increases partially offset the 2% rate reduction and the reduction in the wage initiative payment. Reimbursement generated from the IGT program is projected to remain similar in fiscal year 2013.

MINIMUM OCCUPANCY STANDARDS

There are no minimum occupancy standards applied under Montana's Medicaid reimbursement system.

OTHER RATE PROVISIONS

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 a per diem increase of approximately \$2.00 per day to non-county facilities. However, changes in CMS regulations have enabled the state to receive increased funding through the program. As a result, the average IGT reimbursement for non-county facilities was increased to \$6.39 and \$8.58 per Medicaid day in fiscal years 2011 and 2012, respectively. These increases partially offset the 2% rate reduction and the reduction in the wage initiative payment. Reimbursement generated from the IGT program is projected to remain similar in fiscal year 2013.

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

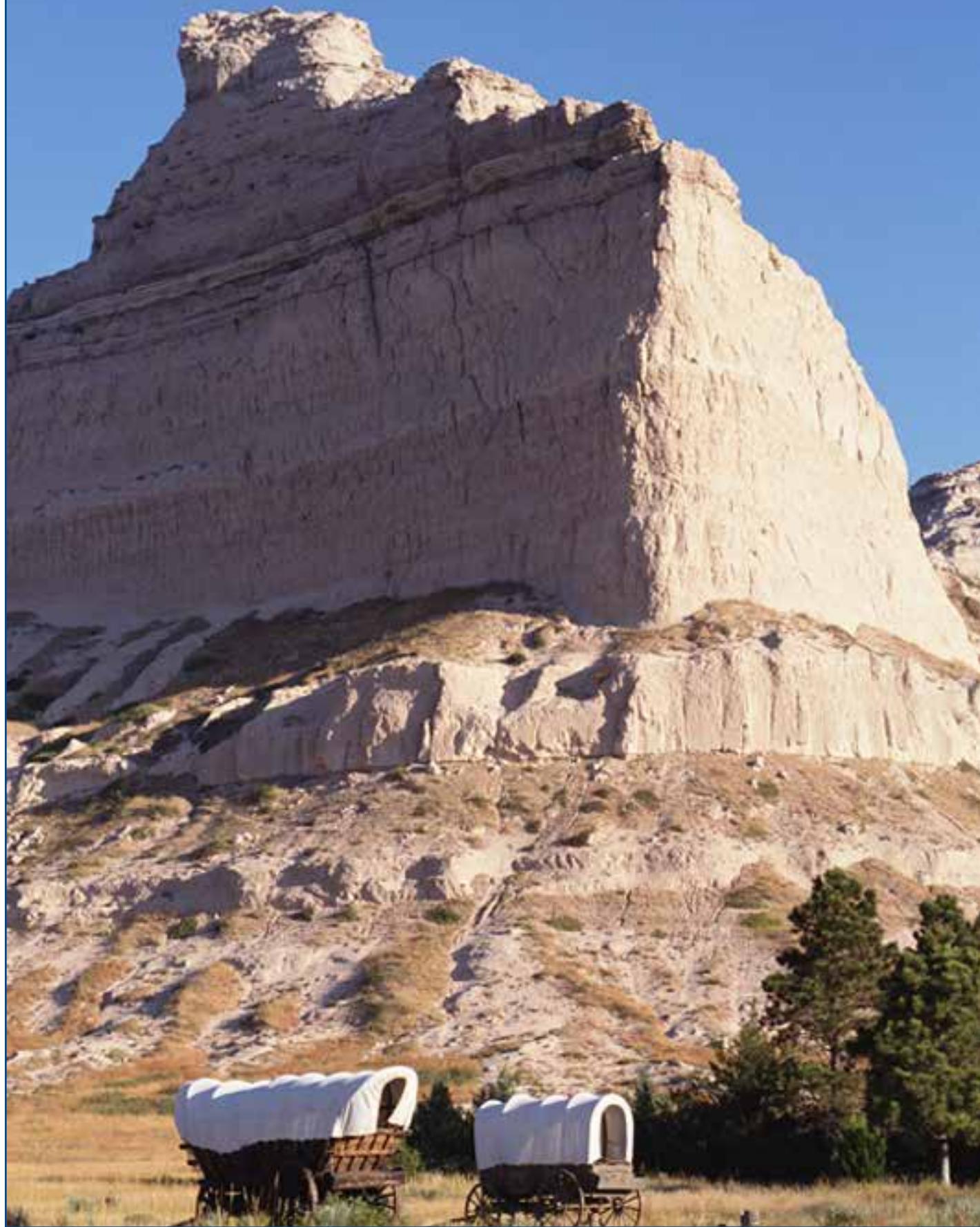
There are currently no changes expected to the Medicaid rate methodology in the immediate future.

Montana

MONTANA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	55.50	49.00	61.00	90.00	72.00	88.50	106.50	100.00	100.75			
Average Daily Census	40.97	40.21	46.09	64.31	58.77	59.06	88.63	76.52	75.98			
Occupancy	62.0%	58.8%	61.7%	73.5%	78.8%	69.5%	83.1%	84.2%	82.8%			
Payor Mix Statistics												
Medicare	3.7%	6.4%	6.2%	9.0%	8.9%	9.1%	14.7%	15.7%	13.7%			
Medicaid	52.6%	54.5%	48.3%	62.0%	61.0%	61.4%	66.4%	67.8%	67.7%			
Other	22.3%	19.6%	24.9%	31.8%	26.6%	35.5%	56.8%	34.2%	75.9%			
Avg. Length of Stay Statistics (Days)												
Medicare	30.06	30.81	28.51	35.55	38.97	40.11	48.20	54.29	54.62			
Medicaid	290.36	334.76	374.79	435.29	370.69	448.00	608.59	494.15	577.28			
Other	92.07	79.08	102.54	159.05	119.38	170.84	310.44	310.96	262.60			
Revenue (PPD)												
Inpatient	\$175.56	\$176.01	\$183.14	\$189.53	\$185.75	\$192.07	\$200.30	\$208.31	\$217.34			
Ancillary	\$9.77	\$12.10	\$20.22	\$30.07	\$29.37	\$30.11	\$52.19	\$63.77	\$58.06			
TOTAL	\$185.53	\$187.59	\$202.61	\$213.92	\$220.23	\$235.05	\$248.16	\$257.71	\$260.32			
Expenses (PPD)												
Employee Benefits	\$15.63	\$15.80	\$16.61	\$21.25	\$19.40	\$19.25	\$24.64	\$22.30	\$22.04			
Administrative and General	\$30.58	\$31.04	\$33.38	\$37.43	\$41.58	\$36.77	\$45.46	\$44.91	\$47.21			
Plant Operations	\$8.75	\$8.67	\$8.75	\$10.49	\$11.04	\$10.36	\$13.50	\$13.41	\$12.73			
Laundry & Linens	\$2.45	\$1.87	\$2.17	\$2.73	\$2.60	\$2.90	\$4.01	\$3.04	\$3.39			
Housekeeping	\$4.27	\$4.09	\$4.51	\$4.69	\$4.84	\$5.02	\$5.87	\$6.00	\$6.38			
Dietary	\$15.56	\$14.75	\$16.11	\$17.38	\$16.75	\$17.51	\$21.73	\$19.11	\$21.09			
Nursing & Medical Related	\$64.91	\$61.33	\$63.50	\$76.98	\$69.39	\$76.12	\$94.25	\$75.35	\$82.47			
Ancillary and Pharmacy	\$5.56	\$9.02	\$8.78	\$14.10	\$16.78	\$16.29	\$29.22	\$37.53	\$32.09			
Social Services	\$2.04	\$3.67	\$2.10	\$3.93	\$4.94	\$4.06	\$5.00	\$6.30	\$5.81			

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*	228
Licensed Nursing Beds*	16,770
Beds per 1,000 Aged 65 >**	60.55
Beds per 1,000 Aged 75 >**	132.70
Occupancy Percentage - 2013***	78.42%

*Source: Nebraska Department of Health & Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 NFOAA 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 regulatorily or statutorily bound to do so. Rates effective July 1, 2014, were calculated utilizing fiscal year 2013 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 year 2015 is 2.13%.

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. Effective October 1, 2010, CMS implemented the RUG IV system and a new MDS 3.0 resident assessment tool, which all nursing facilities will be required to use.

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 the most recently determined federal (CMS) RUG III, version 5.20 effective July 2010, which are based on the Strive Time Study.

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 2015.

Historically, the statewide average Medicaid reimbursement daily rate was \$115.02 in fiscal year 2006, \$124.09 in fiscal year 2007, \$130.59 in fiscal year 2008, \$140.36 in fiscal year 2009, \$142.83 in fiscal year 2010, \$139.69 in fiscal year 2011 and \$146.44 for fiscal year 2012. The most recent statewide average daily Medicaid rate determined by rate setting officials is for calendar year 2013. This rate is \$163.26, which represents an 11.5% increase from the fiscal year 2012 rate.

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 additional planned or proposed changes to the rate system.

NEBRASKA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	47.50	47.00	47.00	64.00	63.00	63.00	88.50	86.50	85.50			
Average Daily Census	41.29	40.86	40.35	57.41	55.83	53.94	86.01	81.17	80.38			
Occupancy	73.4%	73.5%	70.4%	81.7%	81.0%	80.2%	87.4%	87.9%	87.4%			
Payor Mix Statistics												
Medicare	5.5%	5.7%	5.6%	8.0%	7.8%	7.9%	11.6%	10.1%	11.1%			
Medicaid	38.7%	36.3%	37.1%	48.2%	46.3%	45.9%	57.6%	60.1%	58.7%			
Other	32.2%	32.3%	33.8%	47.0%	47.7%	47.2%	60.1%	62.0%	62.1%			
Avg. Length of Stay Statistics (Days)												
Medicare	34.92	34.08	34.94	47.80	47.88	49.64	60.20	66.50	68.64			
Medicaid	336.68	350.33	346.36	549.17	511.00	530.04	1009.86	766.03	807.50			
Other	181.15	184.48	173.04	331.36	298.25	299.43	498.54	497.87	459.07			
Revenue (PPD)												
Inpatient	\$159.01	\$164.59	\$169.86	\$181.30	\$183.44	\$188.61	\$207.96	\$207.95	\$212.44			
Ancillary	\$17.23	\$15.64	\$15.23	\$29.43	\$27.09	\$29.03	\$47.29	\$47.21	\$54.07			
TOTAL	\$179.72	\$185.22	\$189.37	\$211.42	\$207.96	\$216.78	\$246.68	\$249.51	\$263.65			
Expenses (PPD)												
Employee Benefits	\$14.76	\$15.08	\$15.81	\$17.74	\$17.63	\$18.43	\$21.75	\$22.81	\$23.14			
Administrative and General	\$18.27	\$21.23	\$21.04	\$24.66	\$26.15	\$26.10	\$29.61	\$31.00	\$32.65			
Plant Operations	\$8.37	\$8.43	\$9.05	\$10.02	\$9.80	\$10.70	\$11.90	\$12.17	\$13.33			
Laundry & Linens	\$1.95	\$1.92	\$2.01	\$2.54	\$2.54	\$2.67	\$3.17	\$3.32	\$3.42			
Housekeeping	\$3.56	\$3.64	\$3.77	\$4.47	\$4.43	\$4.54	\$5.54	\$5.76	\$6.14			
Dietary	\$14.01	\$14.40	\$15.17	\$16.58	\$16.88	\$17.41	\$20.53	\$21.04	\$21.18			
Nursing & Medical Related	\$62.55	\$64.12	\$66.52	\$72.39	\$74.45	\$75.59	\$85.34	\$86.08	\$90.00			
Ancillary and Pharmacy	\$9.77	\$10.00	\$10.88	\$15.88	\$15.63	\$16.32	\$24.99	\$24.02	\$24.38			
Social Services	\$1.83	\$1.84	\$2.01	\$4.13	\$4.32	\$4.67	\$6.30	\$6.32	\$6.37			

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*	48
Licensed Nursing Beds*	5,767
Beds per 1,000 Aged 65 >**	14.38
Beds per 1,000 Aged 75 >**	37.95
Occupancy Percentage - 2013***	81.82%

*Source: Nevada Department of Health and Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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:

Effective Date	Fee to Increase the Quality of Nursing Care	
	Fee for Facilities w/ Medicaid Occupancy of 65% or greater	Fee for Facilities w/ Medicaid Occupancy of less than 65%
10/1/2011	\$15.46	\$31.48
1/1/2012	\$15.92	\$33.56
4/1/2012	\$16.54	\$30.61
7/1/2012	\$15.24	\$32.17
10/1/2012	\$17.12	\$32.71
1/1/2013	\$17.41	\$30.85
4/1/2013	\$17.64	\$29.68
7/1/2013	\$18.10	\$31.41
10/1/2013	\$18.22	\$32.87
1/1/2014	\$17.75	\$30.54

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. The most recent rebasing was in fiscal year 2012 (effective July 1, 2011), primarily utilizing 2009 and 2010 cost report data, as facilities have differing fiscal years. The state previously rebased rates effective July 1, 2007, and July 1, 2009. The July 1, 2009, rates were based on 2006 and 2007 cost report data. However, the periodic rebasing of rates has had only a limited impact on nursing facility rates given that funding levels for nursing home reimbursement have essentially been flat since October 1, 2001. In addition, the state did not rebase rates in fiscal year 2013.

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. According to Nevada rate setting professionals, no inflation adjustments were applied to costs utilized to calculate fiscal year 2012 and 2013 rates.

Nevada rebased rates on July 1, 2013, and applied the standard inflation adjustment; however, these adjustments had a limited impact given the subject's budget-neutrality adjustment. In addition, funding for the portion of Medicaid reimbursement that is paid out through supplemental payments decreased \$5.00 effective July 1, 2013. However, this was partially offset by an increase in the federal matching percentage for Nevada.

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, 2013, the base value is \$106,016 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>\$106,016</u>
Gross Value	<u>\$10,601,600</u>
Depreciation Rate (1.5% x 20 years)	30.0%
Depreciated Value (70.0%)	<u>\$7,421,120</u>
Rental Rate	9.0%
FRV Payment (Gross)	<u>\$667,901</u>
Divided by Greater of Actual or Minimum Days (at least 92.0%)	33,580
Fair Rental Value Payment	\$19.89

The above facility's Capital component for the current year would be \$19.89. 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. Based on the above described methodology, the weighted average Medicaid rate is determined for the state. Once this is determined, the previously budget neutral rate (\$116.66) is divided by the statewide weighted average rate to calculate the budget adjustment factor. For fiscal year 2013 (effective July 1, 2012), the weighted average rate was \$215.57, which results in a budget adjustment factor of 0.5412 ($\$116.66/\$215.57 = 0.5412$). 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: October 1, 2012 - 0.5396; January 1, 2013 - 0.5405; April 1, 2013 - 0.5429; July 1, 2013 - 0.5429; October 1, 2013 - 0.5244; January 1, 2014 - 0.5256; and April 1, 2014 - 0.5258. 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	= $(\text{Medicaid Nursing Facility Patient Days} + \text{LTC Hospice Patient Days}) / \text{Total Patient Days}$
Medicaid Occupancy Rate	$\times 100 = \text{Medicaid Occupancy Modifier}$
Medicaid Occupancy Modifier	$(\text{Medicaid Nursing Facility Patient Days} + \text{LTC Hospice Patient Days}) = \text{Medicaid Points}$
Medicaid Points	$\times \text{Unit Value for Medicaid Occupancy} = \text{Medicaid Occupancy Supplemental Payment}$

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 long-stay residents who have moderate to severe pain;
- Percentage of high risk long-stay residents who have pressure sores;
- Percentage of long-stay residents who had a urinary tract infection; and
- Percentage of long-stay residents who lose too much weight.

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 Supplemental Payments for Acuity Available / (Medicaid Nursing Facility Patient Days + LTC Hospice Patient Days)
Total Amount of Reimbursement Based on Acuity Weighted Average Portion of Reimbursement Based on Acuity Budget Adjustment Factor For Supplemental Payment	=	Weighted Average Total Amount of Reimbursement Based on Acuity + Standard Per Diem (\$116.66)
	=	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 (0.5412 effective July 1, 2012)
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 anticipated that in fiscal year 2014, the supplemental payments back-fill by approximately 75.0% of the budget adjustments made to Medicaid rates.

As of July 1, 2011, the statewide average budget neutral Medicaid rate is \$184.04, which represents a 2.8% decrease from the 2010 average rate of \$189.38. Although a substantial amount of nursing facility reimbursement is provided on a quarterly supplemental basis, the state still estimates an equivalent daily rate that factors in supplemental payments received. Based on these rates, the average rate for nursing facility effective July 1, 2012, and July 1, 2013, were \$192.12 and \$194.44, respectively.

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.

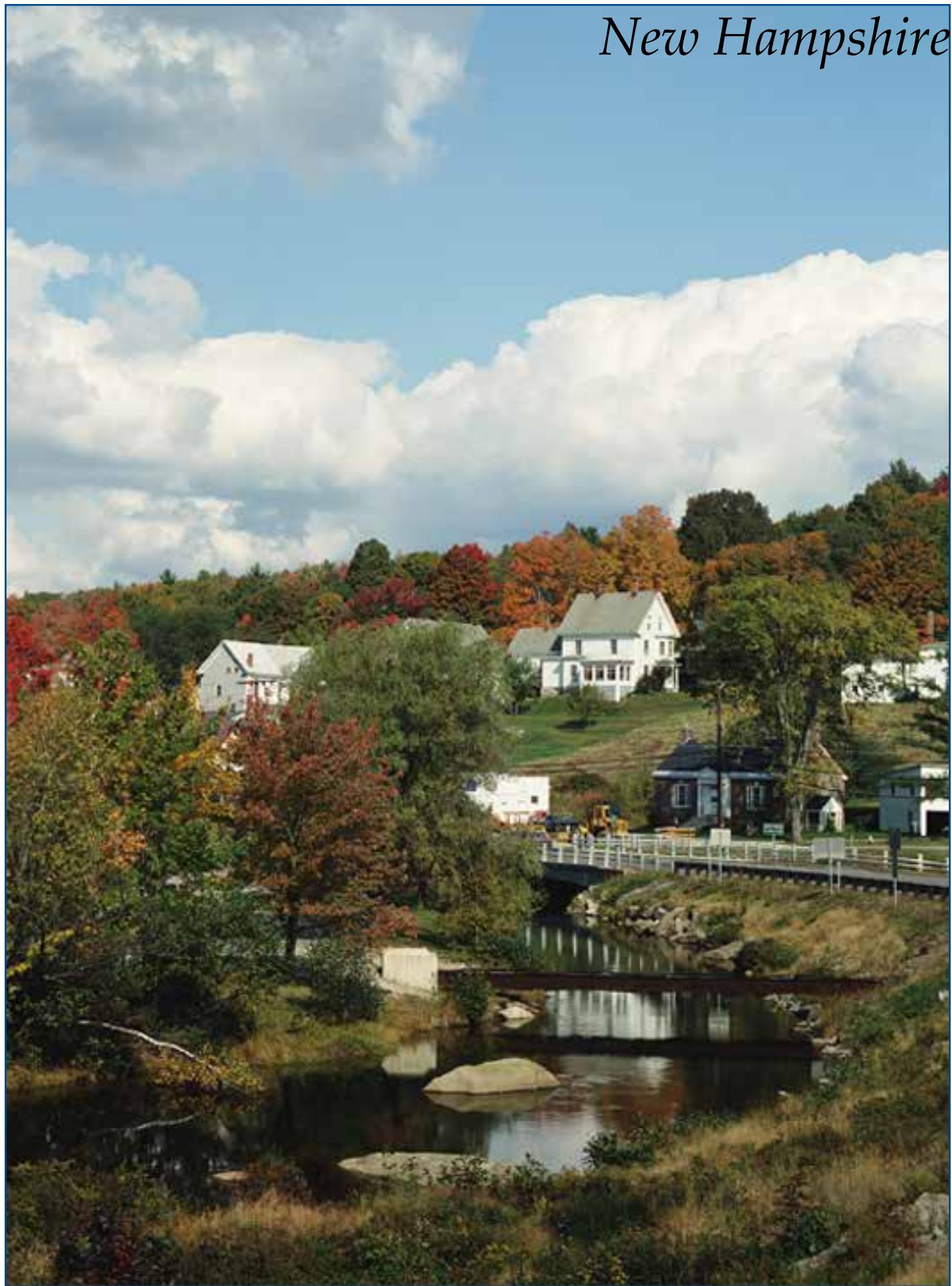
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	98.00	87.00	98.25	125.00	120.00	120.00	182.00	180.00	172.25	
Average Daily Census	89.13	86.28	86.57	129.18	102.11	105.62	155.81	148.27	147.15	
Occupancy	77.0%	72.8%	77.8%	87.1%	85.6%	86.9%	89.7%	90.6%	90.3%	
Payor Mix Statistics										
Medicare	9.8%	10.6%	11.1%	16.0%	20.7%	17.5%	29.5%	35.8%	34.5%	
Medicaid	44.3%	45.6%	46.1%	51.6%	55.8%	56.1%	68.7%	65.9%	68.5%	
Other	17.7%	16.3%	11.4%	22.1%	22.7%	22.9%	27.7%	28.9%	27.1%	
Avg. Length of Stay Statistics (Days)										
Medicare	29.32	28.34	28.49	31.52	32.19	34.22	41.24	37.32	38.26	
Medicaid	144.01	173.68	202.27	195.11	243.04	263.81	332.69	354.90	318.85	
Other	27.52	35.72	32.75	42.61	53.82	49.13	65.73	88.15	88.29	
Revenue (PPD)										
Inpatient	\$207.00	\$215.82	\$231.01	\$227.76	\$249.39	\$258.42	\$275.32	\$290.49	\$306.23	
Ancillary	\$65.86	\$64.43	\$77.62	\$101.50	\$109.78	\$131.25	\$160.92	\$164.21	\$195.52	
TOTAL	\$288.10	\$276.11	\$292.92	\$354.72	\$370.51	\$395.96	\$399.64	\$420.79	\$438.22	
Expenses (PPD)										
Employee Benefits	\$18.31	\$17.96	\$16.48	\$27.12	\$21.61	\$21.41	\$35.16	\$32.41	\$30.55	
Administrative and General	\$51.32	\$51.66	\$55.85	\$58.25	\$59.69	\$61.56	\$64.88	\$66.61	\$70.60	
Plant Operations	\$8.08	\$8.70	\$8.25	\$9.74	\$10.35	\$9.81	\$11.16	\$12.53	\$11.25	
Laundry & Linens	\$1.84	\$1.88	\$1.49	\$2.42	\$2.12	\$2.23	\$3.17	\$2.72	\$2.80	
Housekeeping	\$4.54	\$5.22	\$5.24	\$5.14	\$5.83	\$5.79	\$6.02	\$6.56	\$6.47	
Dietary	\$13.53	\$14.38	\$14.56	\$14.96	\$15.42	\$15.64	\$16.20	\$17.40	\$17.71	
Nursing & Medical Related	\$77.72	\$78.91	\$81.55	\$91.87	\$94.14	\$94.99	\$100.02	\$106.65	\$101.80	
Ancillary and Pharmacy	\$29.94	\$30.56	\$30.41	\$46.47	\$55.31	\$59.43	\$74.23	\$72.58	\$72.86	
Social Services	\$2.63	\$3.19	\$3.00	\$3.99	\$3.91	\$3.90	\$4.83	\$5.41	\$5.45	

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) - Bureau of Health Facilities Administration (BHFA) under the category of "Nursing Home Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEW HAMPSHIRE	
Licensed Nursing Facilities*	81
Licensed Nursing Beds*	7,431
Beds per 1,000 Aged 65 >**	35.06
Beds per 1,000 Aged 75 >**	85.43
Occupancy Percentage - 2013***	90.29%

*Source: New Hampshire Department of Health and Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

CERTIFICATE OF NEED

The Health Services Planning and Review (HSPR) Board, which is administratively attached to DHHS, manages the request and approval processes for a Certificate of Need (CON) in accordance with the New Hampshire statutes. The governor-appointed HSPR Board approves CON requests. A CON is required for a licensed healthcare facility to proceed with construction or renovation projects that exceed a threshold amount established by New Hampshire statutes.

The current (effective March 20, 2014) statutory threshold amount is \$2,034,428 for any nursing home project. Nursing facilities may also be required to obtain a CON for the purchase of any piece of equipment that results in a capital outlay of greater than \$400,000. In addition, CON approval is also required for any change in ownership of a nursing facility that receives Medicaid/Medicare reimbursement. The HSPR Board will also review any proposed changes in services at a nursing facility. However, the facility may not be required to submit an application for a CON if the change in services does not result in a change in licensing. According to professionals from the HSPR board, the state will discontinue the CON program on June 30, 2016.

Currently, there is a moratorium on new nursing home beds in New Hampshire that was scheduled to expire on June 30, 2012, but was extended until June 30, 2014. The moratorium was originally put into effect in 1995. The development of nursing facility beds as part of a continuing care retirement community (CCRC) is exempt from the moratorium under the following conditions:

- Any nursing facility that is part of a CCRC shall be approved at no more than one nursing home bed for every four residential units in a CCRC.
- Admissions to the nursing facility component of a CCRC will be limited to residents derived from the community's other components (independent living and assisted living).

However, developers of CCRCs are still required to obtain a CON for the construction of new nursing facility beds.

BED NEED METHODOLOGY

The HSPR Board calculates unmet bed need for nursing facilities on January 1 of each year. The calculation for the determination of need for long-term care facility beds is as follows:

$$\text{Bed Need} = (\text{Region Population Aged } 65+ \times 40) \div 1,000$$

The "Region Population Aged 65+" is the total number of persons aged 65 and over residing in one of the 10 designated regions, based upon county population statistics provided by the New Hampshire Office of Energy and Planning. Unmet bed need is calculated by deducting the existing bed inventory for nursing facilities from the predetermined bed need estimate for each region. The HSPR Board also ranks the regions based on unmet need. The rankings are used to determine which regions should get the most consideration regarding the development of new nursing facility beds.

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%.

MEDICAID RATE CALCULATION SYSTEM

New Hampshire Medicaid uses a prospective, case mix adjusted, cost-based, facility-specific rate setting system.

New Hampshire

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.

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 III (RUG-III).

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 rate effective July 1, 2014 was \$205.38, including an average MQIP payment of \$45.55. The average Medicaid rates for fiscal years 2011 and 2012 were \$183.93 and \$184.42, respectively.

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.

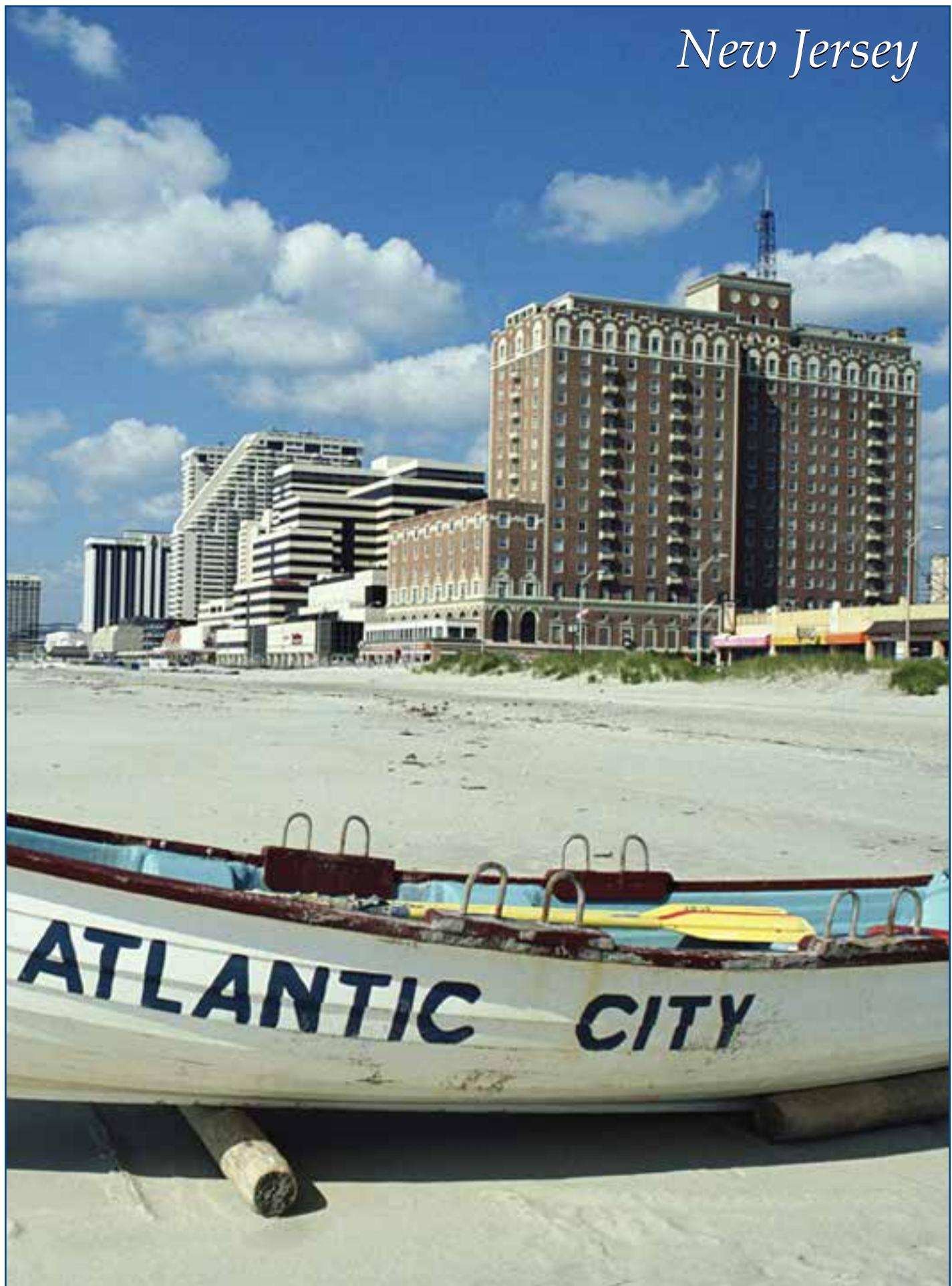
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

Effective April 1, 2015, New Hampshire is projected to convert to a Managed Care Medicaid reimbursement system for nursing facilities. The likelihood of this occurring and the impact on nursing facility Medicaid rates are currently unclear.

NEW HAMPSHIRE COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	58.00	68.00	68.50	87.00	92.50	86.50	118.50	120.00	118.00			
Average Daily Census	66.20	68.73	62.37	92.28	93.56	88.20	119.99	117.44	114.79			
Occupancy	87.3%	87.9%	88.2%	91.9%	93.5%	92.8%	94.5%	95.7%	95.7%			
Payor Mix Statistics												
Medicare	9.1%	9.6%	10.9%	14.8%	14.8%	15.2%	19.1%	20.5%	21.1%			
Medicaid	54.1%	54.3%	57.0%	64.8%	64.0%	64.0%	70.5%	69.9%	72.5%			
Other	15.7%	15.7%	13.2%	20.8%	21.1%	19.5%	29.1%	31.2%	27.6%			
Avg. Length of Stay Statistics (Days)												
Medicare	32.31	32.25	29.34	38.09	39.65	40.77	44.38	48.12	48.42			
Medicaid	325.68	349.78	349.85	431.69	444.20	464.30	646.74	628.36	678.95			
Other	94.63	110.98	82.34	169.06	209.36	160.62	273.38	374.74	296.91			
Revenue (PPD)												
Inpatient	\$251.18	\$259.18	\$269.57	\$286.31	\$289.12	\$306.27	\$315.65	\$314.99	\$324.51			
Ancillary	\$34.18	\$42.23	\$45.15	\$56.27	\$60.88	\$69.98	\$70.45	\$81.56	\$98.09			
TOTAL	\$295.56	\$299.53	\$317.32	\$344.65	\$352.89	\$379.25	\$380.65	\$389.53	\$418.11			
Expenses (PPD)												
Employee Benefits	\$16.61	\$16.33	\$20.86	\$24.23	\$22.47	\$22.28	\$31.74	\$29.70	\$30.95			
Administrative and General	\$41.42	\$41.42	\$46.20	\$49.97	\$49.17	\$52.10	\$56.88	\$58.97	\$57.57			
Plant Operations	\$10.90	\$9.69	\$10.03	\$12.47	\$11.63	\$11.63	\$15.46	\$13.81	\$14.73			
Laundry & Linens	\$2.22	\$2.40	\$2.43	\$2.77	\$2.93	\$3.26	\$3.60	\$3.34	\$4.15			
Housekeeping	\$4.44	\$4.30	\$4.39	\$5.84	\$5.16	\$5.47	\$7.61	\$6.62	\$8.95			
Dietary	\$16.59	\$15.93	\$15.47	\$19.48	\$17.95	\$19.71	\$24.35	\$23.66	\$25.74			
Nursing & Medical Related	\$82.72	\$82.76	\$84.21	\$90.19	\$92.08	\$95.27	\$106.44	\$103.33	\$119.95			
Ancillary and Pharmacy	\$18.24	\$19.17	\$21.56	\$29.25	\$29.88	\$32.43	\$36.01	\$40.00	\$46.32			
Social Services	\$2.73	\$2.90	\$2.44	\$3.92	\$4.07	\$3.34	\$5.09	\$5.07	\$3.91			

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*	372
Licensed Nursing Beds*	52,223
Beds per 1,000 Aged 65 >**	38.90
Beds per 1,000 Aged 75 >**	88.54
Occupancy Percentage - 2013***	86.19%

*Source: The State of New Jersey Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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, 2013. The next scheduled date in which the state will consider issuing a call for new nursing home beds will be on July 1, 2016. However, it is unclear if the state will actually allow for the development of new nursing facility beds on this date.

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 current QAF is \$11.92 and has remained unchanged since July 1, 2006. 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.

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 will be 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, will remain in a fee-for-service environment. Nursing facilities will be 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. However, for at least the next two fiscal year rate years (July 1, 2014, to June 30, 2016), nursing facilities are guaranteed that their rates will not be lower than their last fee-for-service rate (effective April 1, 2014). These rates have been moderately inflated since April 1, 2014. In addition, the state is considering extending the transition period beyond June 30, 2016. This partially reflects delays that the MCOs have had in paying nursing facilities.

The remainder of this overview will focus on how rates were calculated for current and past fiscal years utilizing the prospective cost- and price-based system that was implemented on July 1, 2010. Prior to this system, non-case mix adjusted prospective rates were calculated by applying standards and reasonableness criteria ("Screens") to one of three classes of nursing facilities. The current rate methodology also calculated rate ceilings and prices for these three classes of nursing facilities:

- Class I-Includes proprietary and voluntary nursing facilities.
- Class II-Includes county-operated governmental nursing facilities.
- Class III-Includes special care nursing facilities (SCNFs), which are grouped into six categories: ventilator/respirator; TBI/coma; pediatric; HIV; neurologically impaired; and behavioral management.

Given the limited number of Class III nursing facilities within New Jersey (31 facilities), this analysis will focus on Class I and II nursing facilities. With limited exceptions, Medicaid rates for Class III nursing facilities were calculated based on a similar methodology utilized to determine Medicaid rates for Class I and II nursing facilities.

As part of the phase in, and prior to adjusting nursing facility rates for the QAF add-on, the state implemented a Gain/Loss Provision to nursing facility rates. Based on this provision, a nursing facility's Medicaid rate effective July 1, 2010, prior to the QAF add-on, could not exceed or be less than \$5.00 of its rate effective June 30, 2010. For rates effective July 1, 2011, this provision increased to \$10. This provision was originally set to sunset on June 30, 2012. However, an altered version of this provision was utilized in fiscal years 2013 through 2015. This will be further detailed in the inflation and rebasing section of this overview. In addition, each year under the system implemented on July 1, 2010, 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 was adjusted downward.

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. There is currently a proposal being considered that would remove property taxes from the calculation of this price and reimburse these expenses as a direct pass-through. This add-on will be limited by the state's definition of "reasonable" property taxes that was utilized in the old rate methodology.
- 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.

Prior to July 1, 2010, the state had not rebased rates since the period beginning July 1, 2007. The majority of nursing rates were based on year ending December 31, 2006, cost report data.

New Jersey chose not to rebase nursing facility rates or Screens for fiscal years 2009 and 2010. Fiscal year 2008 rates were inflated to calculate fiscal year 2009 rates. The inflation rate for nursing facilities over 75% Medicaid occupied is 4.63%, and the inflation factor for the remaining facilities is 2.315%. Given budgetary limitations, nursing facilities with a December 31 fiscal year did not receive any rate increase for fiscal year 2010. Nursing facilities with non-December 31 fiscal year ends had their rates adjusted upward to reflect the average payment level during fiscal year 2009.

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 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.

As previously mentioned, initially when the rate setting calculation utilized to determine rates from July 1, 2010, to June 30, 2014, was implemented on July 1, 2010, the state implemented a Gain/Loss Provision that assured that a nursing facility's rate calculated utilizing this new system would not be below their rate calculated utilizing the prior system (last effective June 30, 2010). This provision was supposed to end after two years (July 1, 2012). Therefore, if a nursing facility's rate calculated after this provision ended (July 1, 2012, and future rate periods) was less than their rates effective June 30, 2010, the facility would have to absorb the loss. However, an adjusted version of this provision still existed on July 1, 2014. Effective July 1, 2014, New Jersey Medicaid received a \$17 million increase in funding for nursing facility rates. This was utilized to provide a limited rate increase to certain nursing facilities dependent on what their Medicaid rates would be if calculated on July 1, 2014, utilizing the system implemented on July 1, 2010 (without the Gain/Loss Provision).

Specifically, only nursing facilities for which the calculation of rates effective July 1, 2014, (utilizing the system implemented on July 1, 2010) would result in an increase from their rates effective June 30, 2014, received a rate increase.

New Jersey

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, 2015, nursing facilities are reimbursed for the QAF with an \$8.09 add-on per Medicaid day. A 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 and the QAF add-on.

The state's current reimbursement system was phased in over a two-year period. Therefore, prior to adjusting nursing facility rates for the QAF add-on, the state implemented a Gain/Loss Provision to nursing facility rates. Based on this provision, a nursing facility's Medicaid rate effective July 1, 2010, prior to the QAF add-on, could not exceed or be less than \$5.00 of its rate effective June 30, 2010. For rates effective July 1, 2011, this provision increased to \$10. This provision was set to sunset on June 30, 2012. However, effective July 1, 2012, the state will implement a new Gain/Loss provision. 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. For rates effective July 1, 2011, this provision increased to \$10. This provision was originally set to sunset on June 30, 2012. However, this provision was extended to fiscal year 2013 and then to fiscal year 2014. Specifically, July 1, 2012, rates were not allowed to be lower than June 30, 2012, rates (prior to the QAF add-on) and July 1, 2013, rates were not allowed to be lower than June 30, 2013, rates (prior to the QAF add-on).

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 (currently 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.

In prior fiscal years, nursing facilities in New Jersey were eligible for an "Appropriations Act" or "High Medicaid Occupancy" add-on. This was eliminated to fund the new rate methodology, which resulted in an increase to Direct Health Care rates. This add-on was approximately \$3.20 for state fiscal year 2010.

Based on the \$60 million reduction to Medicaid, a budget adjustment factor was applied to fiscal year 2012 rates. Initially, after costs were rebased and inflated, the Class I Direct Health Care cost component per diem limit was increased from \$119.91 to \$127.10. However, when the ceiling was reduced from 115.0% to 112.0% of the median, the limit was reduced to \$123.79. The Class I Operating and Administrative per diem price was initially inflated from \$88.04 to \$90.42, but was reduced to \$85.90. This reflects that the price was adjusted to equate to 95.0% of the median from 100.0% of the median. However, given the Gain/Loss Provision, these initial adjustments only reduced total projected Medicaid reimbursement by \$15 million. Therefore, an 8% budget adjustment factor was applied to those facilities whose calculated rates were greater than their June 30, 2010, rates, less \$10.

In fiscal year 2013, the state back-filled a significant portion (\$40 million) of the previous rate reduction (\$60 million), but, given budget restrictions, a budget adjustment factor of 9.08% was still required. However, as previously noted, fiscal year 2013 rates were still not allowed to be reduced below June 30, 2012, rates. The Class I Direct Care cost component per diem limit (\$126.21) and the Class I Operating and Administrative per diem price (\$87.79) were calculated at 112.0% and 95.0% of the respective median costs for the cost components. The Class I Direct Care cost component per diem limit (\$125.62) and the Class I Operating and Administrative per diem price (\$85.03) for fiscal year 2014 were also calculated utilizing these percentages. However, in fiscal year 2014, the state back-filled the remaining portion (\$20 million) of the previously mentioned rate reduction. This resulted in the state's budget neutrality adjustment decreasing from 9.58% effective July 1, 2013, to 5.37% effective January 1, 2014. Based on the \$17 million increase in funding effective July 1, 2014, the state's budget neutrality adjustment decreased to 3.78%.

The statewide average rates during the current reimbursement system are as follows: Effective July 1, 2010 - \$205.79; July 1, 2011 - \$196.56; July 1, 2012 - \$202.96; and July 1, 2013 - \$202.86. The fiscal year 2014 statewide average rate remained relatively unchanged from the previous rate. Effective July 1, 2014, the state average rate increased to \$208.08.

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

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATIONS

With the exception of the potential extension of the period of time in which nursing facilities are guaranteed fee-for-service rates, there are no other significant changes to the New Jersey rate calculated system.

- The state calculated the FRV allowance using 40 years of age for the nursing facility unless a verifiable FRV re-age request is submitted and had the effect of re-aging the nursing facility for the purposes of the FRV calculation.

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

With the exception of the imbedding conversion to MLTSS on July 1, 2014, there are no other significant changes to the New Jersey rate calculated system.

New Jersey

NEW JERSEY COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	100.00	101.75	105.25	130.00	128.00	130.00	180.00	180.00	180.00			
Average Daily Census	98.79	97.29	97.08	121.61	116.25	117.03	165.92	164.41	163.41			
Occupancy	83.6%	83.4%	82.4%	89.4%	89.1%	88.6%	93.0%	93.1%	92.0%			
Payor Mix Statistics												
Medicare	9.7%	9.5%	9.4%	14.4%	14.7%	14.8%	20.8%	21.5%	22.0%			
Medicaid	53.8%	50.6%	50.5%	67.9%	66.4%	67.1%	77.4%	78.0%	77.5%			
Other	10.9%	10.3%	10.9%	18.6%	16.7%	17.0%	40.7%	29.3%	28.8%			
Avg. Length of Stay Statistics (Days)												
Medicare	28.05	28.90	29.91	33.52	35.04	35.45	44.31	44.90	44.53			
Medicaid	248.98	278.26	309.25	348.09	409.99	456.34	691.08	693.43	757.90			
Other	46.25	41.86	38.03	87.78	65.63	64.71	264.66	183.53	149.84			
Revenue (PPD)												
Inpatient	\$253.90	\$252.70	\$255.83	\$292.05	\$298.36	\$308.00	\$345.80	\$362.00	\$373.61			
Ancillary	\$26.57	\$29.96	\$31.65	\$42.40	\$49.02	\$51.60	\$67.41	\$74.92	\$85.42			
TOTAL	\$284.73	\$285.14	\$288.62	\$334.73	\$355.91	\$367.68	\$437.49	\$440.37	\$468.05			
Expenses (PPD)												
Employee Benefits	\$21.85	\$22.87	\$22.69	\$28.65	\$28.83	\$29.18	\$39.26	\$37.50	\$37.83			
Administrative and General	\$35.80	\$36.46	\$37.61	\$45.14	\$44.30	\$46.84	\$58.36	\$56.57	\$60.19			
Plant Operations	\$11.36	\$10.52	\$10.97	\$13.61	\$12.65	\$12.87	\$17.25	\$16.23	\$16.53			
Laundry & Linens	\$2.08	\$1.98	\$1.88	\$3.56	\$3.29	\$3.21	\$5.44	\$4.65	\$4.70			
Housekeeping	\$6.75	\$6.43	\$6.56	\$8.15	\$8.04	\$8.09	\$10.05	\$9.97	\$10.21			
Dietary	\$19.52	\$18.62	\$18.09	\$22.27	\$22.05	\$22.22	\$26.50	\$25.82	\$26.39			
Nursing & Medical Related	\$90.32	\$89.24	\$89.20	\$98.62	\$98.41	\$99.46	\$109.56	\$109.96	\$113.68			
Ancillary and Pharmacy	\$16.91	\$18.06	\$19.59	\$26.97	\$28.74	\$29.19	\$39.86	\$43.68	\$46.60			
Social Services	\$1.72	\$1.68	\$1.72	\$2.40	\$2.41	\$2.35	\$3.07	\$3.12	\$3.28			

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 and Certification Bureau under the designation of "Nursing Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEW MEXICO	
Licensed Nursing Facilities*	74
Licensed Nursing Beds*	6,961
Beds per 1,000 Aged 65 >**	22.08
Beds per 1,000 Aged 75 >**	54.14
Occupancy Percentage - 2013***	83.94%

*Source: New Mexico Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 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.

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 were not published or available to the public.

Members of the New Mexico Health Care Association have also indicated that their accounts receivable have increased because of the MCOs' delays in processing payments. The methodology described below is what was previously utilized to determine nursing facilities' rates. The state annually has its auditor (Myers and Stauffer) calculate what Medicaid rates would have been utilizing this system. These rates are not available to the public. However, 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. In addition, it is currently unclear if the MCOs will utilize this methodology to determine Medicaid rates in the future.

The state restructured 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 four MCOs. However, the actual number of MCOs that operate the long-term care reimbursement system increased to four from two. These MCOs are Molina Healthcare of NM, Presbyterian Health Plan, Blue Cross and Blue Shield of NM and UnitedHealthcare Community Plan. Under the new system, the MCOs still have the authority to negotiate rates with nursing facilities. The inflated rates on July 1, 2012, and July 1, 2014, have been treated as minimum rates by MCOs; however, these rates also represent the only rates that some of the MCOs will pay out. These rates 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 implemented additional changes to criteria (effective November 1, 2014) that will restore approximately five to 10 million dollars of the lost funding. In addition, NMHCA is lobbying the state to alter the criteria in an effort to restore the remainder of the lost funding. However, it is currently unclear if this will occur.

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.

The following methodology is what the state utilized to determine Medicaid prior to the implementation of the managed care system. Based on conversations with the NMHCA and New Mexico nursing home providers, it is assumed that this is the system that Myers and Stauffer is utilizing to determine the annual rates that it provides to the MCOs.

RATE METHODOLOGY

Per diem Operating rates are calculated by dividing a facility's allowable operating costs by its patient days. Operating costs are subject to a ceiling that is equal to 110% of the indexed median for all facilities. Separate ceilings exist for state owned and operated nursing facilities and non-state owned and operated nursing facilities.

An operating incentive exists for those facilities that report operating costs below the ceiling. The incentive is equal to half of the difference between the ceiling and the facility's allowable operating costs, up to \$2.00 per diem.

Per diem Facility costs are calculated by dividing a facility's allowable facility costs by its patient days. Facility costs are

subject to a ceiling system that serves as a disincentive to new construction. Any facility that was participating in Medicaid or was granted Section 1122 approval for construction (including bed additions to such facilities) by July 1, 1984, is paid the lower of actual allowable facility costs or the applicable facility cost ceiling, which was set at \$11.50. Any new facility not approved as of July 1, 1984, is paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities in the same category. Because not all facilities in existence prior to July 1, 1984, receive the ceiling (and operate with relatively low facility costs), new facilities generally receive a lower facility cost reimbursement rate.

The total Medicaid rate for a nursing facility is the sum of the Operating cost component, the Operating incentive and the Facility cost component.

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. However, average rates are anticipated to increase approximately 3.65% effective July 1, 2014.

MINIMUM OCCUPANCY STANDARDS

In order to insure that the Medicaid program does not pay for costs associated with unnecessary beds as evidenced by under-utilization, allowable facility costs are calculated by imputing a 90.0% occupancy rate. This rule also serves as an additional disincentive to new construction, as new facilities must be built in areas of high demand.

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.

NEW MEXICO COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	65.25	62.00	65.00	94.50	93.50	95.00	120.00	119.25	120.00			
Average Daily Census	59.77	59.37	57.47	91.43	90.33	86.05	113.75	114.40	105.24			
Occupancy	77.3%	81.7%	79.8%	87.6%	87.2%	86.7%	92.8%	92.6%	92.0%			
Payor Mix Statistics												
Medicare	8.9%	6.7%	8.6%	11.9%	11.3%	13.1%	15.4%	14.5%	15.7%			
Medicaid	60.3%	58.3%	64.6%	70.0%	68.5%	69.2%	74.7%	74.5%	77.0%			
Other	12.9%	13.9%	12.0%	19.3%	20.9%	16.7%	29.3%	36.7%	29.8%			
Avg. Length of Stay Statistics (Days)												
Medicare	30.92	31.32	30.68	39.08	35.57	40.09	48.34	51.44	50.37			
Medicaid	275.73	294.21	244.96	331.98	417.87	321.03	555.73	613.21	562.65			
Other	55.66	44.87	46.11	80.20	93.30	68.70	176.74	163.18	152.48			
Revenue (PPD)												
Inpatient	\$168.90	\$183.27	\$194.53	\$190.10	\$202.74	\$210.85	\$211.69	\$241.19	\$250.55			
Ancillary	\$40.26	\$43.88	\$56.91	\$59.49	\$58.65	\$84.60	\$96.20	\$98.05	\$120.66			
TOTAL	\$208.67	\$220.50	\$257.87	\$260.84	\$273.61	\$315.28	\$305.24	\$360.40	\$374.24			
Expenses (PPD)												
Employee Benefits	\$10.22	\$11.41	\$12.24	\$13.72	\$15.57	\$16.11	\$20.25	\$21.17	\$21.83			
Administrative and General	\$35.51	\$34.99	\$40.21	\$43.79	\$41.15	\$51.25	\$52.64	\$48.80	\$57.01			
Plant Operations	\$7.13	\$7.63	\$7.44	\$7.90	\$8.66	\$8.92	\$10.20	\$13.67	\$11.32			
Laundry & Linens	\$1.91	\$1.79	\$1.67	\$2.61	\$2.57	\$2.58	\$3.22	\$3.00	\$3.88			
Housekeeping	\$3.77	\$3.91	\$3.76	\$4.53	\$4.47	\$4.33	\$5.78	\$5.87	\$5.34			
Dietary	\$12.72	\$13.20	\$12.73	\$13.76	\$15.99	\$13.80	\$18.05	\$20.68	\$17.72			
Nursing & Medical Related	\$62.46	\$64.60	\$65.94	\$67.32	\$71.72	\$74.29	\$76.99	\$81.39	\$79.53			
Ancillary and Pharmacy	\$18.69	\$18.60	\$22.79	\$24.93	\$26.52	\$28.54	\$30.93	\$38.10	\$33.56			
Social Services	\$1.75	\$2.21	\$1.89	\$2.81	\$3.52	\$2.57	\$4.05	\$4.73	\$3.99			

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*	630
Licensed Nursing Beds*	113,491
Beds per 1,000 Aged 65 >**	38.29
Beds per 1,000 Aged 75 >**	86.86
Occupancy Percentage - 2013***	95.63%

*Source: New York State Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$15,000,000.
- Purchases of major medical equipment. The purchase of replacement equipment costing less than \$15,000,000 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 2006 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 9,518 beds in 2016. Approximately 31 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 8,867 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 will be in effect until March 31, 2013. In addition, the state implemented a "temporary nursing home stability contribution," effective the same date. This contribution equates 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. As of April 1, 2014, both representatives from the New York Department of Health and the New York State Health Facilities Association indicated that they are unsure if this will occur. In addition, professionals from both organizations indicated that this issue will not be resolved until the state determines how it plans to "back fill" the 2.0% Medicaid rate reduction that the increase in the quality assessment was created to offset. Given this factor, the state is currently delaying the collection of fees from April to July 2014.

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.

Although the state phased in the former system effective April 1, 2009, the state experienced significant delays in actually reimbursing nursing facilities for rates calculated under this new system. This included several scheduled rates that were supposed to be calculated between April 1, 2009, and July 1, 2011. These rates were to be based on the April 1, 2009, rebasing of costs and were scheduled to be adjusted for case mix and inflation. In the summer of 2011, the state retroactively reimbursed nursing facilities for these rates. In addition, the state also further adjusted rates given budgetary difficulties. These adjustments are referred to as "scale back adjustment" and will be discussed further in the "Inflation and Rebasing" section.

Non-specialty nursing facilities will be transitioned to the cost over a five-year period (2012 to 2016). With the exception of a brief description of the scale back adjustment, 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 previous 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. Under the new price-based system New York rebased non-capital prices/

rates effective January 1, 2012, utilizing 2007 cost report data. It is currently unclear with what frequency Medicaid rates will be rebased. However, Medicaid rates will not be rebased during the phase in (January 1, 2012, to December 31, 2016). During the transition, Direct and Indirect prices will be slightly altered by case mix adjustments (Direct only) and changes in allowable cost adjustments. These adjustments will be explained in the Rate Methodology section of this overview. Non-comparable rates will remain 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.

Although the state rebased rates effective April 1, 2009, the state was significantly delayed in paying out rebased rates over an approximate two-year period. This partially reflects that upon calculation of the rebased rates, the state estimated that the increased cost of the rebased rates would exceed the spending cap the state had placed on rate increases due to the rebasing. Based on New York law implemented in 2009 (Chapter 58), 2010 and 2011 (Chapter 59) the state capped the increased in nursing facility rates from April 1, 2009, to March 31, 2010, at \$210 million net of the Medicaid-only CMI adjustment. In addition, this cap is also effective for the next two periods beginning April 1 and ending on March 31. To offset this significant gap in funding, the state implemented a "scale back adjustment" on rebased rates. This adjustment was applied as a proportional adjustment to ensure that the rebasing and conversion to the Medicaid-only CMI does not result in an increase in aggregate total expenditures (excluding capital and prior-to-trend adjustments) of no more or less than \$210 million. When the scale back adjustment, Medicaid-only CMI adjustment and the reduction in the trend factor were taken into account, there was an approximate \$45.7 million statewide reduction in overall funding for the two-year period ending March 31, 2011.

The April 1, 2011, rates were modified to reflect the implementation of the "uniform rate reduction" based on an approximately \$27.1 million reduction in funding. July 1, 2011, rates are effective April 1, 2011, with the elimination of the uniform rate adjustment. However, these rates still included a scale-back adjustment. Effective July 7, 2011, nursing facility rates were further adjusted to reflect the shift of reimbursement of prescription drugs from the nursing facility rate to fee-for-service payments.

Based on these assumptions, the state is retroactively reimbursing facilities for all the rates between April 1, 2009, to July 7, 2011.

Operating rates (the sum of Direct, Indirect and Non-Comparable rate components) effective from April 1, 2009, to 2012 were held harmless to a nursing facility's operating rate effective December 31, 2008. The hold-harmless was effective until 2012. Nursing facilities received the greater of the facility's current operating rate or the operating rate effective December 31, 2008.

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 during the above discussed periods. 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. All indications are that WEFs will not be recalculated during the transition period.

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.

Effective January 1, 2013, state rate setting officials indicated that New York will reduce nursing facilities' rates on average by approximately \$1.60 per day. This reduction (approximately \$50 million overall) will be utilized to fund the state's Quality Pool Program. The rate reduction reflects that nursing facilities could potentially receive additional reimbursement from the program through supplemental payments. As of the date of this overview, this reduction has not yet been applied and this program has yet to be finalized, as the state is still waiting for approval from the Centers of Medicare and Medicaid (CMS). Potential details of the program are included in the Other Rate Provisions section of this overview. Once this program has been approved and implemented, the state will retroactively adjust rates effective January 1, 2013, for the program, which is based on 2012 data.

New York has recently issued January 1, 2014, rates. These rates will be retroactively adjusted to reflect the implementation of the Quality Pool Program. 2014 Quality Pool Program payments will be based on 2013 data, which is yet to be finalized.

In addition, as previously mentioned, New York has utilized a temporary increase (0.8%) to the state's quality assessment fee to offset a previous 2.0% rate reduction. It is currently unclear how the state will proceed, given that the temporary increase was scheduled to terminate on March 31, 2014. However, representatives of New York State Health Facilities Association indicated that this previous rate reduction will eventually be "back filled". This could potentially occur as the result of the continuance of the increased quality assessment fee. However, as of the date of this overview, it is still unclear how the state will proceed.

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 will equate to 50% of 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. It

New York

does not appear that prices will be rebased during the phase in. However, prior to completing the above described calculation, allowable costs are first 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 will result in increases in both Direct and Indirect prices.

Direct Care prices also will be 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-payer case mix for the base year 2007. The all-payer 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, 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. This occurred for Medicaid rates effective July 1, 2012. These rates were adjusted to reflect a maximum allowable increase of CMI of 5.0%. According to state officials, on average, the state experienced a 7.0% to 8.0% increase in CMI from the prior period. The state temporarily reimburses nursing facilities' rates based on the maximum allowable increase in CMI (5.0%). The state also calculated January 1, 2013, rates with the capped CMI that was used to calculate July 1, 2012, rates. Initially, the state indicated that after it completed an audit of the case mix data for the applicable periods (January 2012 to July 2012), it would retroactively reimburse nursing facilities if its higher CMI is not based on coding errors. Based on this audit, the majority of the CMI increases were determined to be legitimate. However, as of the date of this overview, the state has not retroactively reimbursed nursing facilities for this factor, partially due to litigation pending against the state related to this issue.

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.

During the transition period beginning January 1, 2012, and ending December 31, 2012, facilities are 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 will increase to 7.5% in 2016. The transition adjustment equates 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 interim January 1, 2014, rate is \$214.88, which is only moderately greater than the previous rates effective April 1, 2013 (\$210.96), January 1, 2013 (\$208.60), and January 1, 2012 (\$204.73).

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

As previously mentioned, New York State will implement a Quality Pool program effective January 1, 2013, which will be based on a point system. As of the date of this overview, the final methodology for this program has yet to be approved by CMS. However, it will be based on the following four areas:

- Quality Measures (60 points): including the percentage of specific residents with pressure ulcers, urinary tract infections, rapid weight loss, increased need for assistance with daily living, incontinence issues, those having experienced moderate to severe pain, those having received appropriate vaccines, those having had one or more falls with majority injuries, those having depression symptoms and require psychotic medication in the absence of psychotic or related conditions. This category also includes staffing measurements;

- Satisfaction (unknown points): the state is still in the process of investigating potential data sources to measure patient satisfaction;
- Compliance (20 points): including survey results, the timeliness of submitting cost reports and documenting staff flu immunizations and
- Avoidable Hospitalizations (20 points).

Facilities that are on the CMS Special Focus List and those considered to be specialty nursing homes are not eligible for Quality Pool add-ons.

This program will be financed by an approximate \$1.60 reduction in nursing home rates. This will result in an approximate funding level of \$50 million. The methodology that will be utilized to determine actual quality pool payments is still in the process of being determined. However, the state has indicated that it will not begin to include patient satisfaction data in the calculation of the payment until 2014.

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 hospitalization or therapeutic leave. However, the state's 2012-13 budget required the Department of Health to reduce bed hold reimbursement by \$40 million. The state only partially met this

goal (\$16 million) by reducing bed hold reimbursement. The state achieved the remainder of this goal by implementing an approximate \$3.20 reduction to overall Medicaid rates effective January 1, 2013, to March 31, 2013.

Effective July 1, 2012, payments for a reserved bed related to a hospitalization are made at 50.0% of a facility's Medicaid rate. This represents a reduction from 95.0%. However, 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 is limited to a maximum of 14 days in any 12-month period per hospitalization or therapeutic leave. 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

New York State began the conversion of specific counties to a Medicaid managed care reimbursement system effective October 1, 2013. However, as of the date of this overview, CMS has not yet approved the mandatory enrollment of nursing home residents into the managed care plans. In addition, as of the date of this overview, the implementation time frame of the managed care plan and the effect it will have on nursing home reimbursement is unclear.

NEW YORK COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	120.00	120.00	120.00	163.50	160.00	160.00	240.00	240.00	240.00			
Average Daily Census	108.84	107.54	107.08	155.52	155.23	153.50	229.46	231.07	224.27			
Occupancy	91.3%	91.2%	90.7%	94.5%	94.7%	94.1%	96.7%	96.8%	96.4%			
Payor Mix Statistics												
Medicare	5.7%	5.9%	5.6%	9.1%	9.1%	9.3%	13.8%	13.6%	14.4%			
Medicaid	67.0%	66.6%	65.7%	75.6%	75.0%	74.5%	82.9%	81.9%	81.9%			
Other	8.5%	8.6%	9.1%	14.8%	14.1%	14.1%	28.4%	22.9%	22.9%			
Avg. Length of Stay Statistics (Days)												
Medicare	32.42	33.71	33.93	41.49	43.07	42.86	57.66	61.69	57.63			
Medicaid	291.79	295.77	278.61	443.27	441.12	442.25	790.11	774.72	725.96			
Other	58.65	56.20	54.39	106.73	96.66	91.95	223.50	195.52	194.69			
Revenue (PPD)												
Inpatient	\$269.66	\$270.29	\$278.15	\$321.59	\$324.63	\$335.75	\$383.22	\$385.03	\$406.78			
Ancillary	\$5.06	\$4.16	\$3.64	\$18.13	\$15.98	\$19.21	\$32.25	\$34.11	\$39.46			
TOTAL	\$282.89	\$278.94	\$290.13	\$334.70	\$335.07	\$351.08	\$393.99	\$398.65	\$420.53			
Expenses (PPD)												
Employee Benefits	\$27.82	\$28.21	\$29.54	\$37.81	\$38.42	\$41.65	\$51.97	\$53.45	\$57.76			
Administrative and General	\$36.55	\$36.78	\$38.72	\$45.14	\$44.24	\$46.89	\$55.93	\$54.39	\$58.30			
Plant Operations	\$9.87	\$9.49	\$10.06	\$12.55	\$11.87	\$12.28	\$16.02	\$15.04	\$15.67			
Laundry & Linens	\$2.97	\$2.94	\$2.88	\$3.81	\$3.80	\$3.76	\$4.86	\$4.74	\$4.78			
Housekeeping	\$6.18	\$6.24	\$6.32	\$8.20	\$8.16	\$8.46	\$10.78	\$10.61	\$10.76			
Dietary	\$18.68	\$18.84	\$19.39	\$22.14	\$22.18	\$22.68	\$25.77	\$25.97	\$26.86			
Nursing & Medical Related	\$80.03	\$80.45	\$81.60	\$94.57	\$95.46	\$96.58	\$110.09	\$109.96	\$113.79			
Ancillary and Pharmacy	\$14.19	\$14.60	\$15.08	\$19.10	\$20.00	\$20.94	\$25.96	\$27.69	\$28.67			
Social Services	\$2.24	\$2.36	\$2.34	\$3.27	\$3.34	\$3.31	\$4.48	\$4.64	\$4.82			

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*	411
Licensed Nursing Beds*	43,973
Beds per 1,000 Aged 65 >**	29.70
Beds per 1,000 Aged 75 >**	73.60
Occupancy Percentage - 2013***	83.69%

*Source: State of North Carolina Department of Health and Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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).

The state may exempt a developer from the \$2,000,000 capital expenditure threshold for the sole purpose of renovating, replacing on the same site or expanding an existing nursing facility that does not result in an increase of bed capacity. In addition, the developer must demonstrate that the conversion will be used to convert semiprivate beds into private beds and improve the living conditions of residents.

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. The following table displays the age groups and the most current bed-to-population ratios:

Age Group	Beds Per 1,000 Population
Under 65	0.62
65 - 74	7.38
75 - 84	23.76
85 and Over	82.52

A county's projected bed utilization is calculated by multiplying the age-specific use rates (shown above) by each county's projected age-specific civilian population (in thousands) for the target year (2019), and then adding the products of the four age-specific projections of beds. 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 under the following scenarios:

- 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-half 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.

Based on the above calculation, there are no counties in the state that are projected to possess nursing home bed need in 2019.

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

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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. These rates will remain frozen through March 31, 2016, when the state updates FRV rates.

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.

According to the North Carolina Health Care Association, no inflation will be applied to the historical cost factor that is being utilized to determine April 1, 2016, FRV rates. However, an additional year of depreciation will be applied to facilities. This will result in an average rate decrease of \$0.23. The remaining non-FRV rate components will remain unchanged.

The state also froze case-mix adjustments effective January 1, 2015. Given that factor, nursing facility rates have not changed for acuity since that date and will not change for acuity on April 1, 2016. It is currently unclear when the state will un-freeze case-mix adjustments. More details of this policy will be provided in the rate methodology section of this overview.

It is also currently unclear how the state will determine rates in fiscal year 2017 (effective October 1, 2016).

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. According the North Carolina Health Care Association, no new CMI adjustments will made on April 1, 2016. It is currently unclear when the state will utilize

updated case mix data.

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.

The statewide Direct Care ceiling/price is established at 102.6% of the base year neutralized Case Mix Adjusted and Non-Case Mix Adjusted Medicaid day weighted median cost. This percentage was reduced from 103.5% effective 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.

During fiscal year 2012, the state suspended the quarterly adjustment of Direct Care component rates for CMI. Rates effective July 1, 2011, were based on March 31, 2011, case mix data. However, nursing facility CMIs were frozen until April 1, 2012. April 1, 2012, rates were adjusted based on an average of the September 30, 2011, and December 31, 2011, case mix scores. Also effective April 1, 2012, the state returned to adjusting Direct Care component rates quarterly, based on case mix data for the prior quarter.

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.

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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.

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.

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

As of the date of this overview there are no significant changes planned to the state's reimbursement system.

NORTH CAROLINA COST REPORT STATISTICS												
	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
General Statistics												
Number of Beds	78.00	80.00	80.00	104.00	102.00	104.00	124.00	127.25	127.00			
Average Daily Census	78.69	81.20	80.41	96.57	97.98	97.14	112.05	118.66	117.17			
Occupancy	81.9%	81.2%	79.5%	88.6%	88.0%	86.9%	92.3%	92.2%	91.8%			
Payor Mix Statistics												
Medicare	10.4%	9.7%	9.7%	14.5%	13.6%	13.0%	19.2%	17.8%	18.0%			
Medicaid	56.3%	54.1%	53.1%	68.4%	65.0%	64.7%	74.2%	73.9%	73.8%			
Other	12.4%	13.1%	13.1%	18.6%	20.2%	21.3%	33.5%	31.9%	34.2%			
Avg. Length of Stay Statistics (Days)												
Medicare	36.10	33.24	32.76	42.82	40.66	40.64	53.03	49.96	49.69			
Medicaid	269.42	285.70	280.28	379.02	377.05	366.67	542.35	549.93	534.48			
Other	72.40	86.60	84.04	119.07	130.33	142.43	213.78	234.78	254.44			
Revenue (PPD)												
Inpatient	\$178.47	\$179.43	\$185.32	\$204.35	\$197.66	\$204.06	\$225.38	\$224.77	\$227.28			
Ancillary	\$42.71	\$43.93	\$46.31	\$54.42	\$57.45	\$58.93	\$72.19	\$76.23	\$76.51			
TOTAL	\$229.05	\$230.15	\$239.25	\$261.92	\$258.05	\$265.42	\$298.36	\$303.30	\$308.62			
Expenses (PPD)												
Employee Benefits	\$13.53	\$14.22	\$14.37	\$17.14	\$16.56	\$16.84	\$23.97	\$21.51	\$21.26			
Administrative and General	\$33.77	\$31.79	\$32.74	\$40.08	\$38.12	\$38.61	\$48.97	\$45.01	\$46.98			
Plant Operations	\$7.19	\$7.21	\$7.35	\$8.41	\$8.39	\$8.67	\$10.07	\$10.35	\$10.54			
Laundry & Linens	\$2.12	\$1.99	\$1.87	\$2.54	\$2.58	\$2.49	\$3.07	\$3.11	\$3.08			
Housekeeping	\$4.38	\$4.42	\$4.60	\$4.81	\$5.37	\$5.50	\$6.42	\$6.82	\$6.95			
Dietary	\$12.67	\$13.53	\$13.76	\$14.00	\$14.86	\$15.32	\$15.88	\$17.21	\$17.79			
Nursing & Medical Related	\$62.93	\$63.34	\$64.32	\$69.86	\$71.08	\$72.33	\$79.25	\$80.58	\$82.80			
Ancillary and Pharmacy	\$23.81	\$24.32	\$24.24	\$29.34	\$30.47	\$31.10	\$38.17	\$38.98	\$38.41			
Social Services	\$1.62	\$1.62	\$1.80	\$2.77	\$2.43	\$2.53	\$3.67	\$3.33	\$3.41			

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

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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*	80
Licensed Nursing Beds*	6,040
Beds per 1,000 Aged 65 >**	53.26
Beds per 1,000 Aged 75 >**	112.65
Occupancy Percentage - 2013***	93.25%

*Source: North Dakota Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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. Per House Bill 1325, the moratorium was extended through July 31, 2015.

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 24 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 2014 utilizing cost report data for the period ended June 30, 2010. 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 2009 utilizing cost report data for the period ending June 30, 2008.

In 2005 the state legislature repealed the statute requiring that the state utilize this 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 2014.

Property limits are increased annually by the Consumer Price Index (CPI). Effective July 1, 2014, the per bed limitation basis is \$125,426 for double occupancy and \$188,141 for single occupancy.

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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 2013 was \$17.59 per resident per day. The average property component rate for 2014 was not available.

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 III, 34-group classification system. 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 2014 is \$155.19 per day, which represents a 3.0% increase from 2013 (\$151.19). 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. 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 2014 is \$67.08 per day, which represents a 3.0% increase from 2013 (\$65.13).

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 2014 is \$26.22 per day, which represents a 3.0% increase from 2013 (\$25.46).

An operating margin consisting of 3.0% of the lesser of the actual Other Direct Care per diem cost or the Other Direct Care limit for the preceding year is added to arrive at the facility's Other Direct Care component rate. The facility-specific Other Direct Care per diem cost utilized to determine the operating margin is calculated utilizing un-inflated allowable costs.

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 and \$213.82 in 2012. The statewide weighted average rate was not available for 2013. However, the 2014 statewide average rate was \$238.94, which represents a 10.5% increase from the 2012 weighted average rate. This reflects that the state rebased rates in 2013.

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 24 (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 are currently no significant changes proposed to the state's Medicaid reimbursement system. However, the state has already established the rate setting manual that will be utilized to determine calendar year 2015 rates. The rate methodology will remain unchanged for 2014 and there will be no rebasing of costs. However, there will be a one-time wage pass-through that will impact rates and rate limits. Based on this factor, the Direct Care limit is projected to increase 7.8% to \$167.81 on January 1, 2015. The Indirect Care limit will increase 6.8% to \$71.67 and the Other Direct Care limit will increase 6.3% to \$27.86.

NORTH DAKOTA COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	50.00	56.25	57.75	72.00	81.00	94.00	118.00	128.75	137.00	
Average Daily Census	55.84	57.11	60.46	68.22	78.55	92.21	106.84	113.56	127.83	
Occupancy	85.5%	87.5%	88.9%	90.8%	92.3%	94.1%	95.4%	97.8%	97.4%	
Payor Mix Statistics										
Medicare	4.0%	4.9%	4.6%	6.2%	6.5%	6.9%	8.6%	8.7%	9.8%	
Medicaid	37.4%	41.3%	40.4%	47.5%	47.9%	49.3%	54.8%	54.9%	53.8%	
Other	34.7%	34.9%	34.4%	44.7%	39.8%	40.2%	60.1%	51.4%	55.1%	
Avg. Length of Stay Statistics (Days)										
Medicare	41.96	43.87	40.86	59.16	58.18	60.40	70.04	73.71	74.06	
Medicaid	484.38	548.40	483.06	711.33	634.95	710.21	876.66	897.07	1113.07	
Other	329.75	268.17	228.02	570.97	441.20	440.80	924.29	654.94	707.54	
Revenue (PPD)										
Inpatient	\$161.16	\$174.52	\$190.88	\$203.94	\$221.22	\$236.76	\$226.27	\$250.66	\$260.41	
Ancillary	\$8.51	\$10.90	\$8.81	\$13.93	\$15.19	\$16.09	\$23.25	\$25.69	\$34.77	
TOTAL	\$176.55	\$192.22	\$205.37	\$220.56	\$230.91	\$255.60	\$249.36	\$267.29	\$291.49	
Expenses (PPD)										
Employee Benefits	\$17.44	\$19.69	\$19.14	\$23.46	\$23.16	\$23.91	\$30.13	\$28.80	\$33.17	
Administrative and General	\$19.68	\$20.59	\$22.20	\$21.29	\$23.84	\$23.97	\$24.72	\$27.15	\$26.84	
Plant Operations	\$8.46	\$8.75	\$9.01	\$10.10	\$10.29	\$11.04	\$12.20	\$12.61	\$12.83	
Laundry & Linens	\$2.55	\$2.31	\$2.82	\$3.20	\$3.27	\$3.34	\$3.89	\$3.91	\$4.23	
Housekeeping	\$4.05	\$4.50	\$4.55	\$4.92	\$5.40	\$5.82	\$6.54	\$6.21	\$7.06	
Dietary	\$17.12	\$17.03	\$17.81	\$20.29	\$19.59	\$21.68	\$22.79	\$22.13	\$24.45	
Nursing & Medical Related	\$74.53	\$73.99	\$83.73	\$92.59	\$93.08	\$103.84	\$113.13	\$100.25	\$123.36	
Ancillary and Pharmacy	\$4.44	\$5.14	\$4.20	\$7.72	\$9.51	\$10.59	\$12.52	\$12.92	\$14.36	
Social Services	\$1.78	\$1.76	\$2.01	\$2.68	\$3.00	\$3.27	\$4.68	\$5.75	\$7.49	

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*	937
Licensed Nursing Beds*	90,525
Beds per 1,000 Aged 65 >**	49.44
Beds per 1,000 Aged 75 >**	113.25
Occupancy Percentage - 2013***	83.10%

*Source: Ohio Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 needed for the following activities:

- The establishment, development or construction of a new nursing facility. 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.
- 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.

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:

- 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. Each county's bed need was published on April 1, 2010, and April 1, 2012, and will be published every four years after.

The number of counties eligible for long-term care bed relocation to a county with unmet demand in 2012 was 24, while 20 counties were eligible to receive beds from these counties. According to representatives for the Ohio Department of Health, the state is currently unable to recalculate bed need based on antiquated data collection systems. Given this factor, it is unclear when bed need will next be calculated.

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, 2015, the rates decreased to \$12.05 and \$9.60, respectively.

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 has indicated that it will rebase nursing facility rates effective July 1, 2016, utilizing 2014 cost report data. According to the Ohio Health Care Association, this rebasing, combined with the to-be-mentioned conversion to the RUG IV system, will result in a statewide average rate increase of \$12.

RATE METHODOLOGY

The methodology described below was utilized to calculate Medicaid prices during the last rate rebasing (July 1, 2005) and will be utilized for the next rate period that Ohio rebases prices. 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, Auglaize, 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, Pauoding, 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. DJFS uses 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 will convert from using the RUG III model to the RUG IV, 57-grouper to adjustment direct care rates for case mix. As previously mentioned, the Ohio Health Care Association anticipates that this change, combined with the rebasing of rates, will result in an average stateside rate increase of \$12.

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 is derived from the two fiscal quarters prior to the effective date of the price. 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.

The RUG III system utilizes the MDS 2.0 assessment tool when assessing residents for acuity. Per CMS guidelines, nursing facilities are now required to utilize the MDS 3.0 assessment tool. This assessment tool only correlates to the RUG IV system. Due to difficulty the state is experiencing in converting data from MDS 2.0 to 3.0, the state froze case mix scores for the purpose of calculating July 1, 2011, rates. However, 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 will reduce 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. However, according the Ohio Health Care Association, these changes will be more than 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, 2016, only three facilities did not receive the maximum payment.

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.

Effective July 1, 2010, nursing facilities have received two additional rate add-ons, the Workforce Development Incentive Payment and the Consolidated Services add-on. The Workforce Development Incentive Payment equated to the original increase (\$5.70 per day) in the FPF. The Consolidated Services add-on was a specific per diem amount (\$3.84 per day) that nursing facilities received to offset the cost of providing/contracting ancillary services that were previously reimbursed to third party ancillary providers. Both of these add-ons were eliminated in fiscal year 2012; the Direct Care price was increased by \$1.88 in fiscal year 2012 to account for the elimination of these add-ons.

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 and the quality incentive payment.

In previous years, Ohio had a Stop Loss/Gain Provision to protect nursing facilities from rate reductions derived from converting from a cost-based system to a price-based system, and to protect the state from paying significant rate increases to nursing facilities whose cost-based rates were significantly less than their calculated prices. However, all aspects of the Stop Loss/Gain Provision were eliminated on July 1, 2012, when all of the nursing facilities in the state were converted to the price-based system. In fiscal year 2012, slightly more than 80.0% of the nursing facilities in the state were being reimbursed at the price.

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, 2016, only seven nursing facilities in the state have qualified for this add-on, with an average add-on of \$9.05 per day.

The average nursing facility Medicaid rate effective January 1, 2016, is \$177.31, which 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. None of these estimates is a weighted average rate. The weighted average nursing facility Medicaid rates effective July 1, 2012, and July 1, 2011, were \$174.19 and \$167.65, respectively.

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.

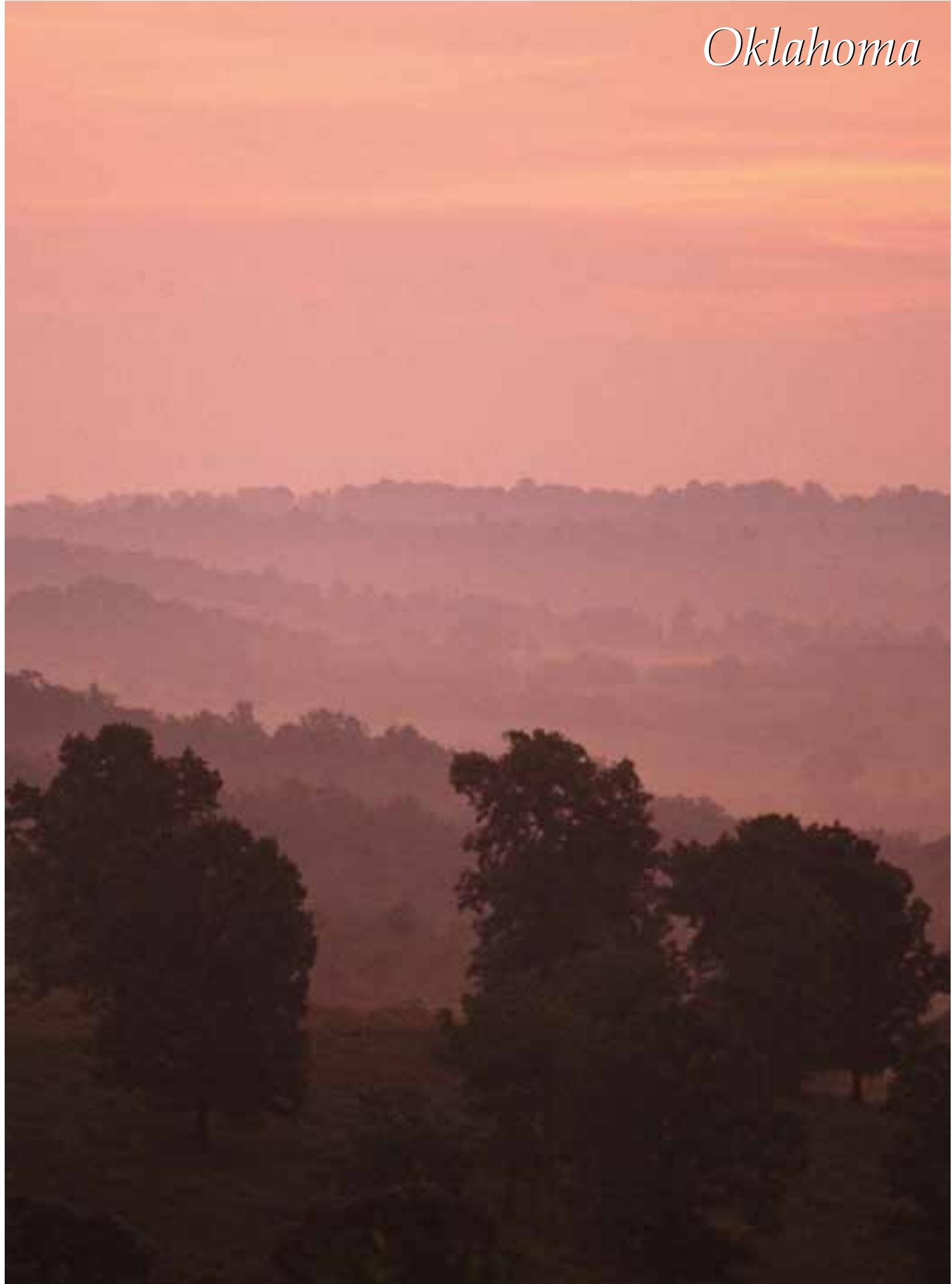
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

In addition to rebasing rates, the state has indicated that it will convert from the RUG III 34-RUG Grouper to the RUG IV 57-RUG Grouper.

OHIO COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	70.00	70.00	68.50	99.00	99.00	98.00	120.00	117.00	116.00			
Average Daily Census	61.32	61.34	60.21	84.54	83.27	82.19	109.14	107.24	107.06			
Occupancy	79.2%	78.2%	78.1%	86.8%	86.3%	86.0%	91.9%	91.7%	91.5%			
Payor Mix Statistics												
Medicare	6.8%	6.5%	6.3%	10.0%	9.9%	9.7%	13.6%	13.2%	13.0%			
Medicaid	51.9%	52.8%	51.7%	63.6%	63.4%	62.4%	73.0%	72.7%	72.3%			
Other	17.8%	18.2%	18.8%	25.7%	26.7%	27.3%	36.1%	36.8%	37.6%			
Avg. Length of Stay Statistics (Days)												
Medicare	33.03	28.86	28.51	38.99	36.05	36.26	48.34	47.21	47.24			
Medicaid	207.02	203.40	199.28	349.53	322.95	312.67	660.68	633.15	570.99			
Other	57.26	58.17	53.98	90.66	86.45	85.45	156.80	140.46	142.95			
Revenue (PPD)												
Inpatient	\$186.56	\$189.77	\$193.51	\$209.42	\$212.25	\$216.32	\$238.53	\$241.62	\$246.02			
Ancillary	\$35.20	\$40.27	\$40.24	\$55.77	\$61.50	\$63.27	\$79.74	\$88.12	\$93.42			
TOTAL	\$229.96	\$236.60	\$240.73	\$267.77	\$275.28	\$281.50	\$315.99	\$326.75	\$336.93			
Expenses (PPD)												
Employee Benefits	\$16.35	\$14.87	\$14.90	\$19.92	\$18.93	\$18.34	\$25.61	\$24.86	\$24.35			
Administrative and General	\$35.68	\$36.50	\$37.10	\$42.09	\$42.83	\$43.04	\$49.99	\$50.27	\$50.95			
Plant Operations	\$8.32	\$8.09	\$8.46	\$9.70	\$9.46	\$9.99	\$11.63	\$11.39	\$12.02			
Laundry & Linens	\$1.57	\$1.48	\$1.51	\$2.26	\$2.18	\$2.13	\$2.99	\$2.88	\$2.94			
Housekeeping	\$3.98	\$4.01	\$4.04	\$4.84	\$4.82	\$4.91	\$5.97	\$5.99	\$5.96			
Dietary	\$13.74	\$13.91	\$14.08	\$15.19	\$15.32	\$15.59	\$17.50	\$17.50	\$18.07			
Nursing & Medical Related	\$61.77	\$61.08	\$61.84	\$69.48	\$68.37	\$69.79	\$77.86	\$76.04	\$77.90			
Ancillary and Pharmacy	\$17.81	\$18.86	\$18.07	\$24.68	\$26.04	\$26.23	\$32.92	\$33.85	\$34.77			
Social Services	\$2.18	\$2.18	\$2.23	\$3.40	\$3.48	\$3.55	\$4.80	\$5.02	\$5.02			

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*	306
Licensed Nursing Beds*	28,991
Beds per 1,000 Aged 65 >**	50.12
Beds per 1,000 Aged 75 >**	119.64
Occupancy Percentage - 2013***	69.40%

*Source: Oklahoma State Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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,

Oklahoma

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).

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.

RATE METHODOLOGY

As previously mentioned, a nursing facility's Medicaid per diem rate is determined as the sum of the statewide base rate (\$107.24), 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 July 1, 2015) is \$10.05 per day. This add-on has been frozen at \$10.05 since July 1, 2013.

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 \$23.13 per day

(effective July 1, 2015) and the add-on ranges from \$15.38 to \$29.58 per day. This average 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 July 1, 2015, was \$2.91.

Effective July 1, 2015, the average Medicaid rate in the state was \$143.70, which 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 January 1, 2016, this rate is \$198.22 per day.

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. However, the state has a public hearing on this policy change effective February 18, 2015. 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 is in the process of developing an Upper Payment Limit (UPL)/Intergovernmental Transfer (IGT) program. The state intends on linking 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 also result in the state utilizing some type of acuity adjustment system to calculate Medicaid rates. Given that the state has not finalized any plans for these programs, and that these changes would require approval from the Centers of Medicare and Medicaid (CMS) prior to implementation, the likelihood and time frame of the implementation of these programs are unclear.

OKLAHOMA COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	65.00	62.00	65.00	91.00	86.00	88.00	114.00	112.00	112.00	
Average Daily Census	49.60	47.00	49.22	68.29	63.34	62.92	84.19	80.71	81.59	
Occupancy	61.0%	59.8%	60.2%	70.5%	71.2%	71.4%	82.6%	82.6%	83.2%	
Payor Mix Statistics										
Medicare	5.4%	5.2%	5.7%	8.6%	8.0%	8.6%	12.2%	11.8%	12.7%	
Medicaid	62.1%	62.9%	62.2%	71.8%	72.1%	72.7%	80.2%	80.2%	80.3%	
Other	11.7%	11.9%	10.8%	18.5%	18.3%	17.7%	27.6%	26.5%	27.5%	
Avg. Length of Stay Statistics (Days)										
Medicare	32.69	32.76	32.04	41.59	40.67	40.80	55.88	52.77	59.05	
Medicaid	202.24	215.39	233.49	255.02	278.02	338.63	457.74	480.33	554.25	
Other	94.53	99.55	92.48	148.83	163.98	163.17	257.40	253.01	283.12	
Revenue (PPD)										
Inpatient	\$131.54	\$135.88	\$144.10	\$141.48	\$146.97	\$155.38	\$153.91	\$164.36	\$170.40	
Ancillary	\$14.52	\$18.53	\$19.52	\$26.04	\$27.90	\$31.64	\$41.29	\$41.85	\$48.46	
TOTAL	\$143.51	\$149.22	\$159.76	\$161.82	\$166.27	\$177.71	\$185.93	\$193.64	\$209.86	
Expenses (PPD)										
Employee Benefits	\$10.55	\$10.58	\$10.80	\$12.06	\$12.37	\$12.65	\$14.73	\$14.60	\$15.43	
Administrative and General	\$21.11	\$22.74	\$25.83	\$26.80	\$28.66	\$31.71	\$33.89	\$36.32	\$39.70	
Plant Operations	\$6.80	\$6.68	\$7.01	\$7.87	\$7.66	\$8.01	\$9.45	\$9.09	\$9.47	
Laundry & Linens	\$1.69	\$1.77	\$1.56	\$2.16	\$2.21	\$2.18	\$2.69	\$2.70	\$2.75	
Housekeeping	\$3.84	\$3.72	\$3.70	\$4.54	\$4.44	\$4.40	\$5.49	\$5.29	\$5.56	
Dietary	\$13.36	\$13.30	\$13.68	\$14.66	\$14.83	\$15.26	\$16.87	\$16.90	\$17.15	
Nursing & Medical Related	\$51.22	\$50.38	\$52.73	\$55.82	\$56.93	\$59.25	\$63.83	\$63.35	\$67.24	
Ancillary and Pharmacy	\$9.46	\$10.32	\$10.05	\$15.02	\$15.25	\$15.51	\$21.37	\$20.87	\$22.02	
Social Services	\$1.41	\$1.35	\$1.55	\$2.16	\$2.14	\$2.42	\$3.02	\$2.94	\$3.09	

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*	137
Licensed Nursing Beds*	12,203
Beds per 1,000 Aged 65 >**	19.17
Beds per 1,000 Aged 75 >**	46.91
Occupancy Percentage - 2013***	64.29%

*Source: Oregon Department of Human Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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.

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.

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, 2014, the tax is \$19.37 per patient day, which represents a \$1.09 decrease from the prior tax of \$20.46 (effective January 1, 2014). The LTCFT prior to this rate was \$20.79 (effective July 1, 2013).

The total LTCFT is calculated by multiplying total patient days by \$19.37. 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 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.

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. For example, for the biennium beginning July 1, 2009, statements However, effective fiscal year 2013, the basic rate will be rebased on an annual basis. For example, for the rate period beginning July 1, 2014, statements for the period ending June 30, 2013, 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 since that date, 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%.

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.

Approximately 111 (85.4%) of 130 Medicaid certified nursing facilities within the state had at least one resident receiving the complex medical needs rate for the period ending June 30, 2013. In addition, complex medical needs patient days represented approximately 10.6% of total Medicaid days over the same period.

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
2015	\$257.56	\$360.38	2.2%
10/1/2013 to 6/30/14	\$257.00	\$359.59	0.2%
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%
2008	\$187.06	\$261.88	8.0%
2007	\$173.14	\$242.40	4.4%
2006	\$165.89	\$232.25	18.6%
2005	\$139.86	\$195.81	N/A

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.

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 will 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

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 criteria utilized by the state to allow for the purchase of long-term care beds was previously defined in the CON section of this overview. The goal of this add-on is to reduce overall nursing home capacity in the state by 1,500 beds before December 31, 2015. As of the effective date of this overview, only one nursing home operator has attempted to take advantage of this add-on.

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		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Number of Beds	69.00	62.75	63.50	93.00	87.50	87.00	116.00	110.00	113.00
Average Daily Census	50.42	48.91	46.79	71.15	65.51	62.15	91.68	83.06	89.47
Occupancy	56.9%	56.6%	59.0%	64.4%	65.1%	65.4%	77.7%	76.8%	75.1%
Payor Mix Statistics									
Medicare	6.5%	7.3%	7.8%	12.2%	11.2%	12.6%	16.9%	16.3%	16.8%
Medicaid	45.7%	45.0%	42.9%	56.7%	57.2%	53.3%	67.9%	68.3%	64.3%
Other	19.9%	21.4%	22.7%	27.1%	28.0%	32.6%	46.8%	52.5%	49.3%
Avg. Length of Stay Statistics (Days)									
Medicare	24.79	24.19	25.15	28.24	28.67	30.11	33.78	33.07	33.89
Medicaid	156.43	167.93	160.66	215.26	190.92	208.61	263.86	241.00	288.44
Other	31.90	31.03	33.28	45.25	42.25	49.57	98.17	77.06	94.83
Revenue (PPD)									
Inpatient	\$221.75	\$225.48	\$233.28	\$253.71	\$251.03	\$263.39	\$284.65	\$282.46	\$294.66
Ancillary	\$46.29	\$66.21	\$65.03	\$79.25	\$100.94	\$105.82	\$108.94	\$142.64	\$156.40
TOTAL	\$270.31	\$291.76	\$321.42	\$319.59	\$359.86	\$379.09	\$404.39	\$431.90	\$456.32
Expenses (PPD)									
Employee Benefits	\$22.55	\$21.81	\$23.50	\$26.84	\$25.48	\$27.11	\$30.05	\$30.35	\$30.29
Administrative and General	\$42.71	\$45.07	\$48.02	\$51.25	\$52.73	\$55.43	\$56.68	\$58.71	\$62.45
Plant Operations	\$8.42	\$8.42	\$8.48	\$9.79	\$9.37	\$10.05	\$11.90	\$11.44	\$11.98
Laundry & Linens	\$2.01	\$2.13	\$2.22	\$2.54	\$2.71	\$2.78	\$3.22	\$3.14	\$3.19
Housekeeping	\$3.75	\$3.71	\$3.93	\$4.35	\$4.42	\$4.61	\$5.24	\$5.43	\$5.48
Dietary	\$14.59	\$14.68	\$14.74	\$16.14	\$15.95	\$16.46	\$17.32	\$17.33	\$17.90
Nursing & Medical Related	\$80.59	\$79.81	\$85.03	\$90.04	\$91.59	\$92.91	\$100.07	\$100.18	\$101.41
Ancillary and Pharmacy	\$25.19	\$26.88	\$28.95	\$36.24	\$42.50	\$42.64	\$54.13	\$54.51	\$57.80
Social Services	\$2.25	\$2.25	\$2.57	\$3.46	\$3.44	\$3.91	\$4.69	\$5.23	\$5.40

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*	708
Licensed Nursing Beds*	102,156
Beds per 1,000 Aged 65 >**	46.94
Beds per 1,000 Aged 75 >**	102.71
Occupancy Percentage - 2013***	89.34%

*Source: Pennsylvania Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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, 2015, the fee is \$8.32 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. This fee did not change from the rate for the prior fiscal year. The fee is \$30.06 for all other nursing facilities. These fees represented a \$0.60 increase from the equivalent fiscal year 2015 rate (\$29.46). 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.

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.

The most recent cost report data used to calculate the final fiscal year 2015 rates were predominantly derived from 2009 to 2012 cost report data, depending on the nursing facility's fiscal year end. Pennsylvania is still in the process of finalizing fiscal year 2016 rates. The state has determined proposed rates for the first two quarters of fiscal year 2016 (effective July 1, 2015, and October 1, 2015), utilizing data derived predominantly from 2010 to 2013 cost reports. As of the date of this overview, these rates have not been finalized for two reasons as follows: the state has yet to pass a fiscal year 2016 budget and the Centers for Medicare and Medicaid (CMS) must approve a state plan amendment with the most recent budget adjustment factor before rates can be finalized. However, professionals from the state's rate setting department and the Pennsylvania Health Care Association have indicated that fiscal year 2016 final rates will not significantly vary from the proposed rates. The rate calculation described below is based on the current regulations and was utilized to calculate final fiscal year 2015 rates and proposed fiscal year 2016 rates.

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

Pennsylvania

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.

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.

In recent years, Pennsylvania approved legislation that phased out county nursing facilities from the peer groups. In fiscal year 2010, the median costs for the three non-capital components (Resident Care, Other Resident Related and Administrative) were calculated with and without county nursing facility costs. The final values used as medians will be a blend of the two medians, with the medians including county costs being weighted at 75% and medians not including county costs being weighted at 25%. In fiscal years 2011 and 2012, medians calculated utilizing county In fiscal year 2011, medians calculated utilizing county costs equated to 50% of the final medians. In fiscal year 2012, medians calculated utilizing county costs equated to 25% of the final medians. 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 and 2014 rates are 5.14% and 4.76%, respectively. A financial yield rate of 4.52% was utilized to determine fiscal year 2015 rates. The yield rate utilized to determine proposed fiscal year 2016 rates was 4.245%. 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, 2014) were determined as follows:

- Group A - 90% overall occupancy and a Medicaid occupancy greater than 90% - \$4.04 per diem;
- Group B - 90% overall occupancy and a Medicaid occupancy ranging from 88% to > 90% - \$2.74 per diem;
- Group C - 90% overall occupancy and a Medicaid occupancy ranging from 86% to > 88% - \$1.63 per diem;
- Group D - 90% overall occupancy and a Medicaid occupancy ranging from 84% to > 86% - \$0.99 per diem;
- Group E - 90% overall occupancy and a Medicaid occupancy ranging from 82% to > 84% - \$0.51 per diem;
- Group F - 90% overall occupancy and a Medicaid occupancy ranging from 80% to > 82% - \$0.37 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 \$15.65 per Medicaid patient day for state fiscal year 2016.

County-owned nursing facilities are reimbursed an approximate additional \$10.31 per Medicaid day for state fiscal year 2015. As of the effective date of this overview, an estimate of the county additional per diem amount for fiscal year 2016 was not yet available. Since the inception of the assessment fee, these rates have changed annually based on calculations made by the PDPW and approved by CMS. The county add-on amount 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.

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 2012 rates are as follows: July 1, 2011, - 0.88598; October 1, 2011, - 0.86825; January 1, 2012, - 0.86829 and April 1, 2012, - 0.86483. The budget adjustment factors for finalized fiscal year 2013 rates are as follows: July 1, 2012, to March 30, 2013, - 0.84559 and April 1, 2013, - 0.85606. The budget adjustment factor for finalized rates effective July 1, 2013, to March 31, 2014, was 0.84801. The budget adjustment factor was 0.86366 effective April 1, 2014, 0.84265 from July 1, 2014, to March 31, 2015. The budget adjustment factor for the most recently finalized rates (April 1, 2015) was 0.85297. The budget adjustment factor for proposed rates effective July 1, 2015, and October 1, 2015, is 0.83105.

The average rates in Pennsylvania effective July 1, 2010, July 1, 2011, July 1, 2012, and July 2, 2013, were \$175.34, \$177.37, \$185.89 and \$190.18, respectively. The average rate for finalized rates effective July 1, 2014, is \$194.00, which represents a 2.0% increase from the prior fiscal year. The average proposed rate effective July 1, 2015, is \$194.49.

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

Pennsylvania

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.

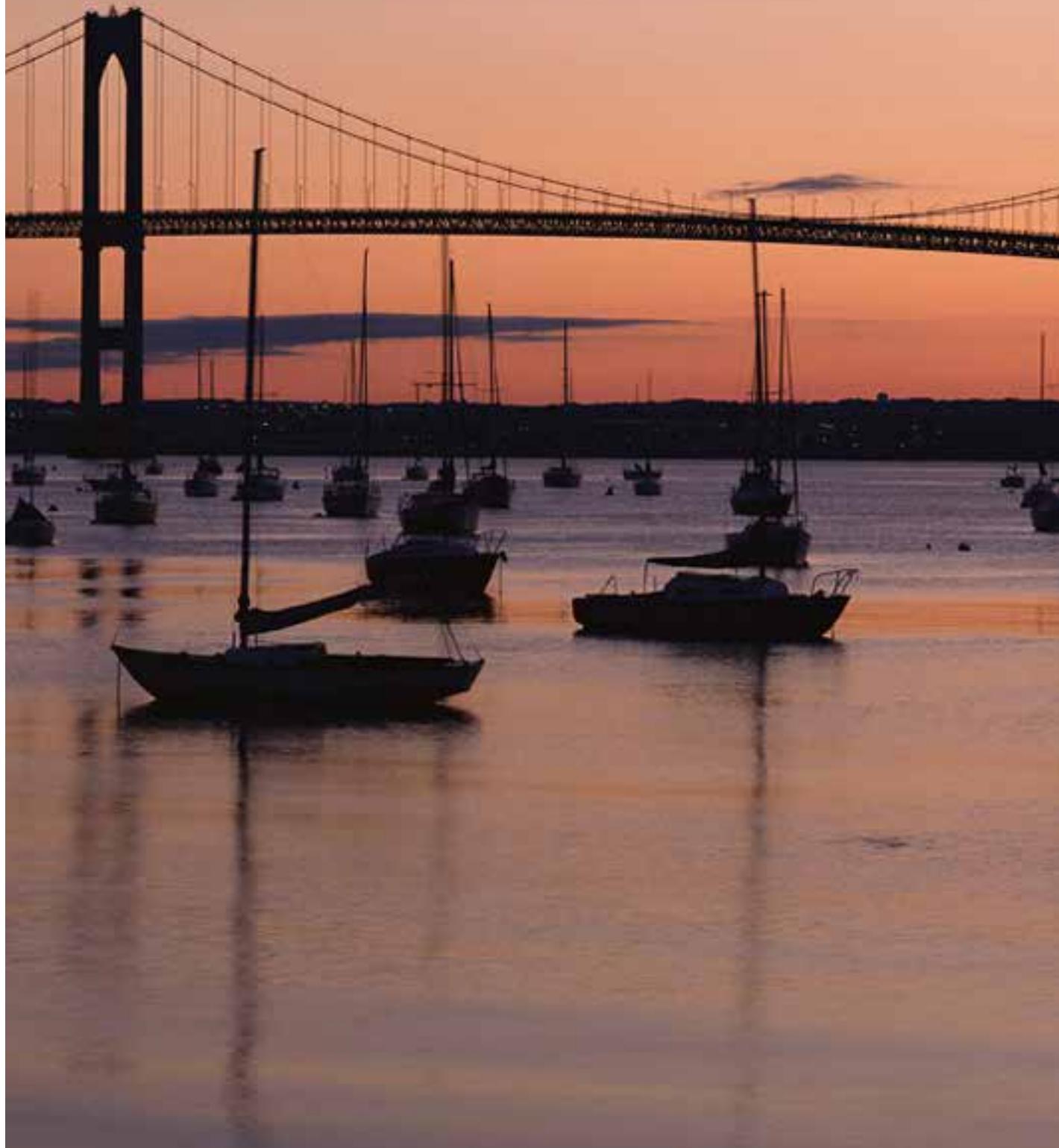
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this report, there are no significant or planned changes to the state's rate setting system. However, the state is in the process of developing a methodology for the implementation of a Managed Care Reimbursement System (Community Health Choices) that is proposed to be implemented in 2017. The details of this system and the impact it will have on nursing facilities have yet to be determined.

Pennsylvania Cost Report Statistics												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	80.00	80.00	79.25	120.00	120.00	120.00	152.00	152.25	150.75			
Average Daily Census	85.33	85.54	84.86	114.24	113.24	113.09	156.53	156.70	151.87			
Occupancy	85.8%	86.9%	86.6%	91.4%	91.7%	91.3%	94.8%	94.8%	94.4%			
Payor Mix Statistics												
Medicare	6.8%	6.2%	6.1%	9.8%	9.4%	9.2%	14.5%	13.9%	12.8%			
Medicaid	54.3%	46.8%	46.5%	67.3%	65.8%	66.2%	76.3%	75.4%	75.8%			
Other	16.2%	15.6%	15.8%	31.9%	29.3%	29.4%	84.0%	63.4%	60.6%			
Avg. Length of Stay Statistics (Days)												
Medicare	33.25	33.76	34.27	46.17	45.81	45.59	62.46	62.12	61.82			
Medicaid	253.46	306.33	324.51	556.66	593.83	597.44	825.12	851.49	825.48			
Other	54.44	57.22	54.58	133.76	118.78	116.29	297.41	255.57	245.71			
Revenue (PPD)												
Inpatient	\$222.35	\$223.36	\$225.89	\$257.95	\$256.86	\$262.57	\$294.58	\$298.76	\$305.56			
Ancillary	\$40.30	\$42.32	\$42.20	\$57.42	\$58.14	\$63.05	\$77.92	\$81.11	\$89.00			
TOTAL	\$278.03	\$277.71	\$285.42	\$321.08	\$322.33	\$336.61	\$374.50	\$390.48	\$414.52			
Expenses (PPD)												
Employee Benefits	\$18.98	\$18.56	\$19.03	\$25.00	\$25.38	\$25.52	\$33.34	\$32.50	\$33.59			
Administrative and General	\$30.47	\$29.63	\$32.23	\$45.25	\$44.57	\$46.40	\$63.58	\$59.34	\$61.63			
Plant Operations	\$9.23	\$8.96	\$9.47	\$11.58	\$11.27	\$12.02	\$17.57	\$16.70	\$18.01			
Laundry & Linens	\$2.34	\$2.34	\$2.42	\$3.20	\$3.15	\$3.33	\$4.11	\$4.09	\$4.40			
Housekeeping	\$5.01	\$5.10	\$5.13	\$6.67	\$6.60	\$6.62	\$9.17	\$9.09	\$9.16			
Dietary	\$16.12	\$16.06	\$16.26	\$19.36	\$19.62	\$20.36	\$25.25	\$25.40	\$26.04			
Nursing & Medical Related	\$78.39	\$78.85	\$81.51	\$96.14	\$94.88	\$97.46	\$111.81	\$112.22	\$114.24			
Ancillary and Pharmacy	\$22.60	\$22.69	\$23.39	\$29.72	\$29.98	\$30.01	\$39.26	\$39.49	\$38.83			
Social Services	\$1.78	\$1.78	\$1.80	\$2.43	\$2.41	\$2.47	\$3.63	\$3.59	\$3.60			

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*	90
Licensed Nursing Beds*	9,052
Beds per 1,000 Aged 65 >**	53.55
Beds per 1,000 Aged 75 >**	117.69
Occupancy Percentage - 2013***	93.74%

*Source: State of Rhode Island Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 service 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, 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.

Rhode Island

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 (every 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

Rhode Island

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 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

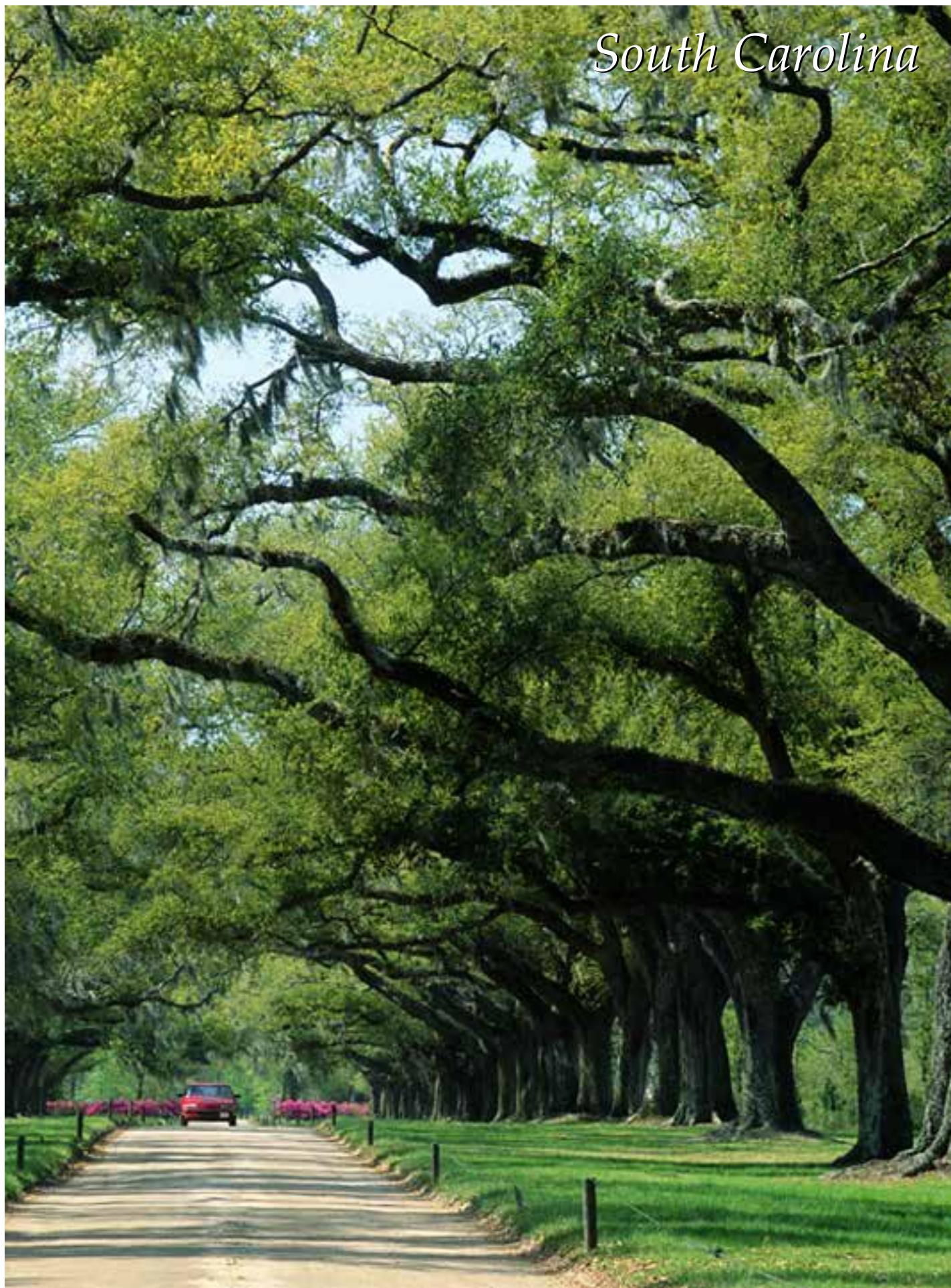
As part of the development of the new price-based system, the state was supposed to implement a quality incentive program and dementia care/behavior health add-on by October 1, 2013. However, this did not occur. According to Rhode Island Rate Setting Professionals, these programs are still in consideration 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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	60.00	63.75	60.00	101.00	111.00	97.00	131.50	142.75	142.75	
Average Daily Census	54.65	57.18	56.20	94.02	102.65	98.58	120.73	133.04	132.54	
Occupancy	89.3%	90.3%	89.8%	92.7%	93.4%	92.4%	94.7%	95.0%	95.3%	
Payor Mix Statistics										
Medicare	5.6%	5.7%	6.0%	9.1%	8.1%	9.5%	12.4%	12.0%	12.9%	
Medicaid	56.1%	59.7%	56.6%	65.6%	65.1%	64.6%	73.4%	73.4%	73.4%	
Other	19.3%	19.3%	18.7%	26.7%	24.3%	26.0%	34.9%	33.0%	31.7%	
Avg. Length of Stay Statistics (Days)										
Medicare	25.26	23.96	24.89	32.62	28.33	32.64	36.05	37.84	42.50	
Medicaid	274.97	286.39	268.96	371.53	359.15	434.05	503.62	490.14	645.09	
Other	42.47	45.46	43.15	64.40	57.70	70.88	116.18	91.35	100.66	
Revenue (PPD)										
Inpatient	\$247.01	\$252.00	\$257.93	\$267.63	\$282.01	\$294.92	\$292.01	\$307.72	\$320.44	
Ancillary	\$32.25	\$36.14	\$35.16	\$52.71	\$52.03	\$53.42	\$76.69	\$72.96	\$83.39	
TOTAL	\$290.70	\$293.47	\$302.01	\$327.10	\$348.95	\$352.89	\$371.18	\$387.87	\$396.57	
Expenses (PPD)										
Employee Benefits	\$24.22	\$23.51	\$23.48	\$29.45	\$28.16	\$29.92	\$34.33	\$35.34	\$35.90	
Administrative and General	\$39.20	\$39.95	\$40.88	\$46.69	\$46.38	\$48.12	\$56.76	\$55.77	\$56.98	
Plant Operations	\$9.56	\$9.41	\$9.60	\$10.76	\$10.73	\$11.67	\$12.63	\$12.79	\$14.00	
Laundry & Linens	\$2.38	\$2.46	\$2.66	\$2.98	\$3.04	\$3.09	\$4.03	\$3.90	\$3.93	
Housekeeping	\$4.84	\$4.99	\$5.32	\$6.10	\$6.07	\$6.20	\$7.49	\$7.48	\$7.89	
Dietary	\$15.59	\$15.76	\$17.50	\$18.37	\$17.96	\$19.93	\$21.37	\$20.87	\$21.70	
Nursing & Medical Related	\$77.47	\$80.11	\$81.11	\$86.64	\$87.76	\$94.73	\$96.55	\$100.21	\$102.70	
Ancillary and Pharmacy	\$18.23	\$17.52	\$19.51	\$26.56	\$27.95	\$29.09	\$36.10	\$35.62	\$38.68	
Social Services	\$1.85	\$2.11	\$1.93	\$2.64	\$2.92	\$2.83	\$3.60	\$3.64	\$3.79	

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*	193
Licensed Nursing Beds*	20,170
Beds per 1,000 Aged 65 >**	26.27
Beds per 1,000 Aged 75 >**	67.52
Occupancy Percentage - 2013***	88.85%

*Source: South Carolina Department of Health and Environment Control

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 2016.

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 2015-2016 State Health Plan (utilizing projected 2017 population data) estimated a demand for 13,152 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, are based on cost report data for the fiscal year ended September 30, 2014.

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, and 3.0% effective October 1, 2015.

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.

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. The following displays cost standards effective October 1, 2015:

Bed Size	General Services Cost Center					
	Percentage of Skilled Nursing Medicaid Patients					
	0-19%	20-39%	40-49%	50-69%	70-84%	85-100%
0 - 60 beds	\$79.34	\$86.34	\$93.34	\$100.34	\$107.34	\$114.34
61 - 99 beds	\$76.82	\$83.60	\$90.38	\$97.16	\$103.94	\$110.72
100+ beds	\$80.38	\$87.47	\$94.56	\$101.65	\$108.74	\$115.84
	85.0%	92.5%	100.0%	107.5%	115.0%	122.5%

% of General Services standard allowed based on % of skilled Medicaid residents

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%.

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 \$52,298 (effective October 1, 2015).

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, 2015, this rate is 3.24%. 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 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. 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, 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 \$169.01 effective October 1, 2015, approximately 1.0% greater than the average rate (\$167.20) effective October 1, 2014. The weighted average rate effective October 1, 2013, is \$160.67.

MINIMUM OCCUPANCY STANDARDS

A minimum occupancy level of 92% is utilized when setting the Medicaid rates. Effective October 1, 2013, Medicaid rates for

nursing facilities located in counties with an occupancy rate less than 85% are established based upon the following policies:

- The 92% minimum occupancy is waived, but standards remain at the 92% 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%. 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 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

South Carolina

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 month's 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.

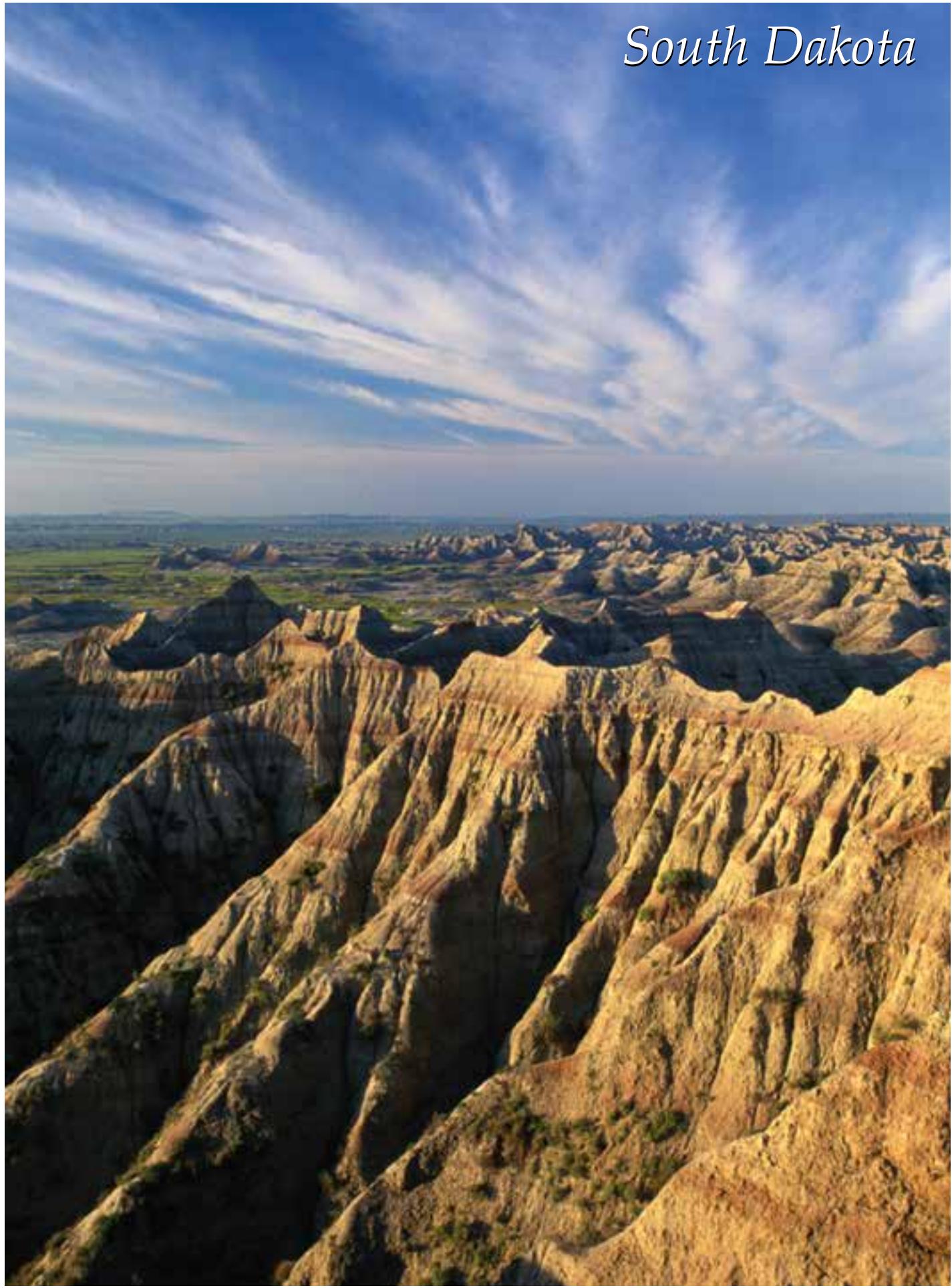
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is no current or proposed state legislation affecting the current Medicaid calculation in South Carolina.

SOUTH CAROLINA COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	45.00	84.00	81.50	99.00	99.00	99.00	132.00	132.00	132.00			
Average Daily Census Occupancy	57.56	73.76	73.74	87.59	91.63	91.57	128.49	123.62	126.07			
	85.6%	86.4%	83.8%	92.2%	91.9%	89.8%	95.6%	94.7%	93.1%			
Payor Mix Statistics												
Medicare	12.3%	10.1%	10.1%	17.3%	13.7%	14.2%	25.2%	21.5%	23.4%			
Medicaid	41.2%	57.6%	54.6%	64.1%	70.1%	70.6%	70.8%	79.1%	79.0%			
Other	18.2%	10.3%	10.5%	32.1%	18.7%	20.0%	78.7%	32.5%	38.9%			
Avg. Length of Stay Statistics (Days)												
Medicare	33.57	33.45	31.74	40.56	42.48	39.80	51.05	61.23	55.00			
Medicaid	229.89	300.61	285.82	370.34	445.67	450.19	624.68	883.20	733.15			
Other	83.21	79.11	71.31	187.89	128.61	113.14	436.48	237.71	230.87			
Revenue (PPD)												
Inpatient	\$174.44	\$170.76	\$173.64	\$199.57	\$190.78	\$198.68	\$225.96	\$219.39	\$232.14			
Ancillary	\$48.30	\$39.30	\$41.95	\$71.10	\$58.42	\$63.18	\$93.09	\$96.50	\$99.65			
TOTAL	\$234.36	\$230.32	\$220.38	\$270.85	\$267.15	\$279.88	\$312.83	\$321.97	\$343.28			
Expenses (PPD)												
Employee Benefits	\$10.83	\$13.00	\$14.57	\$20.17	\$20.28	\$21.58	\$33.28	\$27.32	\$29.03			
Administrative and General	\$25.34	\$22.48	\$22.18	\$33.16	\$30.97	\$30.83	\$42.16	\$38.87	\$41.98			
Plant Operations	\$7.86	\$8.06	\$8.17	\$10.23	\$9.43	\$9.92	\$13.97	\$12.46	\$13.44			
Laundry & Linens	\$2.11	\$2.16	\$2.09	\$2.73	\$2.70	\$2.66	\$3.78	\$3.36	\$3.36			
Housekeeping	\$5.59	\$4.92	\$4.88	\$6.40	\$5.87	\$5.96	\$9.36	\$7.28	\$7.77			
Dietary	\$15.36	\$14.77	\$15.30	\$16.89	\$16.21	\$16.95	\$20.80	\$18.64	\$19.87			
Nursing & Medical Related	\$76.02	\$69.41	\$70.09	\$83.39	\$78.54	\$81.19	\$97.98	\$89.15	\$97.36			
Ancillary and Pharmacy	\$22.10	\$19.68	\$19.35	\$32.82	\$25.99	\$27.42	\$47.00	\$42.56	\$47.88			
Social Services	\$1.90	\$2.03	\$2.23	\$3.18	\$3.30	\$3.73	\$4.81	\$4.42	\$4.60			
Comments: The sample size for the 2011 data (146 facilities) is moderately less than the sample sizes for 2010 (165 facilities) and 2012 (169 facilities), respectively. This may moderately skew the 2011 data.												

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*	110
Licensed Nursing Beds*	6,868
Beds per 1,000 Aged 65 >**	51.59
Beds per 1,000 Aged 75 >**	111.20
Occupancy Percentage - 2013***	88.05%

*Source: South Dakota Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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%.

South Dakota

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.

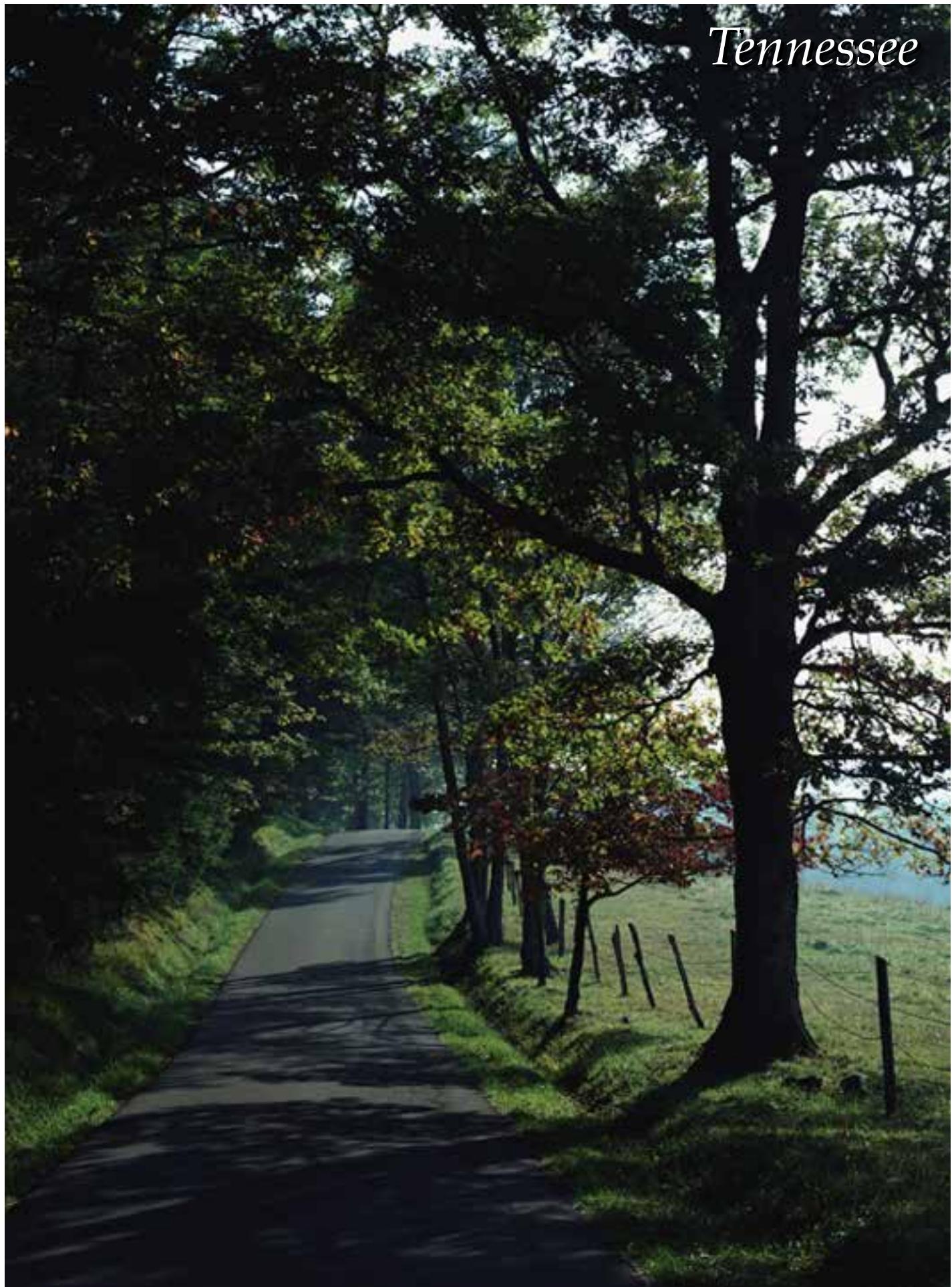
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	54.50	48.00	50.00	63.00	59.00	59.00	90.00	83.00	81.00	
Average Daily Census	45.74	45.03	45.38	57.42	54.67	55.59	81.84	69.66	68.68	
Occupancy	83.6%	86.3%	83.8%	91.1%	91.2%	91.1%	95.5%	94.1%	95.3%	
Payor Mix Statistics										
Medicare	6.9%	6.3%	6.6%	8.4%	9.0%	8.4%	12.5%	11.4%	12.8%	
Medicaid	47.5%	41.5%	43.7%	52.3%	53.3%	54.0%	62.2%	59.3%	59.3%	
Other	38.9%	34.7%	34.2%	54.5%	47.5%	44.3%	86.4%	77.6%	81.2%	
Avg. Length of Stay Statistics (Days)										
Medicare	49.38	44.38	47.07	63.78	57.38	60.01	78.95	74.04	88.68	
Medicaid	365.11	512.77	397.77	542.03	692.63	625.94	834.26	946.14	934.60	
Other	200.23	269.03	177.97	290.81	401.72	319.78	403.40	806.45	571.93	
Revenue (PPD)										
Inpatient	\$154.36	\$167.07	\$175.17	\$194.26	\$186.75	\$199.01	\$224.08	\$216.07	\$226.75	
Ancillary	\$18.53	\$20.62	\$22.12	\$31.18	\$29.27	\$31.73	\$40.13	\$45.52	\$50.56	
TOTAL	\$177.84	\$190.65	\$201.47	\$218.03	\$212.86	\$231.08	\$255.79	\$271.71	\$276.60	
Expenses (PPD)										
Employee Benefits	\$14.08	\$15.49	\$15.87	\$16.23	\$17.10	\$17.66	\$18.03	\$20.95	\$20.84	
Administrative and General	\$19.49	\$19.84	\$20.64	\$23.96	\$23.92	\$24.97	\$26.32	\$27.09	\$29.12	
Plant Operations	\$7.03	\$7.75	\$8.31	\$8.58	\$9.67	\$10.05	\$10.39	\$11.12	\$11.48	
Laundry & Linens	\$2.04	\$2.17	\$2.43	\$2.36	\$2.78	\$2.76	\$2.87	\$3.21	\$3.23	
Housekeeping	\$3.14	\$3.40	\$3.94	\$3.76	\$3.98	\$4.27	\$4.49	\$4.82	\$4.89	
Dietary	\$13.54	\$14.69	\$15.33	\$15.47	\$17.71	\$17.68	\$19.42	\$19.79	\$20.32	
Nursing & Medical Related	\$55.78	\$56.97	\$59.06	\$60.73	\$63.36	\$66.09	\$68.49	\$70.99	\$75.74	
Ancillary and Pharmacy	\$11.38	\$10.90	\$11.57	\$18.20	\$17.92	\$16.60	\$26.53	\$25.05	\$26.25	
Social Services	\$1.84	\$1.83	\$1.86	\$2.39	\$2.42	\$2.48	\$4.36	\$3.75	\$4.37	

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 (DHC) 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*	327
Licensed Nursing Beds*	37,122
Beds per 1,000 Aged 65 >**	36.98
Beds per 1,000 Aged 75 >**	92.47
Occupancy Percentage - 2013***	81.94%

*Source: Tennessee Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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. The Agency is the successor to the Health Facilities Commission (the Commission), which administered the CON process through 2002.

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. The 125-bed pool was extended through June 30, 2016. However, CON professionals have indicated that the bed pool will most likely be extended beyond June 30, 2016, given that it has been annually renewed since the 1990s.

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 determines 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:

$$\begin{aligned}\text{County Bed Need} = & .0005 \times \text{pop. 65 and under, plus} \\& .0120 \times \text{pop. 65-74, plus} \\& .0600 \times \text{pop. 75-84, plus} \\& .1500 \times \text{pop. 85, plus}\end{aligned}$$

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. In addition, nursing facilities with 50,000 or more Medicaid days still pay the old tax of \$2,225 per bed. 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, 2015, nursing facilities with 50 beds or less and nursing facilities within CCRCs are reimbursed \$6.76 per Medicaid day, nursing facilities with 50,000 or more Medicaid patient days are reimbursed \$6.08 per Medicaid day and all other nursing facilities are reimbursed \$11.92 per Medicaid day. 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

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 are calculated utilizing data derived from Medicare cost reports, which utilize a step-down cost reporting system. However, the state has indicated that it intends to convert to an acuity-based system. This system would also include supplemental payments for quality of care. Initially, this new system was supposed to be implemented effective July 1, 2015. However, the new system has yet to be finalized, and representatives of the state's Medicaid agency (TennCare) and the Tennessee Health Care Association (THCA) have indicated that the earliest any acuity-based system could be implemented would be July 1, 2016. It is anticipated that this system will be based on the RUG IV, 48 Grouper assessment system.

In order to transition to a new system, the state is currently utilizing a "bridge process" that provides 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. The methodology utilized to determine these payments will be detailed in the Rate Methodology section of this overview.

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

The Tennessee reimbursement system consists of one cost center that encompasses all reimbursable expenses allowed by the state. A reasonable allowance of compensation for services of owners and their relatives is allowable, provided the services are performed in a necessary function. Disallowable costs include bad debts, charity, Medicare - Part B charges and courtesy allowances.

INFLATION AND REBASING

Nursing facility rates are 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%.

The most recent nursing facility cost data is inflated from the midpoint of the provider's cost reporting period to the midpoint of the state's payment period. A trending factor is calculated for facilities that have submitted cost reports covering at least six months of program operations. For facilities that have submitted cost reports covering at least three full years of program participation, the trending factor is the average cost increase over the three-year period, limited to the 75th percentile trending factor

of facilities participating for at least three years. Negative averages will be considered zero. For facilities that have not completed three full years in the program, the one-year trending factor is the 50th percentile trending factor of facilities participating in the program for at least three years. For facilities that have failed to file timely cost reports, the trending factor will be zero.

Capital related costs are not subject to indexing. Nursing facilities are eligible for reimbursement attributable to a return on equity, which is limited to \$1.50 per resident day. However, nursing facilities must maintain an occupancy of 80.0% to be eligible to receive reimbursement attributable to a return on equity.

Each year an evaluation is made comparing the budget against projected expenditures. Rates are adjusted downward if the budget is projected to be exceeded. The downward adjustment can be made across the board, or rate increases can be delayed or eliminated to ensure the integrity of the budget.

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 recently rebased nursing facility rates for fiscal year 2016 (effective July 1, 2015) utilizing 2014 cost report data and the current rate calculation methodology. According to representatives of THCA, on average, this has resulted in an approximate \$6.00 to \$7.00 increase in nursing facility rates.

The below summary is a description of how nursing facility rates are calculated utilizing the current non-acuity adjusted, rate setting system.

RATE METHODOLOGY

Rates for nursing facilities in Tennessee are set at the lower of the facility's actual allowable inflated costs or the 65th percentile of all reported costs. The 65th percentile is calculated separately for Level I and II nursing facilities. Prior to being incorporated with

operating costs, capital costs are subject to a 75th percentile ceiling and compared to the overall 65th percentile ceiling.

When calculating a nursing facility's cost-based inflated per diem rate, allowable capital costs are adjusted downward if the facility has not maintained a minimum occupancy of 80.0%. A nursing facility's capital costs are reduced 5.0% for every 5.0% the nursing facility's occupancy is below the minimum occupancy. This maximum allowable downward adjustment is capped at 20.0% (60.0% occupancy).

An incentive payment is included in the reimbursable rate for providers who sufficiently contain costs as provided herein and maintain an average occupancy rate of 80.0% or greater. Certain expenses are fixed and not controllable on a day-to-day basis. These expenses include allowable rent, property taxes and insurance, depreciation and interest. Total and fixed costs are determined for each provider and converted to a per-patient-day basis. Variable costs are determined by subtracting the fixed costs from the total costs. Nursing homes with variable costs less than the maximum reimbursement rate (the 65th percentile) are eligible to receive a 50.0% cost containment incentive for every dollar below the maximum reimbursement rate, limited to \$3.00 per patient day and by the maximum reimbursement rate.

Nursing facilities also receive a per diem add-on payment for reimbursement of the state's bed tax. Effective July 1, 2015, nursing facilities with 50 or less beds and nursing facilities within CCRCs are reimbursed \$6.76 per Medicaid day, nursing facilities with 50,000 or more Medicaid patient days are reimbursed \$6.08 per Medicaid day and all other nursing facilities are reimbursed \$11.92 per Medicaid day. The nursing home assessment fee add-on is not subject to the 65th percentile limit.

In addition to the determined Medicaid rates, effective July 1, 2014, nursing facilities were eligible for quarterly supplemental acuity and quality payments that would "bridge" the process of converting to a new acuity-based reimbursement system.

Based on House Bill 1783, approximately 80% of the funding generated from the state's new quality assessment fee were utilized to provide quarterly acuity and quality supplemental "bridge" payments in fiscal year 2015. The remaining portion was utilized to fully fund calculated nursing facility rates. The supplemental payments include two acuity payments (Methods A & B) that will each be funded by 30% of the additional revenue generated by the new quality assessment fee. The quality-based supplemental payments was funded by 20% of the revenue generated from the new assessment fee.

The first step in "Method A" is to determine each facility's direct care cost per diem utilizing the most current cost report data available. This estimate is then case-mix neutralized by dividing the estimate by each facilities' average overall case mix index (CMI). In order to determine the average overall CMI for nursing facilities, the state will establish a CMI score for each facility (utilizing the RUG IV, 48 Grouper) for each quarter, with a CMI for all residents in the quarter and a CMI for Medicaid-only residents in the same quarter. The facility's CMI scores for the most recent four consecutive quarters will be averaged to establish their CMI

for the acuity payment calculation.

The above determined facility-specific case-mix neutralized direct care per diem costs will then be utilized to determine a statewide 90th percentile cap on case-mix neutral per diem direct care costs. The lesser of the facility's case-mix neutralized direct care per diem cost and the 90th percentile will then be multiplied by the facility's average Medicaid CMI. This estimate will then be multiplied by each facility's total Medicaid days to determine total capped Medicaid acuity-adjusted direct care costs for each facility and then divided by the total of all facilities' capped Medicaid acuity-adjusted direct care costs to determine each facility's percentage of total capped Medicaid acuity-adjusted direct care costs. This percentage is then multiplied by the total amount of funds distributed for payment under this methodology to determine each facility's supplemental payment.

"Method B" will determine each facility's supplemental payment by first calculating the facility's percentage of total Medicaid acuity-adjusted patient days across all facilities. The first step in this process is to determine each facility's weighted Medicaid days. This is accomplished by multiplying each facility's total Medicaid days by the facility's Medicaid CMI score (as determined in Method A). This estimate is then divided by all facilities' weighted Medicaid days to determine each facility's percentage of total Medicaid acuity-adjusted patient days. This percentage is then multiplied by the total amount of funds to be distributed for payment under this methodology to determine each facility's supplemental payment.

The supplemental payment for quality was initially based on methodology that the state plans to implement in the future (Value-Based Purchasing Model). The initial supplemental payments were designed to reward facilities for steps made to improve quality for the period 12 months prior to July 1, 2014. Subsequent quarters in the bridge year will offer opportunities and incentives to facilities to pursue new or additional quality improvements and will be based on quality improvement efforts or performance in the preceding quarter. For example, quality payments effective October 1, 2014, were based on quality measures for the period of July 1, 2014, to September 30, 2014. The goal of the bridge payments are to prepare facilities to be successful when the new reimbursement system is implemented.

The proposed Value-Based Purchasing Model that the state plans to implement is based on two categories: threshold measures and quality measures. The state is still determining threshold measures, and the bridge payments were only determined utilizing the quality measures. Reimbursement through this program is based on the percentage of total quality points a facility receives. The methodology currently utilizes four quality measures that, combined, can generate 100 quality points as follows:

- Satisfaction - 35 points (patient, family and staff);
- Culture Change/Quality of Life - 30 points (respectful treatment, resident choice, resident and family input);
- Staffing/Staff Competency - 25 points (RN and CNA hours per day, staff retention and consistent staff assignment); and
- Clinical Performance - 10 points (antipsychotic medication and urinary tract infection).

According to data provided by the Tennessee Health Care Association, on average the acuity and quality supplemental payments have resulted in nursing facilities receiving an approximate additional increase of \$8.00 and \$2.00 per Medicaid day, respectively.

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. Prior to the rate reduction, the initially calculated average Level I rate for fiscal year 2012 (\$154.15) was relatively unchanged from the prior fiscal year. However, based on the 2.5% rate reduction, the average rate is estimated to be approximately \$150.22.

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. Prior to the rate reduction, the initially calculated average Level II rate for fiscal year 2012 (\$160.64) was 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 effective \$10 per day increase of revenue generated from the acuity and quality supplemental payments.

Average rates for fiscal year 2016 were not available. However, representatives of THCA have indicated that on average, the rate rebase has resulted in an approximate \$6.00 to \$7.00 increase in nursing facility rates. In addition, nursing facilities on average are projected to receive the equivalent of a \$5.00 per Medicaid day increase in supplemental acuity/quality payments.

MINIMUM OCCUPANCY STANDARDS

Nursing homes in Tennessee must maintain a minimum occupancy of 80.0% to be eligible for the full reimbursement attributed to the Capital cost component, the incentive add-on and the reimbursement for the return on equity.

OTHER RATE PROVISIONS

Medicaid rates for newly constructed nursing facilities will be based on budgeted expenses and costs until actual cost report and capital cost data is available. Nursing facilities that have recently changed ownership will continue to receive the Medicaid rate attributed to the old ownership until updated cost report and capital cost data is available. However, property costs for nursing facilities that have changed ownership are limited by federal COBRA provisions. Under these provisions, the acquisition cost is limited to the seller's cost increased by the lesser of one-half of the percentage increase as contained in the Dodge Construction System Costs for Nursing Homes, or one-half of the increase in

the United States city average consumer price index for all urban consumers.

Tennessee also reimburses Level I nursing facilities for residents who are Medicaid eligible, but temporarily require hospitalization or therapeutic leave. The state reimburses nursing facilities for a maximum of 10 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 be occupied. Tennessee does not reimburse Level II nursing facilities for bed hold days.

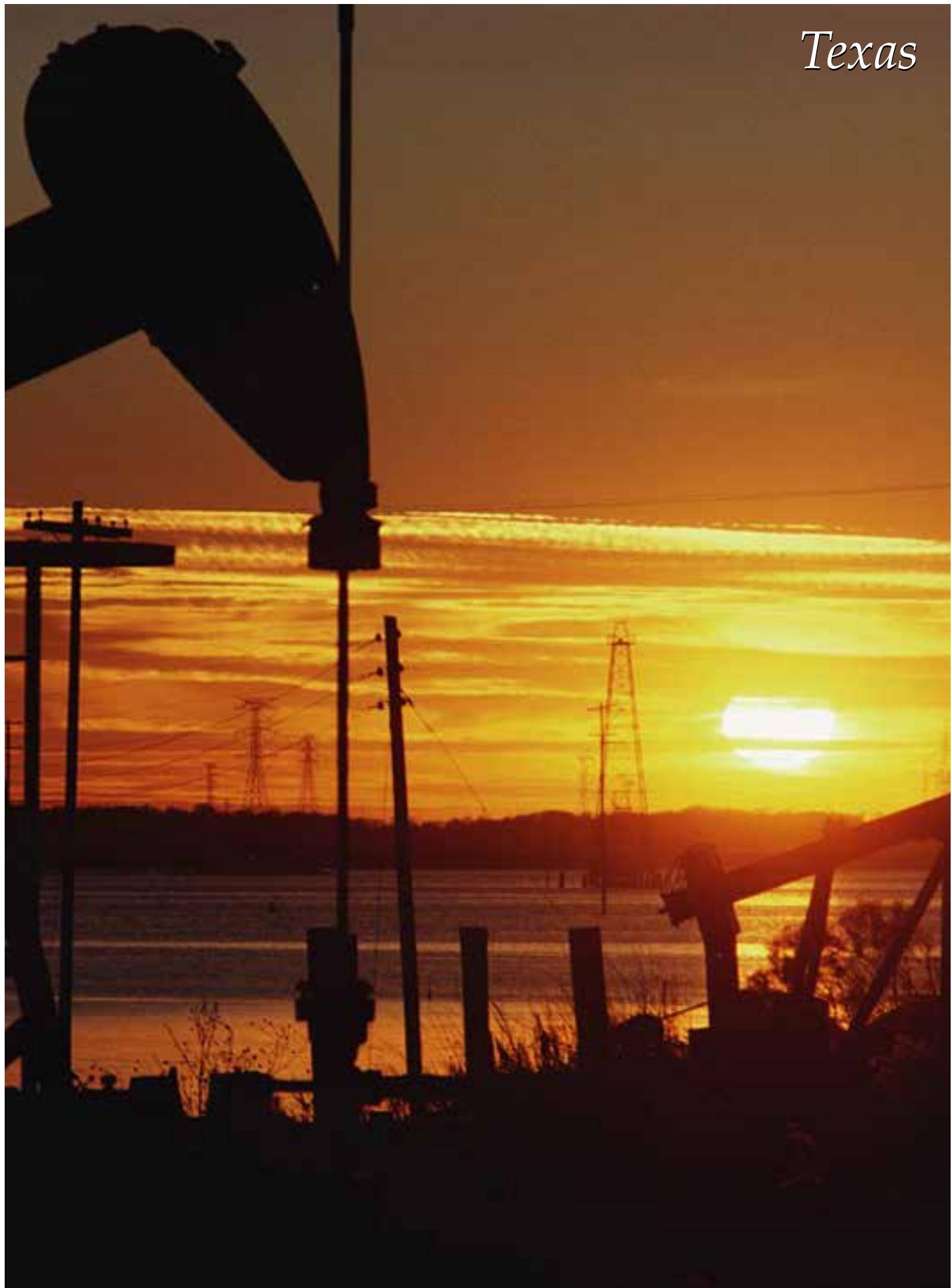
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As previously mentioned, the state is in the process of implementing a new acuity-based reimbursement system. This system was initially supposed to be implemented on July 1, 2015, but professionals from TennCare and THCA both indicated that the earliest the system could be implemented is July 1, 2016. This reflects that the details of the new system have not been finalized.

TENNESSEE COST REPORT STATISTICS											
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values				
	2011	2012	2013	2011	2012	2013	2011	2012	2013		
Number of Beds	62.50	64.00	68.00	100.00	100.00	101.00	125.50	127.00	127.00		
Average Daily Census	78.09	78.57	73.86	99.40	100.69	95.14	124.61	121.79	114.57		
Occupancy	82.6%	80.1%	75.9%	88.7%	87.9%	85.1%	93.5%	92.4%	90.9%		
Payor Mix Statistics											
Medicare	10.9%	11.0%	10.9%	14.8%	14.5%	14.0%	19.6%	18.8%	19.5%		
Medicaid	43.4%	36.2%	40.8%	64.1%	63.1%	62.9%	74.3%	72.8%	72.3%		
Other	13.5%	15.1%	16.0%	29.2%	29.3%	29.1%	76.4%	78.8%	80.6%		
Avg. Length of Stay Statistics (Days)											
Medicare	35.69	34.43	32.68	45.53	41.75	41.08	55.38	55.74	52.63		
Medicaid	176.00	116.82	200.08	353.70	348.32	354.46	619.88	611.50	565.17		
Other	66.33	77.85	66.97	129.51	142.65	122.78	306.98	311.64	330.83		
Revenue (PPD)											
Inpatient	\$167.86	\$171.40	\$175.51	\$177.94	\$182.80	\$190.16	\$195.72	\$201.18	\$210.65		
Ancillary	\$45.16	\$48.43	\$50.60	\$57.68	\$62.70	\$75.87	\$73.07	\$87.74	\$108.05		
TOTAL	\$219.21	\$227.41	\$222.15	\$240.00	\$251.41	\$259.19	\$265.85	\$284.72	\$308.12		
Expenses (PPD)											
Employee Benefits	\$12.19	\$12.32	\$13.17	\$17.84	\$18.57	\$19.00	\$26.90	\$22.97	\$23.45		
Administrative and General	\$32.12	\$31.52	\$32.74	\$38.78	\$39.09	\$40.27	\$43.78	\$44.56	\$47.94		
Plant Operations	\$8.75	\$8.82	\$8.80	\$10.05	\$10.37	\$9.96	\$11.45	\$12.32	\$11.69		
Laundry & Linens	\$2.18	\$2.22	\$2.28	\$2.65	\$2.73	\$2.79	\$3.21	\$3.27	\$3.32		
Housekeeping	\$4.31	\$4.39	\$4.54	\$5.09	\$5.05	\$5.11	\$5.91	\$5.95	\$5.96		
Dietary	\$13.56	\$13.55	\$14.05	\$15.09	\$15.12	\$15.63	\$16.90	\$17.12	\$17.75		
Nursing & Medical Related	\$59.25	\$60.20	\$62.06	\$66.67	\$66.55	\$69.18	\$77.17	\$76.40	\$79.31		
Ancillary and Pharmacy	\$23.26	\$23.29	\$23.21	\$28.54	\$29.18	\$29.95	\$36.15	\$37.42	\$41.16		
Social Services	\$1.57	\$1.53	\$1.61	\$2.55	\$2.54	\$2.70	\$4.23	\$4.22	\$4.43		

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*	1,231
Licensed Nursing Beds*	137,760
Beds per 1,000 Aged 65 >**	43.49
Beds per 1,000 Aged 75 >**	108.09
Occupancy Percentage - 2013***	70.20%

*Source: Texas Department of Aging and Disability Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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.

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. According to professionals from the Texas Healthcare Association, the implementation of the new

system has not resulted in any delays in payment.

Texas nursing facility Medicaid rates will remain frozen at current levels through the next 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.

Texas

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) 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 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 temporally 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.

As previously mentioned, 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.

According to representatives from both Texas Health Care Association and the Texas Medicaid Agency, the state was initially going to alter the system effective September 1, 2016. Alterations

to the program will 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). The methodology and standards for QIPP are still in the process of being developed. In addition, the implementation of QIPP will be delayed until March 1, 2017. This reflects that CMS has some concerns about the QIPP program that have not been resolved. Therefore, the implementation of the program has been delayed for six months.

Nursing facilities can still receive reimbursement under MPAP for these six months. However, no new providers will be allowed into the MPAP (UPL/IGT) during this interim period.

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	90.00	90.00	90.00	119.00	118.00	120.00	129.00	127.50	127.75	
Average Daily Census	64.43	64.84	64.48	88.29	87.31	87.13	107.71	107.87	106.55	
Occupancy	65.2%	65.0%	63.8%	76.0%	76.3%	74.9%	85.2%	85.3%	84.1%	
Payor Mix Statistics										
Medicare	8.9%	8.6%	8.7%	12.3%	11.7%	11.8%	16.5%	16.2%	16.2%	
Medicaid	56.1%	56.7%	56.2%	67.1%	66.4%	65.9%	75.6%	75.4%	76.1%	
Other	13.5%	13.7%	14.0%	21.1%	21.7%	21.9%	30.8%	30.8%	31.2%	
Avg. Length of Stay Statistics (Days)										
Medicare	35.74	37.53	38.53	50.32	49.44	49.45	67.57	67.62	69.19	
Medicaid	269.27	275.75	266.86	345.24	340.72	361.51	507.43	513.59	569.95	
Other	79.48	73.52	65.17	124.08	124.85	118.50	266.08	230.73	204.94	
Revenue (PPD)										
Inpatient	\$140.51	\$142.48	\$145.63	\$157.73	\$158.57	\$166.28	\$186.63	\$187.08	\$202.72	
Ancillary	\$30.53	\$32.96	\$33.24	\$50.05	\$53.09	\$51.83	\$85.91	\$93.28	\$90.36	
TOTAL	\$176.25	\$180.71	\$184.62	\$206.65	\$218.38	\$220.23	\$267.92	\$275.06	\$285.07	
Expenses (PPD)										
Employee Benefits	\$8.55	\$8.41	\$8.65	\$10.55	\$10.23	\$10.38	\$13.57	\$13.94	\$12.90	
Administrative and General	\$22.02	\$21.28	\$22.35	\$28.26	\$27.99	\$28.70	\$34.05	\$34.11	\$35.02	
Plant Operations	\$7.48	\$7.26	\$7.37	\$8.75	\$8.51	\$8.62	\$10.59	\$10.10	\$10.82	
Laundry & Linens	\$1.68	\$1.66	\$1.73	\$2.08	\$2.14	\$2.22	\$2.60	\$2.75	\$2.90	
Housekeeping	\$3.64	\$3.54	\$3.58	\$4.35	\$4.25	\$4.33	\$5.20	\$5.17	\$5.27	
Dietary	\$11.70	\$11.72	\$12.05	\$13.02	\$13.08	\$13.26	\$14.89	\$14.86	\$15.22	
Nursing & Medical Related	\$54.86	\$55.80	\$57.39	\$61.37	\$61.65	\$63.72	\$69.22	\$69.28	\$71.00	
Ancillary and Pharmacy	\$18.58	\$19.46	\$19.25	\$24.62	\$26.40	\$25.73	\$33.36	\$35.95	\$35.19	
Social Services	\$1.24	\$1.23	\$1.32	\$1.61	\$1.66	\$1.76	\$2.41	\$2.56	\$2.71	

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*	99
Licensed Nursing Beds*	8,410
Beds per 1,000 Aged 65 >**	28.03
Beds per 1,000 Aged 75 >**	68.03
Occupancy Percentage - 2013***	64.74%

*Source: Utah Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 to those applicants that can prove the following:

- The facility will be Medicaid certified under the provisions of the Medicaid moratorium;
- The facility will have at least 100 beds; or
- The facility's projected Medicare inpatient revenues do not exceed 49% of the facility's revenues, and the facility has identified projected non-Medicare inpatient revenue sources that will constitute at least 51% of the revenues.

The non-Medicaid nursing facility moratorium was scheduled to sunset on July 1, 2011. However, Senate Bill 86 extends the moratorium to July 1, 2016.

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, 2014, the fee is assessed at \$15.40 per non-Medicare patient day. The fee was previously assessed at \$14.57 per non-Medicare patient day effective July 1, 2013, \$14.50 per non-Medicare patient day effective July 1, 2012, and \$12.75 effective July 1, 2011. 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 2015.

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. Rate setting is completed by the Division of Health Care Financing (DHCF).

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. The Medicaid rate year in Utah is from July 1 to June 30. The state had planned to rebase rates effective July 1, 2008, but this rebase was not completed due to budgetary limitations.

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. Non-property portions of fiscal year 2009 rates were originally inflated 1.7% on July 1, 2008. However, given budget limitations, the state eliminated the inflation increase to the funding amount utilized to determine the base RUG rate component as well as increases to the behaviorally complex, specialized rehabilitation services, tracheostomy and ventilator dependent add-ons on October 1, 2008. Nursing facilities were reimbursed their fiscal year 2008 add-on rates for the remainder of fiscal year 2009 and the base RUG rate component was reduced from \$93.69 to \$91.34.

In fiscal year 2010, budget limitations prevented the state from inflating any of the non-property rate components. However, the increased funds generated from the increase in the NCFA enabled the state to restore the RUG base rate component to a level (\$93.98) that is similar to the July 1, 2008, rate (\$93.69). In addition, the state was able to restore the four previously mentioned add-ons to the July 1, 2008, levels. In fiscal year 2011, nursing facility Medicaid rates and provider add-ons remained relatively flat as the increase in the NCFA offset any potential rate reductions.

In fiscal years 2012 through 2015, the RUG rate component has also remained relatively flat. 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 frozen in fiscal year 2014, but was increased to \$57.83 in fiscal year 2015.

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 2015.

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 2015.

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 2015. 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; 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.

Utah

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, \$161.42 in fiscal year 2011, \$168.67 in fiscal year 2012 and \$168.92 in fiscal year 2013. 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.

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.

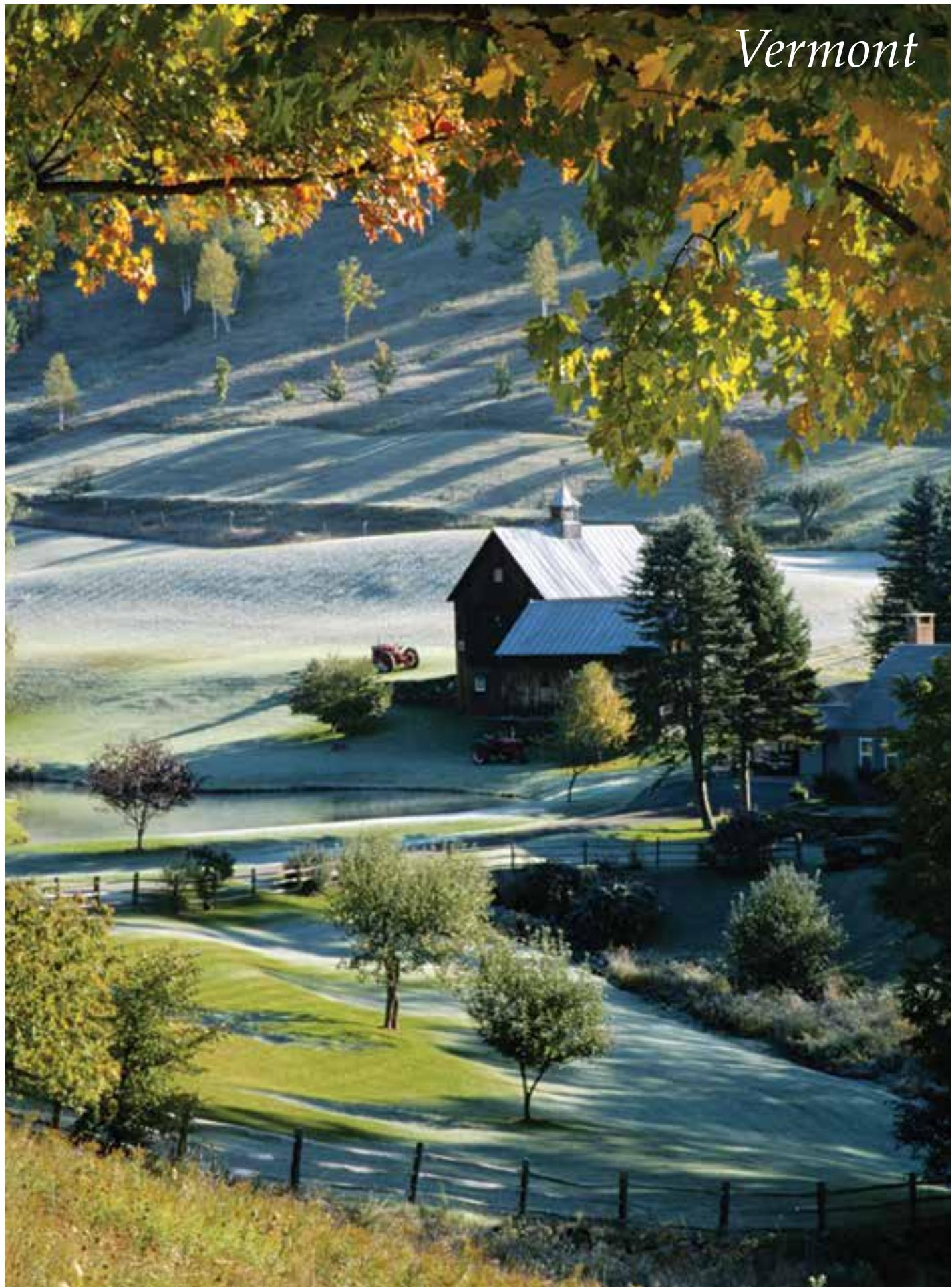
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	47.50	45.00	45.00	88.00	88.00	84.00	109.00	120.00	120.00	
Average Daily Census	36.75	36.47	33.81	60.13	57.98	58.36	76.69	80.02	76.54	
Occupancy	61.9%	60.5%	57.2%	71.4%	69.4%	71.6%	81.3%	80.1%	81.4%	
Payor Mix Statistics										
Medicare	8.1%	8.0%	7.9%	12.3%	14.6%	12.7%	21.5%	25.2%	21.6%	
Medicaid	53.7%	51.9%	47.1%	62.6%	60.1%	56.5%	68.9%	68.3%	67.0%	
Other	23.1%	20.8%	22.7%	29.3%	27.7%	28.8%	38.1%	34.8%	36.3%	
Avg. Length of Stay Statistics (Days)										
Medicare	30.19	28.11	26.21	39.59	33.16	32.86	60.22	39.99	41.62	
Medicaid	236.56	228.79	215.80	344.58	298.06	346.52	624.76	455.06	476.40	
Other	40.54	30.63	37.99	61.61	57.46	51.60	146.20	80.17	86.50	
Revenue (PPD)										
Inpatient	\$169.71	\$170.00	\$172.50	\$187.32	\$195.41	\$197.89	\$222.34	\$297.48	\$254.58	
Ancillary	\$42.41	\$37.97	\$38.41	\$66.09	\$83.59	\$72.70	\$111.11	\$124.07	\$137.14	
TOTAL	\$214.09	\$219.20	\$223.50	\$265.15	\$286.66	\$271.20	\$327.87	\$387.03	\$352.73	
Expenses (PPD)										
Employee Benefits	\$16.05	\$14.12	\$15.43	\$19.71	\$17.96	\$19.19	\$26.28	\$27.97	\$29.05	
Administrative and General	\$40.45	\$42.96	\$42.80	\$48.64	\$49.55	\$50.73	\$61.98	\$60.78	\$63.29	
Plant Operations	\$7.99	\$7.81	\$8.11	\$10.63	\$9.38	\$9.78	\$12.40	\$11.92	\$13.39	
Laundry & Linens	\$1.17	\$1.23	\$1.51	\$2.08	\$2.05	\$2.01	\$2.74	\$2.78	\$2.80	
Housekeeping	\$4.44	\$4.06	\$3.98	\$5.11	\$4.83	\$4.75	\$6.07	\$5.79	\$5.91	
Dietary	\$14.36	\$14.63	\$14.92	\$16.17	\$16.78	\$16.74	\$18.23	\$18.61	\$19.25	
Nursing & Medical Related	\$65.47	\$64.57	\$66.20	\$72.17	\$73.64	\$74.41	\$91.00	\$103.06	\$100.32	
Ancillary and Pharmacy	\$22.34	\$22.76	\$25.49	\$32.99	\$33.16	\$32.89	\$53.02	\$56.84	\$52.66	
Social Services	\$2.14	\$2.47	\$2.35	\$3.41	\$4.53	\$3.97	\$6.14	\$6.14	\$5.69	

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*	36
Licensed Nursing Beds*	3,115
Beds per 1,000 Aged 65 >**	29.31
Beds per 1,000 Aged 75 >**	71.01
Occupancy Percentage - 2013***	86.36%

*Source: Vermont Department of Disabilities, Aging & Independent Living

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 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 and contract nursing. 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).

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. A weighted average rate for fiscal year 2015 will not be available until the year is over, but the average rate per facility was \$216.52.

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											
	Lower Quartile Values			Median Values			Upper Quartile Values				
	2011	2012	2013	2011	2012	2013	2011	2012	2013		
General Statistics											
Number of Beds	44.00	45.50	45.00	71.00	76.50	73.00	115.00	123.50	124.00		
Average Daily Census	48.24	54.43	52.61	71.02	80.67	80.18	89.21	102.18	99.56		
Occupancy	84.2%	84.2%	83.8%	88.7%	89.6%	88.2%	93.0%	93.7%	92.4%		
Payor Mix Statistics											
Medicare	7.9%	7.9%	7.5%	14.5%	13.5%	13.8%	18.1%	17.5%	19.4%		
Medicaid	59.7%	60.3%	63.4%	70.4%	68.3%	70.4%	72.3%	74.4%	78.9%		
Other	14.8%	70.1%	69.1%	75.6%	85.0%	85.3%	90.0%	91.8%	92.4%		
Avg. Length of Stay Statistics (Days)											
Medicare	33.19	31.48	32.20	39.90	36.68	35.72	46.00	42.82	41.64		
Medicaid	305.31	302.76	295.96	382.73	361.97	350.32	432.62	673.10	393.99		
Other	111.67	165.30	145.65	170.59	221.97	239.86	301.09	299.12	326.24		
Revenue (PPD)											
Inpatient	\$227.35	\$238.94	\$247.41	\$244.86	\$264.50	\$271.16	\$292.66	\$303.00	\$310.68		
Ancillary	\$26.66	\$29.53	\$32.50	\$41.18	\$45.74	\$49.51	\$55.67	\$58.44	\$63.56		
TOTAL	\$264.79	\$277.71	\$294.71	\$296.49	\$314.70	\$318.85	\$350.62	\$357.20	\$375.53		
Expenses (PPD)											
Employee Benefits	\$18.52	\$20.81	\$21.82	\$26.88	\$29.03	\$28.45	\$30.90	\$34.87	\$35.05		
Administrative and General	\$39.60	\$38.13	\$40.37	\$44.06	\$47.07	\$47.30	\$53.26	\$51.02	\$56.78		
Plant Operations	\$11.00	\$10.59	\$11.02	\$12.26	\$13.15	\$13.00	\$14.46	\$15.18	\$14.53		
Laundry & Linens	\$2.35	\$2.19	\$2.36	\$3.03	\$2.78	\$2.89	\$3.72	\$3.76	\$3.63		
Housekeeping	\$4.21	\$4.31	\$4.33	\$5.41	\$5.31	\$5.49	\$6.59	\$6.99	\$6.76		
Dietary	\$16.15	\$16.30	\$16.55	\$17.88	\$19.11	\$18.60	\$22.65	\$22.63	\$21.83		
Nursing & Medical Related	\$81.72	\$81.26	\$78.84	\$88.88	\$89.27	\$89.93	\$99.13	\$99.93	\$102.89		
Ancillary and Pharmacy	\$16.00	\$16.68	\$17.21	\$27.79	\$25.34	\$24.73	\$34.69	\$33.75	\$36.19		
Social Services	\$2.03	\$2.71	\$2.22	\$3.33	\$3.77	\$3.95	\$6.40	\$6.43	\$6.62		

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*	282
Licensed Nursing Beds*	33,598
Beds per 1,000 Aged 65 >**	28.69
Beds per 1,000 Aged 75 >**	71.69
Occupancy Percentage - 2013***	88.17%

*Source: Virginia Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 in excess of \$18,136,958, increased annually by an appropriate inflation index. (CPI from the Medical Care Expenditure Category from the Bureau of Labor Statistics). This threshold was established for 2015 and has not yet been updated for 2016.
- 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 will be phased in over a four-year period. 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.

Effective July 1, 2011, Virginia completed a 10-year transition from a cost based system to a fair rental value system (FRV) for the purpose of calculating Capital cost component rates. Previously, nursing facilities enrolled in the Medicaid program prior to July 1, 2000, were paid for capital related costs under a transition policy that ran through June 30, 2011. However, newly constructed facilities and new and replacement beds of previously enrolled facilities completed after July 1, 2000, have been paid under the capital payment methodology based on the FRV system. Effective July 1, 2011, all nursing facilities in the state are reimbursed for capital costs through the FRV system.

The state will continue to utilize the FRV to determine capital rates. In addition, during the phase-in of the new system, the state's operating portion of nursing facility rates (Direct Patient Care and Indirect Patient Care) that the state will reimburse nursing facilities will be calculated as a weighted average rate determined based on percentages of the old and new system, as follows:

- Rates effective July 1, 2014, equated to 75% of the old cost-based system rates and 25% of the new price-based system rates;
- Rates effective July 1, 2015, equate to 50% of the old cost-based system rates and 50% of the new price-based system rates;
- Rates effective July 1, 2016, will equate to 25% of the old cost-based system rates and 75% of the new price-based system rates; and
- Rates effective July 1, 2017, will equate to 100% of new price-based system rates.

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.

The state is next scheduled to rebase rates on July 1, 2017, and the state will rebase rates every three years thereafter using the most

recent calendar year settled cost reports. 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.

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.

RATE METHODOLOGY

Under both the old and new system, 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 following is a summary of how rates were calculated under the old cost-based system.

Cost-Based System

For the purpose of determining cost ceilings for the Direct and Indirect costs, nursing facilities were categorized into peer groups based on geographic location and bed size. Peer groups for the Direct Patient Care cost center were established for the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg MSA, and the rest of the state. Peer groups for the Indirect Patient Care cost center were established for the Virginia portion of the Washington DC-MD-VA MSA, as well as for the rest of the state for facilities with fewer than 61 or more than 60 licensed beds.

Nursing facilities were reimbursed for Direct Patient Care expenses under the Resource Utilization Group III (RUG III) System. To reflect the services required by a nursing facility's resident mix, case weights were assigned to one of the 34 RUG III groups and were used to adjust the nursing facility's per diem rates. Using the individual Medicaid resident RUG score, a facility's average Medicaid CMI was calculated four times per year.

A nursing facility's Direct Patient Care per diem cost was determined annually by dividing total inflated allowable Medicaid costs by total Medicaid patient days. As previously stated, in rebasing years, the facility-specific per diem costs from three years prior trended to the rate year were utilized to determine the Direct Patient Care cost center ceiling. In non-rebasing years, the nursing facility's per diem costs were compared to this same ceiling trended forward one year.

Prior to determining the Direct Patient Care cost center ceiling, nursing facility costs were first case mix normalized. The first step was to case mix normalize the facility's average Medicaid CMI. This was accomplished by dividing the nursing facility's average Medicaid CMI by the statewide average Medicaid CMI.

The next step in determining this cost center ceiling was to multiply the product of the previous calculation by the nursing

facility's Direct Patient Care per diem cost. The facility-specific case mix normalized per diem costs were arrayed by geographic region and a day-weighted median was determined. The Direct Patient Care cost center ceiling, effective for services on and after July 1, 2008, was set at 117% of the respective peer group day-weighted median of the facilities' case mix normalized Direct Care costs per day.

A nursing facility's Direct Patient Care rate was the lesser of the nursing facility's prospective, case mix normalized Direct Patient Care per diem cost or the prospective Direct Patient Care cost ceiling. Additionally, the lower amount was adjusted for the nursing facility's average Medicaid CMI to correspond as closely as possible to the prospective period. Prior to November 1, 2014, Direct Patient Care rates were adjusted semiannually for case mix.

Facility-specific Indirect Patient Care costs per diem were utilized to establish Indirect Patient Care cost ceilings. A nursing facility's Indirect Patient Care per diem cost was determined by dividing inflated allowable Medicaid indirect costs by the total Medicaid days (adjusted by a minimum occupancy requirement, if necessary). In rebasing years, once the facility-specific per diem costs were determined, these costs were arrayed by geographic region and a day-weighted median was determined.

The Indirect Patient Care cost ceiling was set at 107% of the respective peer group day-weighted median. The Indirect Patient Care per diem rate was the lesser of the nursing facility's prospective Indirect Patient Care per diem cost or the prospective Indirect Patient Care cost ceiling. In non-rebasing years, the facility-specific Indirect Patient Care per diem cost was compared to this same ceiling trended forward one year. In prior years, an incentive plan was in effect for nursing facilities with Indirect Patient Care per diem costs that were below the ceilings. The nursing facility was paid, on a sliding scale, up to 25% of the difference between its allowable Indirect Patient Care cost and the Indirect Patient Care ceiling. However, with the phase-in to the new system, the Indirect Incentive was eliminated.

Virginia completed the transition to a new capital payment methodology effective July 1, 2011. Capital component rates for all nursing facilities in the state are calculated utilizing the FRV system.

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%.

The NATCEP interim reimbursement rate was determined by dividing allowable un-inflated costs by total patient days. Reimbursement of nursing facility costs for training and competency evaluation of nurse aides must take into account the nursing facility's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid is not charged for that portion of NATCEP costs, which is properly charged to Medicare or private pay services. As previously mentioned, the NATCEP reimbursement rate was not adjusted for inflation.

Minimum Occupancy Standards

For the purpose of computing the allowable Indirect Patient Care per diem cost, the greater of the actual number of Medicaid patient days in the cost reporting period, or 88% of the facility's maximum annual patient days (adjusted by the Medicaid Utilization Rate) was used in the calculation. The Medicaid Utilization Rate was determined from the most recent cost report.

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, was used in the calculation.

Prior to July 1, 2013, the minimum occupancy percentage for both cost components was 90.0%. The Virginia Department of Medical Assistance Services estimate resulted in a 0.17% increase in reimbursement.

Price-Based System

The price-based system contains the same cost components as the 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 will also be 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.

The new system will continue to adjust the Direct Patient Care and Indirect Patient Care sub-components for regional cost differences. New 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 projected to be 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 105% of the Medicaid day-weighted median for freestanding nursing facilities and the Indirect Patient Care median is calculated to equate to 100.7% 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. As of the date of this overview, this transition has not occurred.

For rates effective July 1, 2014, the case-mix adjustment reflects the facility-average case mix for the two most recent quarters. 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-III, version 34) 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.

Under the new system, the state will continue to reimburse nursing facilities for their capital costs utilizing the previously described 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%). 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.

The new system also includes the development of spending floors. All nursing facilities will receive the full price if their costs (inflated fiscal year 2015) 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.

The CRC add-on is determined by dividing associated costs for criminal record checks by total patient days. This rate component was last determined on July 1, 2014, utilizing uninflated 2011 cost report data.

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.

Prior to July 1, 2013, the minimum occupancy percentage for both cost components was 90.0%. The Virginia Department of Medical Assistance Services estimate resulted in a 0.17% increase in reimbursement.

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 previously mentioned, the state is considering converting to a RUG IV, 48-RUG Grouper. The state has established a nursing facility workgroup that is considering the impact of the implementation of the RUG IV, 48-Grouper. The RUG IV system is a more refined grouper with updated weights, but the state did not start collecting RUG IV, 48-Grouper information until June 2013. The state has indicated that it will need more complete RUGs IV, 48-Grouper data before it can determine either the normalization to the RUG III, 34-Grouper weights or the potential impact to nursing facilities.

Virginia

VIRGINIA COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	60.00	60.00	60.00	112.00	111.00	114.00	133.00	131.00	130.50	
Average Daily Census	81.78	81.42	82.43	109.85	110.22	108.65	144.36	144.06	147.40	
Occupancy	85.6%	85.7%	85.2%	90.6%	90.9%	90.7%	93.9%	93.8%	93.9%	
Payor Mix Statistics										
Medicare	10.6%	10.7%	10.7%	15.2%	15.4%	14.9%	22.5%	23.0%	22.5%	
Medicaid	49.2%	47.6%	46.0%	62.0%	63.0%	62.4%	73.5%	73.2%	73.3%	
Other	13.5%	13.0%	13.0%	18.9%	19.9%	19.4%	39.0%	48.3%	49.4%	
Avg. Length of Stay Statistics (Days)										
Medicare	32.07	29.39	29.97	36.65	36.79	36.43	45.18	49.50	46.44	
Medicaid	221.54	235.61	244.03	322.08	324.85	324.48	452.56	459.82	471.05	
Other	62.85	57.79	58.33	124.16	105.93	111.45	254.81	203.38	248.56	
Revenue (PPD)										
Inpatient	\$178.75	\$182.17	\$188.33	\$204.52	\$209.24	\$218.92	\$240.57	\$250.61	\$259.68	
Ancillary	\$44.89	\$48.87	\$52.66	\$66.05	\$75.03	\$76.06	\$95.59	\$110.94	\$110.91	
TOTAL	\$233.21	\$244.78	\$256.71	\$276.46	\$299.20	\$303.25	\$339.52	\$367.40	\$390.23	
Expenses (PPD)										
Employee Benefits	\$13.76	\$12.02	\$11.87	\$16.94	\$17.58	\$18.06	\$22.87	\$23.11	\$23.47	
Administrative and General	\$25.40	\$25.93	\$26.60	\$30.63	\$31.10	\$31.99	\$37.10	\$36.51	\$37.70	
Plant Operations	\$8.08	\$8.07	\$8.21	\$9.69	\$9.52	\$9.88	\$11.74	\$11.63	\$11.84	
Laundry & Linens	\$1.44	\$1.54	\$1.61	\$2.05	\$2.13	\$2.10	\$2.77	\$2.88	\$2.91	
Housekeeping	\$4.58	\$4.64	\$4.61	\$5.43	\$5.44	\$5.41	\$6.42	\$6.38	\$6.31	
Dietary	\$13.65	\$14.01	\$14.31	\$15.22	\$15.37	\$15.78	\$17.40	\$17.91	\$18.46	
Nursing & Medical Related	\$66.34	\$65.46	\$64.53	\$74.33	\$73.87	\$75.08	\$82.89	\$84.00	\$86.72	
Ancillary and Pharmacy	\$22.21	\$25.40	\$25.07	\$30.18	\$34.29	\$33.07	\$41.92	\$45.24	\$44.48	
Social Services	\$1.42	\$1.44	\$1.45	\$2.06	\$2.06	\$2.19	\$3.48	\$3.67	\$4.02	

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*	229
Licensed Nursing Beds*	22,281
Beds per 1,000 Aged 65 >**	22.10
Beds per 1,000 Aged 75 >**	55.22
Occupancy Percentage - 2013***	79.90%

*Source: Washington Department of Social & Health Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 \$2,403,990 (effective January 1, 2012) for the construction, renovation or alteration of a nursing home.
- Nursing home bed banking transactions.

The state typically updates the capital expenditure threshold every January, but as of the date of this overview this has not occurred in 2013. However, representatives of the Health Professionals and Facilities Division have indicated that this estimate will eventually get updated in 2013.

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 January 10, 2013, 1,085 beds were banked (56 alternate use beds and 1,029 full facility closure beds).

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 January 10, 2013, based on the projected 70-plus population and current number of licensed beds (including banked beds), there will be a statewide shortage of 3,373 beds in 2014, 4,056 beds in 2015 and 5,319 in 2016. However, it should be noted that the state recently 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. 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.

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

Washington

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 February 1, 2013) for nursing facilities with 32,000 or fewer Medicaid patient days and 203 or fewer licensed beds is \$14.00. The prior fee, effective July 1, 2012, was \$13.00 per non-Medicare day. This fee will be reduced to from the previous fee of \$15.60 per non-Medicare day effective March 1, 2012. 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

Washington uses a prospective, cost-based, case mix, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The payment system is administered by the Nursing Home Rates Section of the Office of Rates Management (ORM) within DSHS. Effective July 1, 2011, the state significantly altered its rate setting system. This included eliminating the Variable Return cost component.

COST CENTERS

Each nursing facility receives one rate that is comprised of the following seven components:

- The Direct Care component includes costs related to nursing care, including direct care supplies.
- The Therapy Care component includes physical, speech, occupational and other therapies.
- The Support Services component includes the cost of laundry, dietary, housekeeping and raw food.
- The Operations Care component includes administrative, oversight, management, plant operations and other operating costs.
- The Property component is a depreciation allowance for real property improvements, equipment and personal property used for resident care.
- The Financing Allowance component is a return on a facility's net invested funds. Net invested funds are defined as the net book value of tangible fixed assets utilized by a nursing facility operator to provide services under the medical care program, including land, buildings and equipment as recognized and measured in conformity with generally accepted accounting principles.

INFLATION AND REBASING

The non-capital rate components will be rebased biennially. 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. The Financing and Property cost components are rebased annually. Non-capital cost components will be adjusted annually for economic trends (inflation) by a factor or factors defined in the Biennial Appropriations Act.

Non-capital rate components for fiscal years 2008 and 2009 were based on calendar year 2005 cost report data, subject to any adjustment addressed separately by the final 2007-2009 Biennial Appropriations Act. These adjustments included a 3.2% vendor rate increase (for non-capital rate components) effective July 1, 2007, and an additional adjustment effective July 1, 2008. The 2007 legislative budget included an appropriation of \$29.5 million for nursing homes. Of that amount, \$8.7 million of the general state fund was held for the second year of the biennium. These funds were used to update caseload and resident acuity and to provide a 1.99% inflationary increase for all other cost centers.

Fiscal year 2010 and 2011 non-capital rates were based on calendar year 2007 cost data. However, no vendor rate increase has been applied to rates in either period. Fiscal year 2012 rates were also based on calendar year 2007 cost data and did not receive any inflation adjustment. Non-capital rates for fiscal year 2013 (effective July 1, 2012) were frozen at fiscal year 2012 levels, with the exception of acuity adjustments.

Prior to Senate Bill 5581, non-capital rate components were scheduled to be rebased in even numbered years. However, the bill changed the rebasing cycle to every odd numbered year using adjusted cost report data for two years prior to the rebasing period. Given this factor, non-capital components are scheduled to be rebased on July 1, 2013, using 2011 cost report data. However, both the Washington state house (HB 2042) and senate (SB 5874) are considering legislation that would freeze nursing home rates through June 30, 2015. Both bills would also extend the Hold Harmless add-on and Client Acuity add-ons to the same date. Both add-ons are currently scheduled to expire on June 30, 2013.

The state house has approved HB 2042; however, SB 5874 is still under consideration. It is currently unclear either piece of legislation will be implemented.

RATE METHODOLOGY

The Direct Care Component comprises the majority of the total facility rate. Since legislation was established in October 1998 (beginning fiscal year 1999), this component has been calculated using a case mix system. As of July 1, 2010, this component is adjusted semiannually as the case mix is updated to reflect changes in residents' care needs. Prior to this date, the state adjusted for case mix on a quarterly basis. The Resource Utilization Groups, version III (RUG III) 44-RUG Grouper patient classification system is used to classify residents into case mix groups. The ORM determines both a facility average case mix index (for all residents) and a Medicaid average case mix (for Medicaid residents only). The case mix index (CMI) indicates the intensity of need for services for each facility's residents. The state has indicated that it will transition to the RUG IV, 57-RUG Grouper system and the MDS 3.0 assessment tool effective July 1, 2013.

To allow for the transition to RUG IV and MDS 3.0, from July 1, 2011, through June 30, 2013, the Medicaid average CMI effective January 1, 2011, will be utilized. This CMI will be increased 0.5% every six months. Rates effective July 1, 2013, will utilize 2011 case mix data derived from the RUG IV system. In a non-transitional rate year, the Medicaid case mix index used to adjust the Direct Care component will be taken from the calendar six-month period beginning nine months prior to the effective date of the semiannual rate. The facility average CMI used to establish each nursing facility's Direct Care component rate will be based on an average of calendar quarters of the facility's average CMIs from the four calendar quarters occurring during the cost report period used to rebase the Direct Care rate component.

It should be noted that SB 5874 is also proposing to postpone the conversion to RUG IV and to freeze future case mix adjustments at January 1, 2013, levels.

The ORM is required to array Direct Care costs per case mix unit separately for three peer groups of nursing facilities depending on location. These locations are high labor cost counties (currently only King County), urban counties (counties within MSAs) and non-urban counties (those not in an MSA).

Relative to the Direct Care component, facilities are paid the lower of their costs per case mix unit or the ceiling, which is 110.0% of the facility's peer group median cost per case mix unit (an increase from 112.0% in 2006). Prior to 2006, facilities were also subject to a 90.0% floor. A facility's allowable cost per case mix unit is then multiplied by its Medicaid average case mix index to derive the rate.

In determining the Therapy Care, Support Services and Operations components, facilities are divided into urban and non-urban county peer groups. Facilities receive their allowable costs per unit of therapy use up to a ceiling of 110.0% of the median cost per unit of therapy. For the Support Services component, facilities receive their allowable costs up to a ceiling of 108.0% of the median (a decrease from 110.0% in fiscal year 2011). For the Operations component, facilities receive their allowable costs up to a ceiling at the median.

The Property component for each facility is determined by dividing reported allowable prior period actual depreciation (adjusted for any capitalized additions or replacements) by the greater of the facility's total resident days for the facility in the prior period or resident days calculated utilizing the minimum occupancy requirement (occupancy minimums are discussed in detail below).

Reimbursement for the Financing Allowance component is calculated by multiplying an interest rate by the value of a facility's net invested funds (see the Cost Centers section). Effective July 1, 2011, the state will utilize a uniform interest rate of 4.0% for all facilities. Prior to this change, the applicable interest rate is 10.0% for construction proposed before May 17, 1999, and 8.5% for construction proposed since that date. This amount is divided by the greater of the facility's total resident days in the prior period or resident days calculated utilizing the minimum occupancy requirement.

Additionally, effective July 1, 2008, nursing facilities were eligible to receive a low wage worker rate add-on. The add-on was calculated by dividing total funding (\$6.2 million for fiscal years 2009 and 2010) available for the add-on by the total number of Medicaid days forecasted for each fiscal year, not to exceed \$1.57 per day. The purpose of the add-on was to increase the wages and benefits of nursing and dietary aides, housekeepers, laundry aides and any other category of worker whose average wage was less than \$15.00 per hour in calendar year 2008. The wage earner add-on is subject to the settlement process, with reporting standards to be developed by the ORM. Effective July 1, 2010, the add-on was set at \$1.57 per day for those facilities electing to accept it.

In fiscal year 2011, the state established a pay-for-performance supplemental payment structure. Nursing facilities that have a greater than 75% Direct Care turnover rate will receive a 1% rate reduction. Facilities with a direct care turnover rate of 75% or less received a \$0.24 per day add-on from July 1, 2011, to December 31, 2011. No add-ons were paid out from January 1, 2012, to June 30, 2012. This add-on was reduced to \$0.08 per day from July 1, 2012, to January 1, 2013, and reduced further to \$0.04 per day effective February 1, 2013.

For fiscal years 2012 and 2013, subject to state appropriations, the state will hold nursing facilities' base rates (total rate excluding the safety net add-on and the client acuity add-on) harmless to base rates effective June 30, 2010. If a nursing facility's base rate on July 1, 2011, or July 1, 2012, is less than the facility's base rate effective June 30, 2010, the difference will be reimbursed to the facility as a rate add-on. This add-on is scheduled to terminate on July 1, 2013. However, both House Bill 2042 and Senate Bill 5874 propose to extend this add-on until June 30, 2015.

In addition, if during the comparative analysis it is determined that any facility's Direct Care rate is greater than its direct care rate in effect on June 30, 2010, the facility will receive a Client Acuity rate add-on that equates to 10% of its current Direct Care rate to compensate the facility for accepting higher acuity patients. Effective May 1, 2013, approximately 90.7% of all nursing facilities receive the Client Acuity add-on the average Client Acuity add-on was \$9.63. This add-on is scheduled to terminate on July 1, 2013. However, both House Bill 2042 and Senate Bill 5874 propose to extend this add-on until June 30, 2015.

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.

For fiscal year 2010, beginning July 1, 2009, the state legislature set the budget dial at \$156.37. Rates set and issued by DSHS were to include a 7.29% percentage reduction factor in order to comply with the maximum allowable weighted average rate. On July 14, 2009, revised rates for fiscal year 2010 were calculated and sent

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to nursing facilities, excluding the percentage reduction factor, as the result of a restraining order issued by the U.S. District Court for the Western District of Washington at Tacoma. The restraining order, which essentially enjoined the DSHS from applying the budget dial provision to fiscal year 2010 rates, stemmed from the case known as Washington Health Care Association, et al. v. Dreyfus. The state eventually eliminated the budget dial adjustment for fiscal year 2010 and the association dismissed the lawsuit.

The state established rates effective July 1, 2010, utilizing the above described methodology. This resulted in a weighted average rate of \$168.20, which was greater than the weighted average rate of \$166.24 determined by the supplemental operating budget. Therefore, effective December 1, 2010, a 1.8621426% budget dial reduction was applied to all nursing facility rates. This budget dial reduction was also applied to rates effective January 1, 2011, which were adjusted for case mix.

However, the governor approved a supplemental budget that reduces the state's overall budget by \$242 million. This resulted in an approximate \$28 million reduction in DSHS funding, which in turn resulted in a recalculation of the budgeted weighted average rate to \$161.24 effective April 1, 2011. This initially equated to a budget dial adjustment of approximately 2.7% for rates effective April 1, 2011, to June 30, 2011. However, the state decided to retroactively apply this budget dial adjustment to rates effective as of the beginning of the state fiscal year (July 1, 2010). To reflect this adjustment, rates from April 1, 2011, to June 30, 2011, were to be reduced 12.238%.

On April 12, 2011, a Washington District Court issued a temporary restraining order on the implementation of the new rates. Effective May 11, 2011, the judge granted a permanent injunction against the implementation of the new rates, and nursing facilities were reimbursed their rates effective March 31, 2011. The state reimbursed facilities these rates for the remainder of the fiscal year and did not apply the budget dial adjustment. The state also recalculated rates effective July 1, 2011. These factors effectively ended the lawsuit against the state. The state did not impose a budget dial adjustment during fiscal year 2012, and it has not been applied in fiscal year 2013.

The statewide non-weighted average rate (\$184.77) effective February 1, 2013, decreased slightly from the rate effective March 1, 2012 (\$185.14). The statewide weighted average rate effective February 1, 2013, is \$184.93.

MINIMUM OCCUPANCY STANDARDS

In order to set all component rates, the number of total resident days is used. All allowable costs are divided by total resident days to express facility costs on a per-resident-day basis. Total resident days utilized in the Medicaid rate calculation are subject to a minimum occupancy level. Effective July 1, 2011, the state increased the minimum occupancy requirement for the Operations, Property, and Financing cost components to 87% (from 85% in fiscal year 2011) for nursing facilities that are essential community providers, to 92% (from 90% in fiscal year 2011) for small non-essential (60 or fewer beds) community

providers and to 95% (from 92% in fiscal year 2011) for large non-essential (greater than 60 beds) community providers. The minimum occupancy requirement for the Therapy and Support cost components is 85% regardless of facility type. There is no minimum occupancy requirement for the Direct Care component.

Prior to July 1, 2010, for facilities other than essential community providers that have banked beds since May 25, 2001, Medicaid rates are revised upward in the non-capital rate components according to the facility's decreased licensed bed capacity. Effective July 1, 2010, for purposes of determining the minimum occupancy used to determine Medicaid rates, licensed beds will include banked beds.

With each annual nursing facility cost report, contractors are required to submit a proposed settlement report showing underspending or overspending in each component rate during the cost report year on a per-resident-day basis. Contractors are not required to refund payments made in the Operations, Variable Return, Property and Financing Allowance component rates in excess of the adjusted costs of providing services corresponding to these components. The facility will return to the department any overpayment amounts in each of the Direct Care, Therapy Care and Support Services rate components that are identified following the audit and settlement procedures described in this section, provided that the contractor retains any overpayment that does not exceed 1.0% of the facility's Direct Care, Therapy Care and Support Services component rate.

The ORM will establish an initial prospective Medicaid payment for a new contractor within the 60 days following the new contractor's application and approval for a license to operate the facility. A new contractor is defined as one who receives a new vendor number and:

- Builds from the ground up a new facility operated with completely new staff, administration and residents; or
- Currently operates, acquires or assumes responsibility for operating an existing nursing facility.

Except for quarterly case mix updates, the rate established for a new contractor will remain in effect until the rate can be reset effective July 1 using the first cost report under the new contractor's operation that contains at least six months' data from the prior calendar year.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of the previously mentioned House Bill 2042 and Senate Bill 5874, there are no significant changes proposed to the state's reimbursement methodology.

WASHINGTON COST REPORT STATISTICS											
	Lower Quartile Values			Median Values			Upper Quartile Values				
	2011	2012	2013	2011	2012	2013	2011	2012	2013		
General Statistics											
Number of Beds	70.00	67.00	70.00	96.50	96.00	96.00	120.00	120.00	120.00		
Average Daily Census	60.80	59.42	56.66	83.10	81.29	80.05	102.75	100.32	100.25		
Occupancy	73.7%	73.2%	72.2%	84.6%	84.6%	83.8%	90.9%	91.6%	90.3%		
Payor Mix Statistics											
Medicare	10.0%	9.5%	9.2%	15.7%	15.6%	16.4%	24.7%	24.3%	25.2%		
Medicaid	49.6%	48.9%	48.3%	62.4%	61.5%	59.1%	69.9%	70.8%	71.2%		
Other	14.9%	16.0%	15.1%	22.1%	22.2%	21.3%	33.5%	34.4%	34.4%		
Avg. Length of Stay Statistics (Days)											
Medicare	30.82	28.12	28.48	36.25	34.72	34.98	43.87	40.39	41.97		
Medicaid	183.84	198.04	217.84	283.33	278.02	282.00	405.88	408.90	402.44		
Other	40.87	42.98	38.19	65.03	61.85	61.50	109.43	101.27	103.21		
Revenue (PPD)											
Inpatient	\$209.48	\$223.67	\$227.32	\$244.44	\$251.35	\$258.76	\$285.05	\$284.73	\$296.90		
Ancillary	\$48.93	\$49.86	\$47.01	\$75.36	\$82.72	\$82.19	\$96.55	\$107.78	\$118.75		
TOTAL	\$272.23	\$283.04	\$289.38	\$316.07	\$333.70	\$349.58	\$377.86	\$395.46	\$413.43		
Expenses (PPD)											
Employee Benefits	\$19.86	\$19.84	\$19.61	\$24.96	\$24.18	\$24.06	\$34.12	\$30.55	\$30.75		
Administrative and General	\$33.86	\$38.79	\$41.90	\$42.74	\$48.71	\$51.36	\$52.10	\$57.53	\$60.89		
Plant Operations	\$8.26	\$8.29	\$8.47	\$9.74	\$10.01	\$10.37	\$12.26	\$12.21	\$12.39		
Laundry & Linens	\$2.42	\$2.40	\$2.38	\$2.98	\$3.09	\$3.08	\$3.77	\$3.88	\$3.92		
Housekeeping	\$4.78	\$4.80	\$4.92	\$5.38	\$5.69	\$5.86	\$6.58	\$7.25	\$7.70		
Dietary	\$14.71	\$14.75	\$15.07	\$16.19	\$16.93	\$17.35	\$18.11	\$19.11	\$20.13		
Nursing & Medical Related	\$79.18	\$80.93	\$82.13	\$89.89	\$92.97	\$96.06	\$107.38	\$110.94	\$116.61		
Ancillary and Pharmacy	\$26.01	\$26.31	\$27.11	\$38.28	\$40.19	\$41.33	\$51.35	\$54.13	\$53.25		
Social Services	\$2.81	\$3.32	\$3.50	\$4.63	\$4.83	\$4.87	\$6.46	\$7.02	\$6.92		

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*	129
Licensed Nursing Beds*	10,550
Beds per 1,000 Aged 65 >**	31.67
Beds per 1,000 Aged 75 >**	75.84
Occupancy Percentage - 2013***	89.72%

*Source: State of West Virginia Department of Health and Human Resources

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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. Other criteria in the review process include quality, accessibility and continuum of care.

In West Virginia, all healthcare providers, unless otherwise exempt, must obtain a (CON) before:

- The construction, development, acquisition of or other establishment of a new healthcare facility or health organization.
- Adding or expanding healthcare services, including ventilator services.
- Exceeding the capital expenditure threshold of \$3,112,828 effective January 1, 2015.
- Obtaining major medical equipment valued at \$3,112,828 or more effective January 1, 2015.
- A substantial change to the bed capacity of a healthcare facility or its services with which a capital expenditure is associated.
- The acquisition of a nursing facility.

The state will be increasing the capital expenditure and medical equipment thresholds to \$3,167,746 effective January 1, 2016.

A moratorium on nursing home beds has been in effect since 1987 and is currently in place with no set expiration date. The state is currently in the process of considering and revising CON standards and the review process, but as of the date of this overview, it is unclear when any changes will be submitted.

BED NEED METHODOLOGY

West Virginia calculates its 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. As of the most recent study, there is no need for additional long-term care beds.

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%. The West Virginia Tax Law indicates that the fee will revert back to 5.5% on July 1, 2016; however, it is currently unclear if this will occur.

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, and were last rebased on April 1, 2014, using cost report data for the six-month period of January 1 to June 30, 2015. 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.

West Virginia

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 is also applying a temporary \$2.75 rate reduction to non-state owned nursing facilities effective from October 1, 2015, to June 30, 2016. It is currently unclear if the state will continue this reduction after June 30, 2016.

Rates effective April 1, 2015, received no inflation adjustment. However, a 2.27% inflation adjustment was previously applied to October 1, 2014, rates. No inflation adjustment was applied to April 1, 2014, rates. The inflation adjustments for the prior periods were 0.016999% on October 1, 2013, 0.000538% on April 1, 2013, 1.6870% on October 1, 2012, no inflation adjustment on April 1, 2012, 0.029852% on October 1, 2011, 0.5569% on April 1, 2011, 0.9336% on October 1, 2010, and 2.5996% on October 1, 2009.

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 rate effective October 1, 2015, is \$213.75, which is 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.

West Virginia

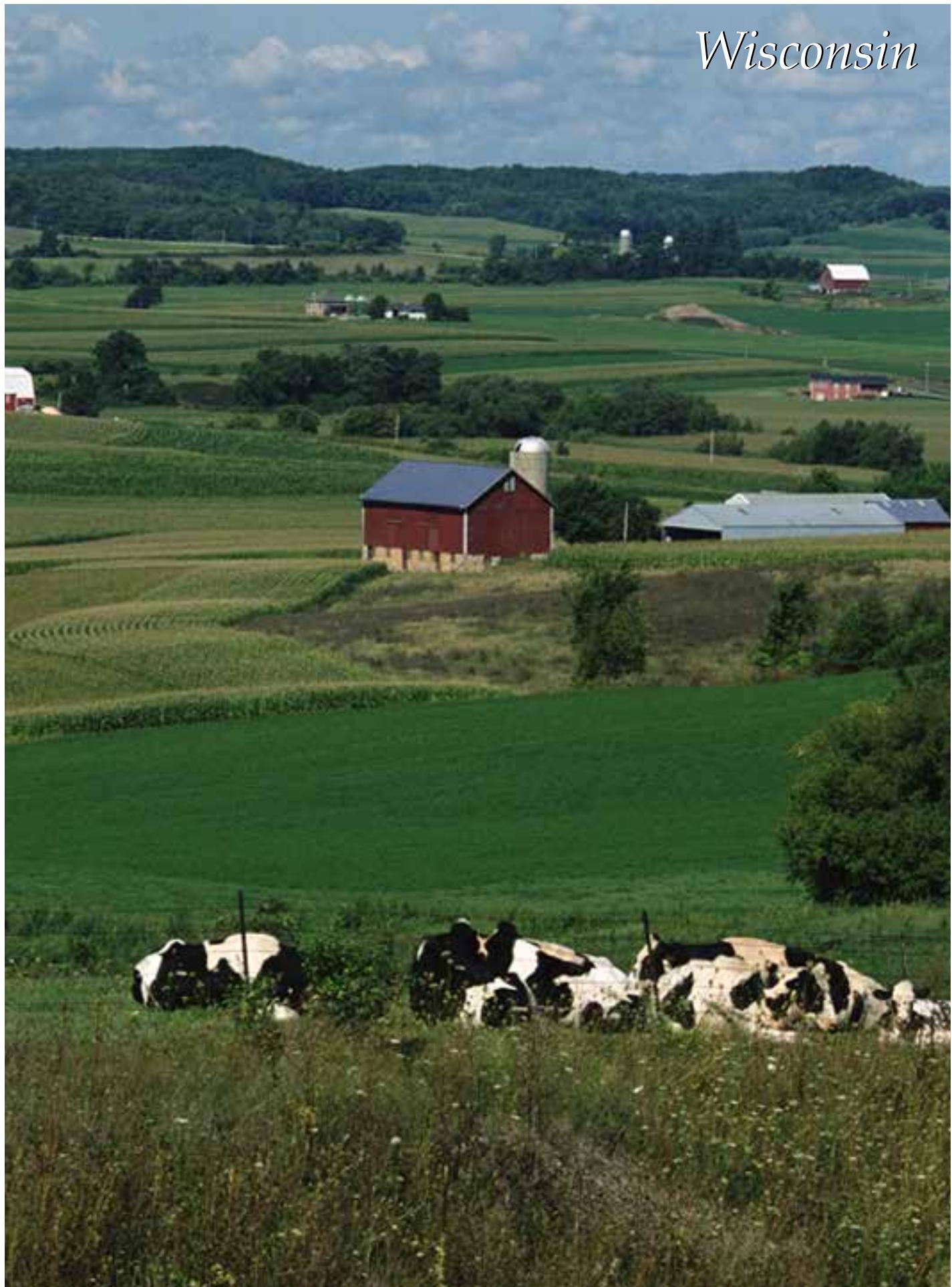
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	60.00	62.00	62.00	99.00	94.00	90.50	120.00	120.00	120.00			
Average Daily Census	57.43	58.24	58.06	88.31	88.31	84.66	110.16	110.49	103.20			
Occupancy	87.0%	88.2%	88.5%	92.6%	93.6%	93.0%	95.2%	96.2%	95.6%			
Payor Mix Statistics												
Medicare	8.4%	8.9%	8.5%	10.7%	10.6%	11.4%	13.9%	14.7%	14.9%			
Medicaid	69.3%	67.6%	70.4%	76.8%	77.8%	76.5%	80.1%	82.0%	82.3%			
Other	8.8%	7.5%	7.2%	14.0%	12.6%	10.9%	18.4%	17.8%	17.5%			
Avg. Length of Stay Statistics (Days)												
Medicare	38.96	29.01	36.50	47.95	36.25	42.98	58.00	48.58	52.47			
Medicaid	268.27	243.05	278.36	448.30	317.74	358.74	718.13	448.74	537.93			
Other	85.93	40.65	51.76	157.92	89.07	79.67	275.47	150.36	138.24			
Revenue (PPD)												
Inpatient	\$210.94	\$230.84	\$254.01	\$234.86	\$266.86	\$291.96	\$272.69	\$287.02	\$304.77			
Ancillary	\$31.34	\$36.57	\$40.07	\$44.11	\$48.72	\$56.38	\$61.01	\$63.86	\$77.57			
TOTAL	\$245.38	\$266.86	\$290.18	\$286.97	\$321.30	\$346.65	\$313.24	\$348.90	\$373.51			
Expenses (PPD)												
Employee Benefits	\$20.98	\$17.44	\$17.74	\$26.30	\$25.74	\$20.69	\$30.37	\$29.58	\$27.28			
Administrative and General	\$41.94	\$45.26	\$45.33	\$47.09	\$52.62	\$49.30	\$54.71	\$59.23	\$56.96			
Plant Operations	\$8.98	\$8.07	\$8.36	\$10.46	\$9.48	\$9.44	\$12.71	\$12.99	\$12.38			
Laundry & Linens	\$2.53	\$2.76	\$2.95	\$3.20	\$3.56	\$3.60	\$3.97	\$4.24	\$4.25			
Housekeeping	\$4.45	\$4.52	\$4.64	\$5.14	\$5.35	\$5.44	\$7.03	\$6.71	\$6.29			
Dietary	\$14.74	\$14.92	\$14.75	\$17.08	\$16.25	\$16.38	\$18.43	\$18.18	\$18.57			
Nursing & Medical Related	\$67.84	\$71.34	\$71.36	\$72.42	\$76.69	\$78.60	\$79.95	\$83.24	\$83.34			
Ancillary and Pharmacy	\$18.61	\$20.29	\$22.00	\$22.86	\$27.50	\$29.38	\$29.62	\$33.51	\$36.97			
Social Services	\$3.86	\$3.55	\$3.34	\$5.28	\$4.64	\$4.73	\$6.76	\$5.90	\$6.54			

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*	396
Licensed Nursing Beds*	34,006
Beds per 1,000 Aged 65 >**	38.41
Beds per 1,000 Aged 75 >**	87.53
Occupancy Percentage - 2013***	79.95%

*Source: Wisconsin Department of Health Services

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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.

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, recreation 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 rebased Medicaid rates effective July 1, 2009, utilizing costs reports that had a fiscal year end in 2008. These rates reflected a rate increase. However, the state recalculated rates effective August 1, 2009, to reflect slight rate reductions. The increase in the quality assurance fee enabled the state to only reduce rates by a net effect of approximately \$0.22. Rates effective August 1, 2009, were effective until June 30, 2010, and were based on the same cost report data utilized to calculate July 1, 2009, rates. The state has rebased rates every year since July 1, 2010. The state most recently rebased rates in fiscal year 2016 (effective July 1, 2015) utilizing 2014 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 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 used to determine July 1, 2015, rates are displayed as follows:

	Inflation Factors by Quarter of Cost Report Year End				
	January February March-14	April May June-14	July August September-14	October November December-14	
Direct Care:					
Wages	4.7%	4.3%	4.0%	3.6%	
Fringe Benefits	7.3%	6.1%	4.8%	3.7%	
Supplies	2.7%	2.2%	1.7%	1.4%	
Purchased Services	5.6%	4.9%	4.2%	3.6%	
Composite Support Services Expenses	4.5%	3.8%	3.2%	2.6%	

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, 2015: Picture Quarter - October 1 to December 31, 2014;
- Rates effective October 1, 2015: Picture Quarter - January 1, 2015, to March 31, 2015;
- Rates effective January 1, 2016: Picture Quarter – April 1, 2015, to June 30, 2015;
- Rates effective April 1, 2016: Picture Quarter – July 1, 2016, to September 30, 2016.

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 cost figure minus \$2.00, then the facility is reimbursed the case mix neutralized nursing per diem cost figure. If a nursing facility's case mix neutralized nursing per diem cost figure is less than the target but within \$2.00 of it, the facility is reimbursed the target per diem.

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, 2015, is \$77.28 per resident day, which is unchanged from the July 1, 2014, base rate. The current base rate does represent a 1.9% increase from the prior base rate (\$75.83) 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, 2015, the above determined amount is increased by a flat dollar price of \$12.97 to cover the Other Supplies and Services per diem costs. This represents a \$0.27 increase from the prior price (\$12.70) effective 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. The statewide target rate is \$44.95, which is 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.

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 E.H. Boeckh Valuation System. 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, 2015, 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, 2015, were not reduced by more than \$3.50 from the rate effective June 30, 2015, 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 of \$0.12 to calculate both incentives. Effective July 1, 2015, the BCHCI-13 incentive base is \$0.415 and the BCHCI-14 incentive is \$0.403.

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%.

Wisconsin

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 >50 Beds	Incentive <=50 Beds	Incentive City of Milw.
MM%	MM%			
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 date is not yet available for fiscal years 2015 and 2016. However, total funds that were dedicated to Medicaid nursing facility reimbursement were increased 2.0% and 0.0% for these periods, respectively.

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.

The initial rate for a recently completed nursing facility will be a negotiated rate between the facility and state based on budgeted cost report data. The rate will be recalculated utilizing the state's standard rate setting methodology after the nursing facility has accumulated six months of cost and case mix data. The new rate for a replacement nursing facility will be calculated similarly, but will utilize the case mix data for the original facility to the replacement facility's interim rate.

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

October 1, 2015, there are 62 counties participating in the program, and effective October 1, 2015, there are approximately 18,627 senior enrollees.

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). However, MCO long-term care members tend to possess higher acuity levels than fee for service residences. Given this factor, the state provides additional funding to MCOs to pay contracting nursing facilities' acuity-adjusted rates. An MCO's rate for each nursing facility must be calculated at least quarterly and be based upon the MCO members' RUG classes. Unlike fee for service rates, the state has begun utilizing the RUG IV, 48-Grouper system to determine MCO nursing facility rates.

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.

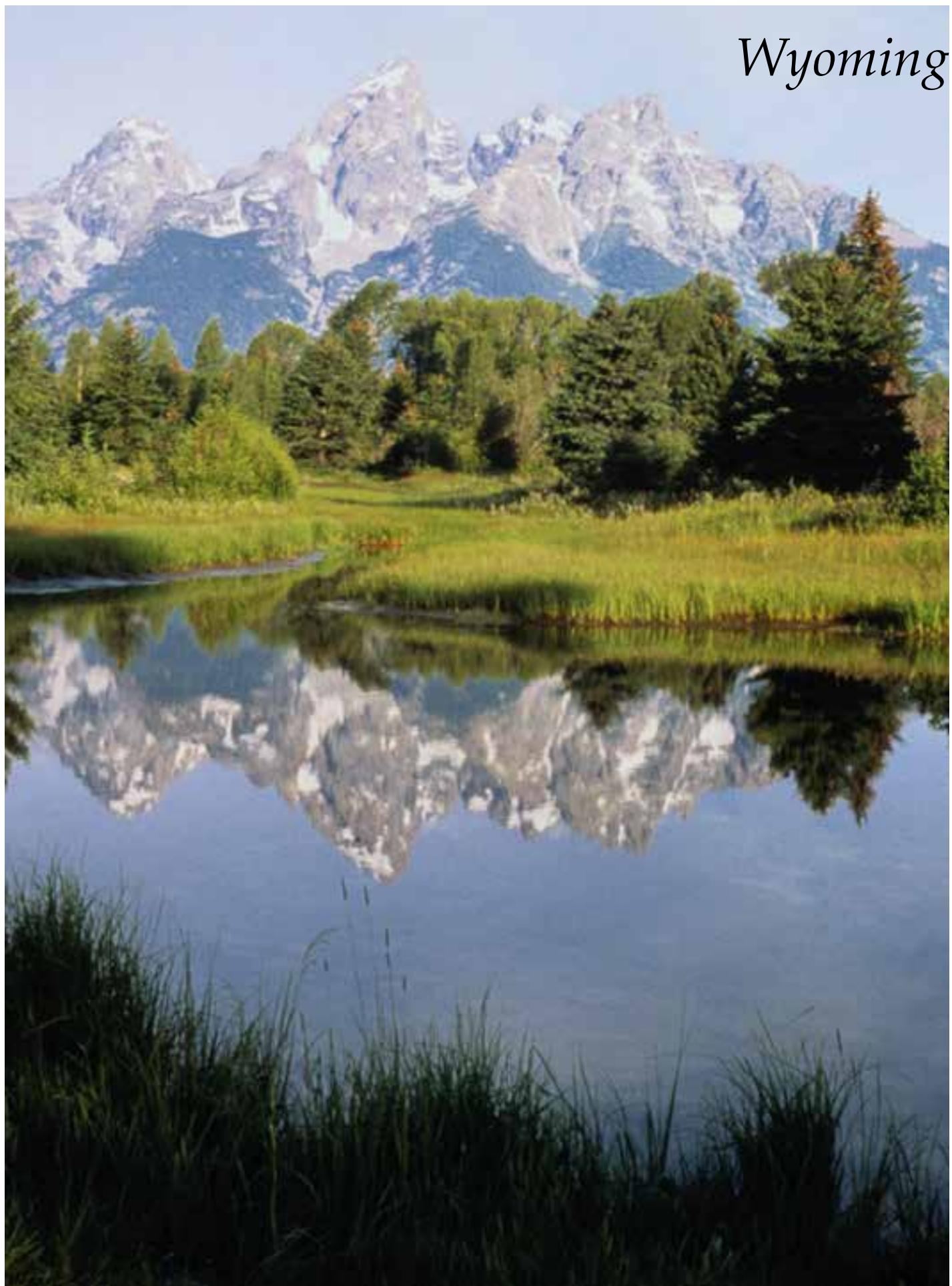
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

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			
	2011	2012	2013	2011	2012	2013	2011	2012	2013	
Number of Beds	60.00	59.25	58.00	90.00	87.00	84.00	120.00	120.00	117.00	
Average Daily Census	52.05	49.40	46.13	73.37	71.37	67.56	99.30	96.28	93.11	
Occupancy	77.2%	75.6%	74.9%	86.0%	84.9%	84.8%	91.0%	90.6%	90.8%	
Payor Mix Statistics										
Medicare	7.3%	6.8%	7.3%	10.4%	10.2%	11.1%	14.6%	14.2%	15.6%	
Medicaid	51.7%	51.0%	51.8%	62.5%	61.8%	60.2%	71.5%	69.2%	69.4%	
Other	23.4%	23.8%	23.6%	36.8%	34.3%	36.9%	83.5%	82.2%	82.1%	
Avg. Length of Stay Statistics (Days)										
Medicare	29.07	31.61	31.39	39.34	40.25	39.82	52.35	50.85	50.52	
Medicaid	288.66	312.91	287.77	485.10	528.68	510.58	766.33	749.13	789.87	
Other	91.34	81.40	80.90	149.48	133.77	123.93	265.86	240.84	213.85	
Revenue (PPD)										
Inpatient	\$189.40	\$194.85	\$198.81	\$218.26	\$222.90	\$229.61	\$256.65	\$256.77	\$266.99	
Ancillary	\$32.02	\$33.29	\$35.38	\$47.80	\$54.38	\$56.12	\$72.37	\$77.40	\$86.88	
TOTAL	\$227.79	\$234.37	\$242.70	\$272.64	\$283.07	\$292.38	\$320.48	\$330.55	\$350.41	
Expenses (PPD)										
Employee Benefits	\$18.93	\$18.32	\$17.86	\$24.70	\$24.10	\$23.83	\$35.99	\$35.67	\$35.05	
Administrative and General	\$26.63	\$28.78	\$29.65	\$33.94	\$35.35	\$36.75	\$45.40	\$45.91	\$47.87	
Plant Operations	\$8.92	\$9.02	\$9.73	\$10.47	\$10.68	\$11.32	\$12.87	\$13.18	\$13.71	
Laundry & Linens	\$2.23	\$2.30	\$2.26	\$2.84	\$2.86	\$2.93	\$3.74	\$3.67	\$3.80	
Housekeeping	\$4.28	\$4.34	\$4.52	\$5.50	\$5.57	\$5.79	\$6.78	\$7.07	\$7.19	
Dietary	\$14.92	\$15.13	\$15.82	\$17.30	\$17.58	\$18.03	\$21.02	\$21.14	\$22.02	
Nursing & Medical Related	\$71.85	\$73.07	\$75.42	\$81.22	\$83.95	\$86.39	\$94.43	\$97.71	\$102.15	
Ancillary and Pharmacy	\$16.08	\$16.83	\$18.40	\$23.69	\$26.10	\$26.26	\$34.58	\$34.86	\$36.06	
Social Services	\$2.07	\$2.05	\$2.20	\$2.92	\$2.95	\$3.16	\$4.63	\$4.44	\$4.80	

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), Facility Licensing and Certification Division under the designation "Adult Care Homes." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN WYOMING	
Licensed Nursing Facilities*	38
Licensed Nursing Beds*	2,950
Beds per 1,000 Aged 65 >**	34.90
Beds per 1,000 Aged 75 >**	87.19
Occupancy Percentage - 2013***	78.23%

*Source: Wyoming Department of Health

**Source: The Nielsen Company - 2015 Population

***Source: 2013 Medicare Cost Reports

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 is currently \$19.67 (effective October 1, 2013) per non-Medicare day. The state has yet to determine the NFA that will be effective October 1, 2013. This current fee represents a 6.5% increase from the prior fee (\$18.47) that was effective October 1, 2012. The rate (\$17.7644) established on October 1, 2011 represented a 19.9% increase from the previous rate (\$14.82). This increase corresponds with the sunset of the Tax Relief and Health Care Act of 2006 on the same date (October 1, 2011). This act reduced the maximum quality assessment fee that states could charge from 6.0% to 5.5% of total revenue. Effective October 1, 2011, the ceiling reverted back to 6.0%, and Wyoming increased its NFA to take advantage of the increased ceiling.

Wyoming nursing facilities are reimbursed for the assessment fee on a quarterly supplemental basis as determined by payor class (private nursing care facilities, state government-owned nursing facilities and non-state government-owned nursing facilities). The supplemental payment is based on the facility's actual Medicaid days. Effective October 1, 2013, the per-Medicaid-day amount used to determine supplemental payments is \$56.98 for private nursing care facilities, \$43.76 for state-government-owned nursing facilities and \$57.85 for non-state government owned nursing facilities.

MEDICAID RATE CALCULATION SYSTEM

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

COSTS CENTERS

Per diem reimbursement rates are based on the following three cost components:

- The Health Care cost component includes labor costs and supplies associated with activities, dietary, direct healthcare and social services.
- The Capital cost component includes leasehold amortization, rent/lease expenses, straight-line depreciation and interest on real estate and personal property.
- The Operating cost component includes labor costs and supplies associated with housekeeping, laundry, medical records, patient-related administration costs (including home office and management fees) and plant operations and equipment costs.

INFLATION AND REBASING

Effective October 1, 2009, the state's Medicaid rate year was changed to October 1 to September 30. Prior to this date, each provider had its own specific rate year based on its fiscal year end. Facility-specific rates and cost limits are rebased annually utilizing the most recent cost report in the prior calendar year. The state establishes a minimum and maximum rate for all nursing facilities, which are rebased once every three to five years based on the most recent cost report data available.

However, given current economic conditions, the state has not rebased Medicaid rates since October 1, 2009, utilizing 2008 cost report data. Medicaid rates have been frozen since that date and the state has indicated that rates will continue to be frozen through fiscal year 2015 (effective October 1, 2014). The minimum and maximum rates were last rebased on July 1, 2006, and were scheduled to be rebased on October 1, 2011. However, as Medicaid rates have been frozen since October 1, 2009, the rebase of the minimum and maximum allowable rates will not occur.

In previous rate years, facilities' allowable operating and healthcare costs were inflated using an annualized eight-quarter average rate of change in the inflation factor (the Skilled Nursing Facility Market Basket, published quarterly by Global Insight). Allowable costs were inflated from the midpoint of the cost reporting period to the midpoint of the rate period. However,

according to Wyoming rate setting professionals, since Medicaid rates have been frozen since October 1, 2009, 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 following is the state's current reimbursement methodology. However, this methodology has not been utilized since October 1, 2009, and it is unclear if it will be adjusted.

RATE METHODOLOGY

Wyoming excludes all costs related to providing Medicare services from the calculation of nursing facility Medicaid rates. Medicaid allowable costs are first determined by excluding costs attributable to Medicare patients from total allowable costs. The costs attributable to Medicare patients (both routine and ancillary) are determined from each facility's Medicare cost reports, utilizing Medicare's step-down cost allocation and apportionment methodology. The Medicare excluded allowable inflated costs for each cost component are then divided by non-Medicare patient days to derive a Medicaid allowable per diem cost for each cost component.

Nursing facilities are reimbursed the lesser of their inflated per diem cost (per cost component) or the defined cost ceiling for each cost component. The cost ceilings for the Health Care and Operating cost components are determined as a percentage of the median cost (per component) for all facilities in the state. The ceilings for the Health Care cost component and the Operating cost component are 125% and 105% of the median, respectively.

A facility with allowable Operating costs below the Operating cost component ceiling is eligible for an incentive adjustment. The incentive adjustment is equal to 25.0% of the difference between the facility's allowable Operating cost and the Operating cost component ceiling. That amount is calculated on a per diem basis and added to the facility's inflation adjusted Operating costs. The adjustment may not exceed \$2.00 per day.

The Capital cost component is subject to a maximum capital basis per licensed bed. A maximum of \$28,500 per bed was established in 1989 and is increased effective July 1 of each year by the lesser of one-half of the percentage increase in the McGraw Hill-Dodge Construction Index or one-half of the increase in the consumer price index. (If either the McGraw Hill-Dodge Construction Index or the Consumer Price Index is discontinued, DOH will use whichever index is available.)

To determine the allowable maximum capital basis for a facility, the per-bed maximum capital basis in effect for the more recent of two periods (the date of construction or January 1, 1989) is selected. The allowable maximum capital basis is this amount plus one-half of the difference between this amount and the maximum capital basis per bed at the rate effective date. The maximum capital basis utilized during the last unfrozen rate period (fiscal year 2010) was \$38,000.

For nursing facilities constructed, acquired or leased prior to January 1, 1989, and facilities constructed after January 1, 1989,

a Capital component limitation will be calculated. This limit will equate to the allowable total maximum capital basis for all licensed beds multiplied by the average annual Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family Rate (rounded to the nearest half-percent). The rate utilized during the last unfrozen rate period was 11.5%.

For facilities acquired through purchase or capital lease on or after January 1, 1989, the buyer/lessee's maximum capital basis will be limited to the seller/lessor's maximum capital basis at the date of the transaction. Any additional allowable capital expenditures incurred by the buyer/lessee will be treated in the same manner as if the seller/lessor had made the additional capital expenditure. The lesser of the facility's actual resident days or 90% of the facility's total available resident days is utilized to calculate the maximum allowable capital per diem.

A nursing facility's Capital cost component rate is the lesser of the facility's actual per diem cost or the maximum allowable Capital per diem. If a nursing facility's actual occupancy percentage is above 80.0%, then the facility's actual non-Medicare resident days are utilized to calculate the facility's actual per diem cost. However, if the facility's occupancy is below 80.0%, 90.0% of the facility's total available non-Medicare resident days are utilized to calculate the per diem. To determine 90.0% of a facility's available non-Medicare days, the facility's current Medicare resident days are adjusted out of the calculation. This is accomplished by dividing the facility's actual Medicare resident days by the facility's current occupancy percentage and then subtracting this amount from total available resident days. The adjusted total available resident days are then multiplied by 90.0% to calculate total non-Medicare resident days for minimum occupancy purposes.

Once the facility-specific rates per cost component are determined, a minimum and maximum total per diem rate is established for each facility. The minimum rate is equal to the facility's base rate (the sum of all three component rates as of the last rebasing on July 1, 2006), minus the Capital component of that rate, plus the facility's current Capital component rate. The base rate as of the last rebasing was calculated utilizing the cost component rates effective June 30, 2005. The minimum rate is paid if it is greater than the calculated rate. The maximum rate is equal to the base rate, minus the Capital component of that rate, multiplied by 110% of the inflation factor as measured from the midpoint of the base rate to the midpoint of the current rate period, plus the current Capital component rate. The maximum rate is paid if it is less than the calculated rate.

The statewide weighted average rate effective July 1, 2013, is \$165.21. Given that rates have been frozen since July 1, 2009, the statewide weighted average rate most likely has not significantly changed in several years.

MINIMUM OCCUPANCY STANDARDS

The allowable inflated costs utilized to calculate the rate for the Capital cost component are subject to an imputed minimum occupancy as follows:

- A minimum occupancy requirement of 90.0% of total resident days is utilized to calculate the Capital cost component through the maximum Capital basis methodology; and
- If a facility's overall occupancy percentage is below 80.0%, a minimum occupancy requirement of 90.0% of non-Medicare resident days is utilized to calculate the Capital cost component when the cost component rate is based on the facility's actual costs.

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.

A new facility receives a per diem rate equal to 110% of the median per diem rate in effect as of the most recent July 1, except that the capital component of the rate is equal to the median allowable capital cost currently in effect for the state. A new facility's initial rate is effective until the end of the first fiscal year ending six or more months after the certification date, at which time a per diem rate is established based on the above methodology. There are no retroactive adjustments if the new per diem rate is different from the initial rate.

A facility that has a change of ownership receives the per diem rate in effect for that facility on the date of the change of ownership. This rate remains in effect until the end of the first fiscal year ending six or more months after the date of the change of ownership, at which time a per diem rate is established based on the previously discussed methodology. However, property costs for nursing facilities that have changed ownership are limited by the federal Deficit Reduction Act (DEFRA) provisions.

DOH may pay a contracted rate to a facility that furnishes added value. The contracted rate may exceed the facility's established per diem rate. The DOH can negotiate and enter into contracts for added value using the following procedures:

- Determine what constitutes added value.
- Solicit proposals for added value contracts.
- Negotiate with providers.

In determining what constitutes added value, DOH takes into consideration the average level of care and the quality of care furnished in each facility, as well as the following objectives:

- Reduction in the number and frequency of institutionally acquired infections.
- Reduction in the number and frequency of adverse resident incidents, such as falls, skin tears and wandering from the facility.
- Reduction in official and unofficial complaints.
- Maintenance of residents' ideal body weight.
- Maintenance or improvement of facility survey results.
- Maintenance of ambulatory levels of residents from admission to discharge.
- Increasing the number of discharges to lesser acute settings.
- Decreasing the incidence of residents' incontinence.

Prior to the establishment of the new rate, the nursing facility must provide a proposed contracted rate and the estimated additional cost (including documentation) the facility will incur to provide this added value. The contracted rate is the rate agreed upon by the DOH and the provider and applies to all recipients in the facility, unless otherwise agreed upon by the DOH and the provider. If the DOH determines that the value added criteria are not being satisfied, the provider's rate can be reduced to the calculated per diem rate.

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.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no planned changes to the state's reimbursement system.

Wyoming

WYOMING COST REPORT STATISTICS												
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			2011	2012	2013
	2011	2012	2013	2011	2012	2013	2011	2012	2013			
Number of Beds	56.75	60.00	60.00	61.00	90.00	84.00	90.50	119.00	116.25			
Average Daily Census	37.86	53.30	47.00	54.32	72.25	66.75	71.42	99.21	83.86			
Occupancy	74.8%	74.8%	72.0%	82.0%	82.2%	79.8%	87.3%	89.1%	88.1%			
Payor Mix Statistics												
Medicare	8.9%	9.4%	9.6%	10.6%	11.1%	10.7%	14.6%	15.3%	14.8%			
Medicaid	53.8%	58.1%	54.5%	61.5%	64.1%	64.0%	70.3%	69.7%	66.7%			
Other	20.2%	18.5%	17.8%	25.9%	23.3%	24.9%	34.1%	28.0%	30.0%			
Avg. Length of Stay Statistics (Days)												
Medicare	34.31	38.86	35.72	41.66	47.92	49.84	57.35	70.65	70.98			
Medicaid	301.06	326.79	405.37	454.10	512.21	523.21	575.63	844.57	632.13			
Other	124.76	119.61	118.38	167.78	195.28	168.20	231.43	317.86	259.43			
Revenue (PPD)												
Inpatient	\$189.27	\$203.20	\$204.68	\$200.50	\$212.86	\$216.23	\$213.27	\$234.29	\$243.00			
Ancillary	\$33.39	\$31.13	\$33.84	\$41.82	\$47.04	\$46.66	\$47.08	\$54.21	\$56.80			
TOTAL	\$226.87	\$236.97	\$247.16	\$243.89	\$269.71	\$268.71	\$275.90	\$289.30	\$293.40			
Expenses (PPD)												
Employee Benefits	\$23.25	\$18.01	\$22.04	\$30.98	\$24.17	\$25.83	\$38.87	\$28.48	\$33.01			
Administrative and General	\$27.13	\$41.00	\$41.13	\$42.51	\$49.79	\$51.54	\$56.94	\$53.52	\$57.94			
Plant Operations	\$8.97	\$8.45	\$9.18	\$10.95	\$9.82	\$10.41	\$12.45	\$10.86	\$11.44			
Laundry & Linens	\$2.11	\$1.96	\$2.25	\$2.58	\$2.49	\$2.68	\$3.04	\$2.83	\$3.02			
Housekeeping	\$4.58	\$4.79	\$4.63	\$5.00	\$5.24	\$5.41	\$6.57	\$6.16	\$6.27			
Dietary	\$15.12	\$15.17	\$14.89	\$18.14	\$16.53	\$17.24	\$22.56	\$19.52	\$20.78			
Nursing & Medical Related	\$67.00	\$72.69	\$75.37	\$87.13	\$79.08	\$84.47	\$95.07	\$91.18	\$93.29			
Ancillary and Pharmacy	\$18.35	\$19.12	\$19.70	\$24.56	\$23.73	\$24.54	\$28.03	\$26.76	\$26.36			
Social Services	\$1.44	\$1.77	\$1.92	\$2.07	\$3.01	\$3.58	\$6.94	\$5.94	\$6.07			

Comments: The data displayed above may be moderately skewed, given that the average sample size over the three-year period is 21 nursing facilities.

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

 *Appendices*

Appendix A - State Summary Chart

Summary of States												
Operational Statistics				Licensing Factors			Medicaid Reimbursement System					
State	Number of facilities	Number of licensed beds	2013 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	18	692	89.03%	Yes	No	Yes	Cost	Prospective	Facility	No	No	
AL	233	27,131	86.71%	Yes	Yes	Yes	Cost	Prospective	Facility	No	Yes	
AR	259	25,701	72.16%	Yes	No	Yes	Cost & Price	Prospective	Facility	No	Yes	
AZ	146	16,150	72.18%	No	No	No	Price	Prospective	Neither	Yes	Yes	
CA	1,226	114,764	86.08%	No	No	No	Cost	Prospective	Facility	No	Yes	
CO	226	21,124	81.28%	Yes	Yes	No	Cost	Prospective	Facility	Yes	Yes	
CT	235	27,815	90.29%	No	Yes	Yes	Cost	Prospective	Facility	No	Yes	
DC	19	2,770	90.94%	No	No	Yes	Cost	Prospective	Facility	Yes	Yes	
DE	50	5,133	87.81%	Yes	No	Yes	Cost	Prospective	Resident	Yes	Yes	
FL	681	83,428	87.63%	Yes	No	Yes	Cost	Prospective	Facility	No	Yes	
GA	369	39,546	85.45%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes	
HI	50	4,060	80.79%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes	
IA	442	31,167	80.78%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes	
ID	79	5,977	67.70%	No	No	No	Cost	Prospective	Facility	Yes	Yes	
IL	787	102,383	76.27%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes	
IN	541	52,594	76.56%	No	Yes (Medicaid only)	No	Cost	Prospective	Facility	Yes	Yes	
KS	345	24,253	82.34%	No		No	Cost	Prospective	Facility	Yes	Yes	
KY	310	27,467	87.66%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes	
LA	280	34,987	73.75%	No	Yes	Yes	Price	Prospective	Facility	Yes	Yes	
MA	420	48,365	88.78%	Yes	Yes	Yes	Price	Prospective	Resident	Yes	Yes	
MD	230	28,011	88.65%	Yes	No	Yes	Cost	Retrospective	Facility	Yes	Yes	
ME	103	6,840	92.34%	Yes	No	Yes	Cost	Pro & Retro	Facility	Yes	Yes	
MI	445	46,865	83.66%	Yes	No	Yes	Cost	Prospective	Facility	No	Yes	
MN	375	29,269	89.82%	No	Yes	No	Cost & Price	Prospective	Combination	Yes	Yes	
MO	496	54,370	72.13%	Yes	No	Yes	Cost	Prospective	Facility	No	Yes	
MS	206	19,076	87.01%	Yes	Yes	Yes	Cost	Prospective	Facility	Yes	Yes	
MT	84	6,772	66.32%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes	
NC	411	43,973	83.69%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes	
ND	80	6,040	93.25%	No	Yes	No	Cost	Prospective	Combination	Yes	No	
NE	228	16,770	78.42%	Yes	Yes	Yes	Cost	Prospective	Resident	Yes	Yes	
NH	81	7,431	90.29%	Yes	Yes	Yes	Cost	Prospective	Facility	Yes	Yes	
NJ	372	52,223	86.19%	No	No	Yes	Cost & Price	Prospective	Facility	Yes	Yes	
NM	74	6,961	83.94%	No	No	No	Cost	Prospective	Facility	No	No	
NV	48	5,767	81.82%	No	No	Yes	Price	Prospective	Facility	Yes	Yes	
NY	630	113,491	95.63%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes	
OH	937	90,525	83.10%	Yes	Yes	Yes	Price	Prospective	Facility	Yes	Yes	
OK	306	28,991	69.40%	Yes	No	Yes	Cost & Price	Prospective	Facility	No	Yes	
OR	137	12,203	64.29%	Yes	No	Yes	Price	Prospective	Neither	No	Yes	
PA	708	102,156	89.34%	No	No	No	Cost	Prospective	Facility	Yes	Yes	
RI	90	9,052	93.74%	No	Yes	Yes	Price	Prospective	Resident	Yes	Yes	
SC	193	20,170	88.85%	Yes	Yes (Medicaid only)	Yes	Cost	Prospective	Facility	No	No	
SD	110	6,868	88.05%	No		No	Cost	Prospective	Facility	Yes	No	
TN	327	37,122	81.94%	Yes	Yes	Yes	Cost	Prospective	Facility	No*	Yes	
TX	1,231	137,760	70.20%	No	Yes	No	Price	Prospective	Resident	Yes	No	
UT	99	8,410	64.74%	No	Yes	No	Price	Prospective	Facility	Yes	Yes	
VA	282	33,598	88.17%	Yes	No	Yes	Price	Prospective	Resident	Yes	No	
VT	36	3,115	86.36%	No	Yes	Yes	Cost	Prospective	Facility	Yes	Yes	
WA	229	22,281	79.90%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes	
WI	396	34,006	79.95%	No	Yes	Yes	Cost & Price	Prospective	Facility	Yes	Yes	
WV	129	10,550	89.72%	Yes	Yes	Yes	Cost	Prospective	Combination	Yes	Yes	
WY	38	2,950	78.23%	No	No	No	Cost	Prospective	Facility	No	Yes	

*The state has indicated that it intends to convert to an acuity-based system. This system would also include supplemental payments for quality of care. Initially, this new system was supposed to be implemented effective July 1, 2015. However, the new system has yet to be finalized, and representatives of the state's Medicaid agency (TennCare) and the Tennessee Health Care Association (THCA) have indicated that the earliest any acuity-based system could be implemented would be July 1, 2016.

Appendix B - Beds per 1,000 Persons Aged 65 and 75 or Older by State

State	Beds	Beds Per 1,000	Beds Per 1,000
		Aged 65+ Population	Aged 75+ Population
AK	692	9.39	29.00
AL	27,131	35.96	87.59
AR	25,701	54.36	130.33
AZ	16,150	15.40	37.06
CA	114,764	22.96	54.03
CO	21,124	30.46	77.68
CT	27,815	48.88	109.57
DC	2,770	34.02	80.68
DE	5,133	33.54	82.14
FL	83,428	21.87	49.25
GA	39,546	31.31	81.60
HI	4,060	17.75	40.03
IA	31,167	62.00	133.25
ID	5,977	25.81	63.83
IL	102,383	56.47	130.92
IN	52,594	54.76	128.90
KS	24,253	57.49	128.10
KY	27,467	41.13	101.09
LA	34,987	54.03	131.59
MA	48,365	46.46	105.02
MD	28,011	33.31	80.79
ME	6,840	28.20	66.50
MI	46,865	30.24	71.34
MN	29,269	36.91	84.48
MO	54,370	57.46	133.68
MS	19,076	43.97	106.21
MT	6,772	39.10	94.61
NC	43,973	29.70	73.60
ND	6,040	53.26	112.65
NE	16,770	60.55	132.70
NH	7,431	35.06	85.43
NJ	5,223	38.90	88.54
NM	6,961	22.08	54.14
NV	5,767	14.38	37.95
NY	113,491	38.29	86.86
OH	90,525	49.44	113.25
OK	28,991	50.12	119.64
OR	12,203	19.17	46.91
PA	102,156	46.94	102.71
RI	9,052	53.55	117.69
SC	20,170	26.27	67.52
SD	6,868	51.59	111.20
TN	37,122	36.98	92.47
TX	137,760	43.49	108.09
UT	8,410	28.03	68.03
VA	33,598	28.69	71.69
VT	3,115	29.31	71.01
WA	22,281	22.10	55.22
WI	34,006	38.41	87.53
WV	10,550	31.67	75.84
WY	2,950	34.90	87.19

* Source data is footnoted in the state overviews

Appendix C - Weighted Average Days by RUG Classification

RUG - CLASS	National Average	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	District Of Columbia	Florida	Georgia
RUC	16.6%	17.3%	2.3%	15.2%	14.3%	22.7%	17.0%	12.4%	17.4%	16.2%	20.7%	14.1%
RUB	21.7%	17.9%	4.1%	24.3%	16.3%	28.3%	26.2%	16.2%	26.8%	20.7%	32.6%	18.8%
RUA	11.4%	14.5%	0.9%	14.9%	14.2%	9.3%	10.6%	8.2%	18.0%	7.3%	11.9%	8.6%
RUX	0.6%	0.3%	0.0%	1.0%	0.5%	1.2%	0.9%	0.3%	0.3%	0.3%	0.7%	0.5%
RUL	0.4%	0.3%	0.0%	0.9%	0.6%	0.6%	1.1%	0.2%	0.2%	0.2%	0.6%	0.3%
RVC	8.5%	10.1%	2.6%	6.6%	9.8%	7.0%	7.1%	10.4%	6.5%	10.2%	6.1%	9.4%
RVB	9.2%	7.8%	10.0%	9.1%	7.4%	8.7%	10.9%	11.9%	7.1%	10.5%	7.0%	10.0%
RVA	6.9%	6.5%	1.0%	7.4%	8.1%	4.8%	6.7%	7.7%	5.6%	6.0%	3.9%	6.5%
RVX	0.2%	0.2%	0.1%	0.3%	0.5%	0.3%	0.4%	0.2%	0.1%	0.5%	0.2%	0.3%
RVL	0.2%	0.2%	0.0%	0.4%	0.4%	0.3%	0.6%	0.2%	0.1%	0.1%	0.2%	0.2%
RHC	3.6%	3.8%	9.8%	2.2%	4.1%	2.2%	2.2%	4.6%	2.4%	4.4%	2.4%	4.7%
RHB	3.0%	2.4%	17.2%	2.7%	3.1%	2.2%	2.5%	4.0%	2.1%	2.6%	2.0%	4.1%
RHA	2.5%	2.1%	5.2%	2.2%	3.3%	1.7%	2.0%	2.6%	1.3%	1.8%	1.4%	3.2%
RHX	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.1%	0.0%	0.2%	0.1%	0.2%
RHL	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%	0.1%
RMC	2.4%	3.2%	9.4%	1.4%	2.2%	1.2%	1.5%	2.9%	2.0%	2.5%	1.5%	2.7%
RMB	1.7%	1.9%	11.8%	1.5%	1.5%	1.1%	1.5%	2.1%	1.6%	1.3%	1.2%	2.3%
RMA	1.4%	1.7%	5.6%	1.3%	1.7%	0.7%	1.2%	1.4%	1.1%	0.8%	0.8%	1.8%
RMX	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.2%	0.1%	0.1%
RML	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%
RLB	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
RLA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
RLX	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
CC2	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
CC1	0.4%	0.4%	2.1%	0.6%	0.4%	0.4%	0.6%	0.8%	0.4%	0.4%	0.4%	0.5%
CB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CB1	0.3%	0.2%	0.7%	0.5%	0.3%	0.2%	0.2%	0.4%	0.2%	0.2%	0.2%	0.3%
CA2	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
CA1	0.5%	0.3%	2.0%	0.6%	0.4%	0.3%	0.4%	0.8%	0.4%	0.3%	0.4%	0.4%
BB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BB1	0.1%	0.1%	0.0%	0.1%	0.3%	0.1%	0.1%	0.3%	0.1%	0.1%	0.1%	0.2%
BA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BA1	0.1%	0.1%	0.0%	0.0%	0.2%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%
PE2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PE1	0.2%	0.2%	0.0%	0.1%	0.3%	0.0%	0.1%	0.3%	0.1%	0.2%	0.1%	0.1%
PD2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
PD1	0.3%	0.4%	0.2%	0.3%	0.5%	0.1%	0.2%	0.5%	0.5%	0.4%	0.2%	0.3%
PC2	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
PC1	0.4%	0.4%	1.4%	0.4%	0.5%	0.2%	0.4%	0.8%	0.8%	0.4%	0.4%	0.5%
PB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PB1	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.3%	0.2%	0.2%	0.1%	0.1%
PA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PA1	0.2%	0.1%	0.3%	0.2%	0.2%	0.1%	0.2%	0.3%	0.3%	0.1%	0.1%	0.1%
ES3	0.3%	0.1%	0.0%	0.4%	0.0%	0.6%	0.0%	0.1%	0.2%	0.0%	0.1%	0.2%
ES2	0.2%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%
ES1	0.2%	0.3%	0.0%	0.2%	0.8%	0.2%	0.2%	0.2%	0.1%	0.2%	0.1%	0.2%
HE2	0.2%	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.3%	0.1%	0.2%	0.1%	0.3%
HE1	0.4%	0.6%	0.3%	0.2%	0.7%	0.3%	0.2%	0.9%	0.3%	0.5%	0.4%	0.5%
HD2	0.1%	0.1%	0.4%	0.1%	0.1%	0.1%	0.1%	0.3%	0.1%	0.1%	0.1%	0.3%
HD1	0.4%	0.5%	1.0%	0.3%	0.7%	0.4%	0.2%	1.0%	0.2%	0.3%	0.3%	0.6%
HC2	0.1%	0.1%	1.4%	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.0%	0.3%
HC1	0.3%	0.3%	1.3%	0.3%	0.3%	0.3%	0.2%	0.7%	0.2%	0.1%	0.3%	0.5%
HB2	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
HB1	0.4%	0.3%	0.7%	0.4%	0.4%	0.2%	0.3%	0.7%	0.2%	0.3%	0.2%	0.6%
LE2	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.3%
LE1	0.7%	1.0%	0.1%	0.4%	1.2%	0.7%	0.3%	0.8%	0.4%	1.5%	0.6%	0.8%
LD2	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.4%
LD1	0.8%	1.1%	1.6%	0.6%	0.8%	1.0%	0.5%	0.9%	0.5%	1.6%	0.7%	1.0%
LC2	0.1%	0.0%	0.7%	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.0%	0.2%
LC1	0.5%	0.6%	1.3%	0.5%	0.5%	0.6%	0.3%	0.7%	0.4%	0.2%	0.4%	0.6%
LB2	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LB1	0.2%	0.1%	1.3%	0.3%	0.2%	0.2%	0.1%	0.3%	0.2%	0.1%	0.1%	0.2%
CE2	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%
CE1	0.2%	0.2%	0.1%	0.2%	0.3%	0.1%	0.2%	0.3%	0.2%	0.2%	0.1%	0.2%
CD1	0.4%	0.5%	1.0%	0.4%	0.6%	0.3%	0.5%	0.6%	0.4%	0.4%	0.3%	0.4%
Default	0.2%	0.1%	0.2%	0.3%	0.1%	0.3%	0.6%	0.4%	0.1%	5.4%	0.1%	0.3%

Appendix C - Weighted Average Days by RUG Classification

RUG - CLASS	National Average	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland
RUC	16.6%	13.6%	15.5%	14.2%	14.4%	8.8%	11.1%	19.9%	14.0%	13.3%	14.5%
RUB	21.7%	34.6%	20.4%	21.2%	17.7%	8.3%	13.1%	14.1%	13.7%	18.2%	25.0%
RUA	11.4%	8.7%	12.4%	13.5%	12.5%	6.4%	16.0%	10.7%	15.1%	17.2%	12.7%
RUX	0.6%	0.1%	0.3%	0.9%	0.4%	0.3%	0.3%	0.7%	0.4%	0.1%	0.6%
RUL	0.4%	0.1%	0.1%	0.7%	0.4%	0.1%	0.3%	0.2%	0.3%	0.0%	0.3%
RVC	8.5%	6.8%	8.4%	8.0%	10.9%	10.8%	9.1%	12.5%	11.1%	8.9%	7.1%
RVB	9.2%	12.2%	9.2%	10.5%	10.4%	10.5%	8.7%	8.1%	9.5%	10.3%	9.6%
RVA	6.9%	3.0%	6.4%	10.0%	7.7%	12.0%	13.4%	6.0%	11.7%	9.8%	6.2%
RVX	0.2%	0.1%	0.1%	0.4%	0.4%	0.2%	0.2%	0.1%	0.2%	0.0%	0.2%
RVL	0.2%	0.1%	0.1%	0.4%	0.3%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%
RHC	3.6%	2.1%	3.9%	2.8%	5.0%	7.7%	4.5%	5.4%	4.5%	3.2%	2.7%
RHB	3.0%	3.6%	3.0%	2.9%	3.6%	6.7%	3.5%	2.8%	3.2%	2.6%	2.5%
RHA	2.5%	0.9%	3.5%	3.4%	2.6%	8.7%	5.5%	2.0%	3.6%	2.3%	1.6%
RHX	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%
RHL	0.1%	0.0%	0.0%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.0%	0.1%
RMC	2.4%	1.5%	2.6%	1.5%	3.2%	3.2%	1.9%	3.7%	2.5%	2.3%	1.9%
RMB	1.7%	2.9%	2.2%	1.3%	2.0%	2.5%	1.5%	1.7%	1.4%	1.7%	1.6%
RMA	1.4%	1.3%	2.0%	1.3%	1.5%	3.5%	2.5%	1.2%	1.6%	1.4%	1.0%
RMX	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%
RML	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
RLB	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%
RLA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
RLX	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
CC2	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%
CC1	0.4%	0.4%	0.8%	0.2%	0.3%	0.4%	0.3%	0.5%	0.2%	0.4%	0.6%
CB2	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
CB1	0.3%	0.2%	0.3%	0.2%	0.2%	0.4%	0.3%	0.3%	0.1%	0.4%	0.4%
CA2	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%
CA1	0.5%	0.3%	0.6%	0.3%	0.3%	0.8%	0.5%	0.4%	0.3%	0.7%	0.7%
BB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BB1	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.2%
BA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BA1	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.0%	0.1%
PE2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
PE1	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.3%	0.1%	0.2%	0.2%
PD2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%
PD1	0.3%	0.1%	0.4%	0.1%	0.3%	0.4%	0.3%	0.5%	0.2%	0.4%	0.5%
PC2	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%
PC1	0.4%	0.2%	0.6%	0.2%	0.3%	0.4%	0.4%	0.5%	0.2%	0.5%	0.8%
PB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PB1	0.2%	0.1%	0.2%	0.1%	0.1%	0.3%	0.3%	0.2%	0.1%	0.3%	0.3%
PA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PA1	0.2%	0.1%	0.2%	0.2%	0.1%	0.4%	0.3%	0.2%	0.1%	0.2%	0.3%
ES3	0.3%	0.7%	0.4%	0.4%	0.1%	0.1%	0.0%	0.0%	0.2%	0.0%	0.5%
ES2	0.2%	0.3%	0.1%	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%	0.0%	0.2%
ES1	0.2%	0.0%	0.1%	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%	0.0%	0.1%
HE2	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%
HE1	0.4%	0.4%	0.2%	0.2%	0.4%	0.3%	0.3%	0.7%	0.4%	0.2%	0.3%
HD2	0.1%	0.0%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.3%	0.2%
HD1	0.4%	0.1%	0.3%	0.2%	0.2%	0.3%	0.3%	0.5%	0.2%	0.4%	0.4%
HC2	0.1%	0.0%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.0%	0.2%	0.1%
HC1	0.3%	0.2%	0.5%	0.2%	0.2%	0.2%	0.2%	0.4%	0.1%	0.5%	0.4%
HB2	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%
HB1	0.4%	0.1%	0.5%	0.2%	0.3%	0.7%	0.5%	0.3%	0.3%	0.4%	0.4%
LE2	0.2%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%
LE1	0.7%	0.9%	0.3%	0.5%	0.5%	0.4%	0.3%	1.1%	1.1%	0.2%	0.8%
LD2	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
LD1	0.8%	0.9%	0.5%	0.6%	0.4%	0.5%	0.4%	0.8%	1.0%	0.5%	1.2%
LC2	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.1%
LC1	0.5%	1.0%	0.6%	0.4%	0.3%	0.4%	0.4%	0.5%	0.4%	0.4%	0.9%
LB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LB1	0.2%	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%	0.3%
CE2	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%
CE1	0.2%	0.1%	0.2%	0.1%	0.2%	0.2%	0.2%	0.4%	0.1%	0.1%	0.2%
CD1	0.4%	0.1%	0.7%	0.2%	0.3%	0.4%	0.3%	0.6%	0.2%	0.4%	0.4%
Default	0.2%	0.5%	0.3%	0.1%	0.2%	0.1%	0.2%	0.2%	0.2%	0.4%	0.4%

Appendix C - Weighted Average Days by RUG Classification

RUG - CLASS	National Average	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey
RUC	16.6%	17.1%	13.5%	9.1%	18.0%	10.0%	8.6%	9.4%	17.2%	16.5%	17.8%
RUB	21.7%	26.4%	21.8%	14.0%	14.2%	13.5%	12.9%	11.4%	24.0%	22.4%	30.4%
RUA	11.4%	9.0%	15.4%	9.1%	13.5%	13.0%	9.1%	14.3%	12.5%	16.9%	9.2%
RUX	0.6%	0.2%	0.4%	0.2%	0.3%	0.2%	0.1%	0.2%	1.0%	0.1%	0.5%
RUL	0.4%	0.1%	0.4%	0.2%	0.2%	0.2%	0.1%	0.2%	0.8%	0.2%	0.4%
RVC	8.5%	7.7%	7.9%	9.9%	11.3%	9.3%	6.7%	8.4%	6.8%	6.1%	7.0%
RVB	9.2%	9.6%	9.7%	14.1%	8.0%	11.2%	9.6%	9.0%	9.1%	6.7%	8.6%
RVA	6.9%	5.0%	8.4%	11.1%	8.1%	14.0%	10.7%	11.3%	5.7%	6.1%	3.8%
RVX	0.2%	0.1%	0.3%	0.1%	0.2%	0.1%	0.1%	0.1%	0.4%	0.1%	0.2%
RVL	0.2%	0.1%	0.3%	0.1%	0.1%	0.3%	0.1%	0.1%	0.4%	0.1%	0.2%
RHC	3.6%	2.7%	3.0%	5.3%	5.2%	4.2%	4.6%	5.2%	2.5%	2.3%	2.8%
RHB	3.0%	2.6%	2.9%	5.7%	2.6%	3.6%	5.9%	4.5%	2.8%	2.1%	2.7%
RHA	2.5%	1.7%	2.4%	4.7%	3.0%	5.2%	7.4%	6.3%	1.9%	2.5%	1.1%
RHX	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%
RHL	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%
RMC	2.4%	2.3%	1.8%	2.6%	3.5%	2.1%	4.0%	3.3%	1.7%	2.1%	2.4%
RMB	1.7%	1.9%	1.6%	2.5%	1.6%	1.6%	3.5%	2.4%	1.8%	1.7%	1.9%
RMA	1.4%	1.2%	1.3%	2.6%	1.7%	2.3%	4.9%	3.5%	1.1%	1.6%	0.9%
RMX	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%
RML	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
RLB	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%
RLA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
RLX	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CC2	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
CC1	0.4%	0.6%	0.5%	0.5%	0.3%	0.4%	0.8%	0.5%	0.7%	0.6%	0.4%
CB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
CB1	0.3%	0.4%	0.3%	0.4%	0.1%	0.3%	0.6%	0.5%	0.5%	0.4%	0.3%
CA2	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%
CA1	0.5%	0.8%	0.5%	1.1%	0.2%	0.6%	1.3%	0.8%	0.5%	1.0%	0.4%
BB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
BB1	0.1%	0.3%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%	0.1%	0.3%	0.1%
BA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BA1	0.1%	0.2%	0.1%	0.1%	0.2%	0.3%	0.2%	0.2%	0.0%	0.2%	0.1%
PE2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PE1	0.2%	0.3%	0.1%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	0.4%	0.1%
PD2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
PD1	0.3%	0.7%	0.3%	0.3%	0.3%	0.3%	0.3%	0.5%	0.2%	0.7%	0.2%
PC2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%
PC1	0.4%	0.9%	0.5%	0.4%	0.3%	0.4%	0.8%	0.5%	0.4%	0.9%	0.4%
PB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PB1	0.2%	0.3%	0.2%	0.2%	0.1%	0.2%	0.3%	0.4%	0.2%	0.4%	0.1%
PA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PA1	0.2%	0.3%	0.3%	0.3%	0.2%	0.3%	0.5%	0.3%	0.2%	0.4%	0.1%
ES3	0.3%	0.1%	0.3%	0.1%	0.0%	0.0%	0.0%	0.1%	1.7%	0.0%	0.4%
ES2	0.2%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.0%	0.2%
ES1	0.2%	0.0%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.5%	0.1%	0.1%
HE2	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.2%
HE1	0.4%	0.6%	0.3%	0.3%	0.7%	0.3%	0.2%	0.2%	0.2%	0.4%	0.6%
HD2	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.0%	0.3%	0.2%
HD1	0.4%	0.7%	0.3%	0.3%	0.5%	0.3%	0.5%	0.4%	0.2%	0.6%	0.5%
HC2	0.1%	0.2%	0.1%	0.2%	0.0%	0.1%	0.1%	0.1%	0.0%	0.3%	0.2%
HC1	0.3%	0.8%	0.2%	0.3%	0.2%	0.3%	0.5%	0.2%	0.2%	0.7%	0.4%
HB2	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%
HB1	0.4%	0.6%	0.3%	0.5%	0.3%	0.5%	0.9%	0.6%	0.2%	0.7%	0.4%
LE2	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%
LE1	0.7%	0.5%	0.6%	0.4%	1.3%	0.5%	0.2%	0.4%	0.6%	0.3%	0.8%
LD2	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%
LD1	0.8%	0.6%	0.8%	0.5%	1.0%	0.7%	0.5%	0.5%	0.8%	0.5%	0.8%
LC2	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%
LC1	0.5%	0.6%	0.6%	0.5%	0.4%	0.5%	0.4%	0.5%	0.7%	0.5%	0.6%
LB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LB1	0.2%	0.2%	0.2%	0.3%	0.1%	0.3%	0.2%	0.2%	0.3%	0.2%	0.2%
CE2	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%
CE1	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%
CD1	0.4%	0.5%	0.4%	0.3%	0.4%	0.4%	0.6%	0.5%	0.4%	0.6%	0.3%
Default	0.2%	0.3%	0.4%	0.2%	0.1%	0.2%	0.7%	0.3%	0.2%	0.2%	0.1%

Appendix C - Weighted Average Days by RUG Classification

RUG - CLASS	National Average	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina
RUC	16.6%	15.4%	15.2%	13.5%	10.5%	18.0%	9.4%	17.5%	21.9%	13.8%	13.1%
RUB	21.7%	22.7%	23.5%	15.9%	9.6%	22.9%	13.0%	20.7%	18.6%	25.2%	21.5%
RUA	11.4%	13.8%	6.5%	12.6%	5.3%	12.4%	14.1%	11.2%	9.8%	19.1%	12.3%
RUX	0.6%	0.7%	0.5%	0.3%	0.1%	0.6%	0.4%	0.3%	0.4%	0.4%	0.4%
RUL	0.4%	0.6%	0.2%	0.3%	0.0%	0.4%	0.5%	0.2%	0.2%	0.3%	0.6%
RVC	8.5%	6.0%	7.1%	8.7%	9.2%	8.6%	8.5%	9.4%	11.9%	5.4%	8.5%
RVB	9.2%	9.9%	8.2%	10.7%	8.2%	9.0%	9.8%	10.1%	8.1%	7.9%	10.0%
RVA	6.9%	7.5%	4.0%	9.1%	5.7%	6.1%	13.8%	6.9%	4.8%	7.7%	6.0%
RVX	0.2%	0.3%	0.1%	0.2%	0.1%	0.2%	0.3%	0.1%	0.2%	0.1%	0.3%
RVL	0.2%	0.3%	0.1%	0.3%	0.0%	0.2%	0.5%	0.1%	0.1%	0.1%	0.4%
RHC	3.6%	2.5%	5.6%	4.0%	8.7%	3.1%	3.8%	3.7%	4.8%	1.8%	4.3%
RHB	3.0%	3.1%	4.6%	3.9%	7.7%	2.4%	3.3%	3.4%	2.5%	2.0%	4.0%
RHA	2.5%	3.2%	2.4%	3.3%	5.6%	2.0%	4.9%	2.7%	1.5%	2.4%	2.4%
RHX	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.0%	0.2%
RHL	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.0%	0.0%	0.1%
RMC	2.4%	2.0%	3.9%	2.9%	5.7%	2.3%	2.0%	2.4%	3.8%	1.4%	3.0%
RMB	1.7%	1.8%	2.6%	2.4%	5.0%	1.7%	1.6%	2.1%	1.6%	1.3%	2.4%
RMA	1.4%	1.5%	1.8%	1.8%	3.4%	1.5%	2.4%	1.7%	1.1%	1.3%	1.3%
RMX	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%
RML	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%
RLB	0.1%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
RLA	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
RLX	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CC2	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%
CC1	0.4%	1.0%	0.4%	0.6%	0.6%	0.3%	0.5%	0.6%	0.4%	0.6%	0.5%
CB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CB1	0.3%	0.3%	0.2%	0.4%	0.5%	0.2%	0.5%	0.4%	0.2%	0.4%	0.2%
CA2	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
CA1	0.5%	0.4%	0.4%	0.5%	0.7%	0.5%	0.8%	0.8%	0.4%	1.0%	0.2%
BB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BB1	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.3%	0.0%	0.1%	0.2%	0.1%
BA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BA1	0.1%	0.2%	0.0%	0.1%	0.1%	0.1%	0.3%	0.0%	0.0%	0.1%	0.0%
PE2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
PE1	0.2%	0.1%	0.1%	0.2%	0.4%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%
PD2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
PD1	0.3%	0.3%	0.1%	0.5%	0.7%	0.2%	0.5%	0.2%	0.3%	0.4%	0.5%
PC2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
PC1	0.4%	0.5%	0.2%	0.6%	1.0%	0.3%	0.5%	0.4%	0.3%	0.7%	0.7%
PB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PB1	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.3%	0.1%	0.1%	0.2%	0.1%
PA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PA1	0.2%	0.1%	0.2%	0.2%	0.4%	0.2%	0.5%	0.2%	0.2%	0.2%	0.1%
ES3	0.3%	0.0%	1.2%	0.1%	0.1%	0.3%	0.2%	0.0%	0.4%	0.3%	0.0%
ES2	0.2%	0.1%	0.2%	0.2%	0.4%	0.2%	0.2%	0.1%	0.2%	0.1%	0.1%
ES1	0.2%	0.2%	0.1%	0.2%	0.0%	0.1%	0.3%	0.1%	0.1%	0.1%	0.1%
HE2	0.2%	0.0%	0.6%	0.1%	0.3%	0.3%	0.1%	0.1%	0.1%	0.1%	0.1%
HE1	0.4%	0.3%	1.0%	0.2%	0.7%	0.4%	0.3%	0.3%	0.6%	0.2%	0.4%
HD2	0.1%	0.0%	0.3%	0.1%	0.3%	0.3%	0.2%	0.1%	0.1%	0.1%	0.1%
HD1	0.4%	0.4%	0.5%	0.3%	0.7%	0.3%	0.3%	0.3%	0.4%	0.6%	0.5%
HC2	0.1%	0.1%	0.3%	0.1%	0.6%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%
HC1	0.3%	0.4%	0.4%	0.3%	0.6%	0.3%	0.2%	0.3%	0.3%	0.4%	0.4%
HB2	0.1%	0.0%	0.1%	0.0%	0.2%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%
HB1	0.4%	0.3%	0.5%	0.3%	0.9%	0.4%	0.5%	0.5%	0.3%	0.7%	0.3%
LE2	0.2%	0.1%	0.7%	0.1%	0.3%	0.3%	0.2%	0.1%	0.1%	0.1%	0.2%
LE1	0.7%	0.5%	1.5%	0.6%	0.9%	0.5%	0.7%	0.2%	0.8%	0.3%	0.7%
LD2	0.1%	0.1%	0.3%	0.2%	0.2%	0.3%	0.2%	0.1%	0.1%	0.2%	0.1%
LD1	0.8%	0.7%	0.9%	1.0%	1.0%	0.5%	1.0%	0.4%	0.8%	0.4%	1.2%
LC2	0.1%	0.0%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%
LC1	0.5%	0.4%	0.6%	0.9%	0.6%	0.4%	0.5%	0.4%	0.4%	0.6%	0.7%
LB2	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
LB1	0.2%	0.2%	0.2%	0.3%	0.1%	0.2%	0.3%	0.3%	0.1%	0.3%	0.2%
CE2	0.1%	0.0%	0.1%	0.1%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
CE1	0.2%	0.3%	0.2%	0.2%	0.6%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%
CD1	0.4%	0.7%	0.3%	0.5%	0.9%	0.3%	0.5%	0.6%	0.4%	0.5%	0.4%
Default	0.2%	0.2%	0.2%	0.3%	0.1%	0.2%	0.2%	0.3%	0.1%	0.3%	0.1%

Appendix C - Weighted Average Days by RUG Classification

RUG - CLASS	National Average	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
RUC	16.6%	8.9%	20.2%	17.6%	18.9%	14.1%	12.7%	20.1%	21.3%	13.1%	13.9%
RUB	21.7%	12.1%	19.0%	18.0%	30.8%	14.5%	17.2%	22.9%	15.8%	16.3%	21.5%
RUA	11.4%	9.9%	10.6%	13.1%	9.7%	11.1%	12.0%	9.7%	10.4%	10.6%	7.4%
RUX	0.8%	0.1%	0.6%	1.3%	0.9%	0.2%	0.4%	0.5%	0.4%	0.2%	0.3%
RUL	0.4%	0.1%	0.3%	0.5%	0.9%	0.1%	0.3%	0.2%	0.2%	0.2%	0.4%
RVC	8.5%	8.6%	10.1%	8.9%	7.4%	8.4%	8.7%	8.1%	11.1%	10.1%	5.7%
RVB	9.2%	9.5%	7.7%	8.3%	9.2%	8.8%	11.2%	9.0%	6.5%	12.4%	9.7%
RVA	6.9%	12.0%	5.4%	7.6%	4.7%	7.2%	8.3%	5.3%	4.6%	10.1%	6.1%
RVX	0.2%	0.2%	0.3%	0.4%	0.3%	0.0%	0.2%	0.1%	0.3%	0.2%	0.2%
RVL	0.2%	0.3%	0.2%	0.3%	1.3%	0.1%	0.3%	0.1%	0.1%	0.2%	0.2%
RHC	3.6%	6.2%	4.1%	3.4%	3.1%	4.4%	4.1%	2.8%	5.4%	4.6%	2.6%
RHB	3.0%	4.9%	2.6%	2.6%	2.6%	3.7%	4.1%	2.7%	2.5%	4.4%	4.2%
RHA	2.5%	6.8%	1.9%	2.6%	1.6%	3.7%	2.7%	1.8%	2.5%	3.7%	3.9%
RHX	0.1%	0.1%	0.1%	0.2%	0.4%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%
RHL	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
RMC	2.4%	3.0%	3.0%	2.1%	1.2%	4.3%	3.0%	2.0%	4.3%	2.2%	2.1%
RMB	1.7%	2.3%	1.5%	1.4%	1.2%	2.7%	2.4%	1.7%	1.9%	1.7%	2.9%
RMA	1.4%	3.0%	1.0%	1.4%	0.8%	2.9%	1.6%	1.2%	1.7%	1.7%	3.4%
RMX	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%
RML	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%
RLB	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%
RLA	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
RLX	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CC2	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.3%
CC1	0.4%	0.6%	0.5%	0.4%	0.4%	0.4%	0.6%	0.5%	0.5%	0.4%	1.2%
CB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%
CB1	0.3%	0.3%	0.2%	0.3%	0.2%	0.3%	0.4%	0.4%	0.3%	0.3%	0.6%
CA2	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%
CA1	0.5%	1.1%	0.3%	0.4%	0.1%	1.1%	0.5%	0.9%	0.4%	0.7%	1.1%
BB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BB1	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%	0.3%
BA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
BA1	0.1%	0.1%	0.2%	0.2%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.4%
PE2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PE1	0.2%	0.2%	0.4%	0.2%	0.0%	0.3%	0.2%	0.3%	0.3%	0.1%	0.2%
PD2	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PD1	0.3%	0.5%	0.6%	0.4%	0.1%	0.6%	0.4%	0.5%	0.5%	0.2%	0.4%
PC2	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%
PC1	0.4%	0.4%	0.6%	0.5%	0.2%	0.7%	0.6%	0.8%	0.5%	0.3%	1.1%
PB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PB1	0.2%	0.2%	0.2%	0.2%	0.0%	0.2%	0.2%	0.3%	0.2%	0.1%	0.4%
PA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PA1	0.2%	0.4%	0.1%	0.2%	0.0%	0.2%	0.2%	0.3%	0.3%	0.2%	0.7%
ES3	0.3%	0.0%	0.3%	0.2%	0.2%	0.2%	0.1%	0.2%	0.0%	0.1%	0.0%
ES2	0.2%	0.1%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.0%
ES1	0.2%	0.2%	0.3%	0.3%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%
HE2	0.2%	0.3%	0.1%	0.2%	0.1%	0.5%	0.1%	0.3%	0.1%	0.1%	0.1%
HE1	0.4%	0.4%	0.7%	0.5%	0.1%	0.3%	0.4%	0.4%	0.5%	0.3%	0.3%
HD2	0.1%	0.3%	0.1%	0.2%	0.1%	0.7%	0.1%	0.3%	0.2%	0.1%	0.2%
HD1	0.4%	0.5%	0.7%	0.4%	0.1%	0.9%	0.5%	0.4%	0.7%	0.3%	0.7%
HC2	0.1%	0.2%	0.1%	0.1%	0.2%	0.5%	0.1%	0.2%	0.1%	0.2%	0.2%
HC1	0.3%	0.4%	0.5%	0.3%	0.1%	0.8%	0.3%	0.4%	0.3%	0.3%	0.7%
HB2	0.1%	0.2%	0.0%	0.1%	0.1%	0.4%	0.0%	0.1%	0.1%	0.1%	0.0%
HB1	0.4%	0.5%	0.4%	0.3%	0.2%	0.9%	0.4%	0.5%	0.4%	0.6%	0.5%
LE2	0.2%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	0.0%
LE1	0.7%	0.3%	0.7%	0.8%	0.1%	0.2%	0.7%	0.5%	0.8%	0.3%	0.4%
LD2	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
LD1	0.8%	0.6%	0.9%	0.8%	0.3%	0.4%	1.2%	0.6%	0.9%	0.5%	0.5%
LC2	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
LC1	0.5%	0.5%	0.5%	0.5%	0.2%	0.3%	0.8%	0.6%	0.5%	0.5%	0.5%
LB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LB1	0.2%	0.4%	0.1%	0.2%	0.1%	0.2%	0.3%	0.3%	0.1%	0.2%	0.1%
CE2	0.1%	0.1%	0.1%	0.1%	0.0%	0.2%	0.0%	0.2%	0.1%	0.0%	0.2%
CE1	0.2%	0.5%	0.4%	0.2%	0.0%	0.2%	0.2%	0.2%	0.3%	0.1%	0.5%
CD1	0.4%	0.5%	0.6%	0.4%	0.2%	0.6%	0.5%	0.5%	0.6%	0.3%	1.2%
Default	0.2%	0.3%	0.2%	0.5%	0.3%	0.3%	0.2%	0.2%	0.4%	0.2%	1.2%

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	Nursing facilities with 43,500 or greater annual Medicaid days = \$1.40 per non-Medicare day. All remaining non-exempt facilities = \$10.50 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	\$11.76 x total non-Medicare patient days.	Nursing facilities located within life care communities (LCC).
California*	Nursing facilities with < 100,000 total patient days = \$16.26 x total patient days. Nursing facilities with ≥ 100,000 total patient days = \$15.39 x total patient days.	Nursing facilities located within multi-level retirement communities.
Colorado	Effective July 1, 2015, nursing facilities with ≤ 55,000 Medicaid days = \$13.64 per non-Medicare day. Nursing facilities with > 55,000 Medicaid days = \$2.09 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, 2015, \$13.65 for facilities with > 44,000 Medicaid days and \$25.76 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 September 1, 2015, the fee is \$24.58 per non-Medicare day for nursing facilities 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.	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	\$16.84 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	\$1.38 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) = \$325 x total licensed beds. All other nursing facilities (Tier II) = \$1,950 x total licensed beds. There is currently a proposal to increase the state's Tier I provider assessment to \$818 and Tier II assessment to \$4,908 effective July 1, 2016. It is currently	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	\$10.00 x total patient days.	None
Maine	6.0% x total patient service revenue.	None
Maryland	The five nursing facilities with the highest Medicaid volume = \$5.97 x total non-Medicare patient days. All other nursing facilities = \$24.32 x total non-Medicare patient days.	Nursing facilities located within CCRCs and nursing facilities with < 45 beds.
Massachusetts	Nursing facilities located within non-profit CCRCs = \$1.84 x total non-Medicare patient days. Nursing facilities with > 66,000 Medicaid patient days = \$1.84 x total non-Medicare patient days. All other nursing facilities = \$18.41 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	State Quality Assessment Fee Summary	
	Quality Assessment Fee Calculation	Exempt Facilities
Michigan	Effective October 1, 2015, nursing facilities with < 40 beds = \$2.00 x total non-Medicare patient days. Nursing facilities with > 51,000 total Medicaid days = \$16.30 x total non-Medicare patient days. All other nursing facilities = \$24.05 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	\$8.30 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 January 1, 2016, nursing facilities with < 65% Medicaid Payor Percentage = \$35.38 per non-Medicare day. Nursing facilities with > 65% Medicaid Payor Percentage = \$19.19 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. It is currently unclear if (or when) the state will eliminate the temporary increase.	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, 2015, for a nursing facility's first 200 beds = \$12.05 x Total Licensed Beds x 365 days. For each licensed nursing bed greater than 200 = \$9.60 x Total Licensed Beds x 365 days.	None
Oklahoma	Effective July 1, 2015, \$10.79 per day for all non-CCRCs and \$6.70 per day for CCRCs.	None
Oregon	Effective January 1, 2015, \$22.56 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, 2015, nursing facilities located within CCRCs, county-owned nursing facilities, nursing facilities with less than 50 beds = \$8.01 x Total Non-Medicare Patient Days. All Other Nursing Facilities = \$30.06 x Total Non-Medicare Patient Days.	None
South Carolina	None	Not Applicable
South Dakota	None	Not Applicable
Tennessee	Effective July 1, 2015, nursing facilities with 50 or less beds and nursing facilities within CCRCs are reimbursed \$6.76 per Medicaid day, nursing facilities with 50,000 or more Medicaid patient days are reimbursed \$6.08 per Medicaid day and all other nursing facilities are reimbursed \$11.92 per Medicaid day.	None
Texas	None	Not Applicable
Utah	Effective July 1, 2015, \$18.32 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. This fee is projected to increase to \$23.00 per non-Medicare day on April 1, 2016.	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.	\$5,473.93 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 \$19.67 (effective October 1, 2013) 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) = $(40/1,000) \times (65 \text{ and older population})$ 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) = $((0.70/1,000) \times (\text{below 65 population}) + (10.0/1,000) \times (65-74 \text{ population}) + (39.3/1,000) \times (75-84 \text{ population}) + (160/1,000) \times (85 \text{ and older population})) \times 1.05 - \text{total licensed nursing facility beds}$ 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	None
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 has 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) = $(\text{Total } 65-74 \text{ population} \times 65-74 \text{ bed need rate}) + (\text{Total } 75+ \text{ population} \times 75+ \text{ bed need rate})$ 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 = $(0.43/1,000) \times (\text{below 65 population})$ $(9.77/1,000) \times (65-74 \text{ population})$ $(32.50/1,000) \times (75-84 \text{ population})$ $(120/1,000) \times (85 \text{ and older population})$ 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: $[0.09 \times (65+ \text{ population}) + 0.0015 \times (64 - \text{population})] \times 110\%$ In urban counties total long-term bed need is equal to: $[0.07 \times (65+ \text{ population}) + 0.0015 \times (64 - \text{population})] \times 110\%$ 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 + waiver 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	Bed Need exists if: the national estimate of beds per 1,000 (65+ population) plus 10% > county estimate (and the estimate for the surrounding counties) of beds per 1,000 (65+ population)
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 bed need = state bed need rate x the 65 and older population in each county Net Bed Need (per county) = the total supply of existing nursing facilities in the county - the gross bed need estimate
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	2011	2012	2013
AK - Alaska	86.4%	89.4%	89.0%
AL - Alabama	87.4%	86.8%	86.7%
AR - Arkansas	71.7%	73.6%	72.2%
AZ - Arizona	73.7%	71.7%	72.2%
CA - California	86.5%	85.0%	86.1%
CO - Colorado	84.2%	82.9%	81.3%
CT - Connecticut	88.1%	89.8%	90.3%
DC - District of Columbia	91.1%	91.0%	90.9%
DE - Delaware	89.4%	88.2%	87.8%
FL - Florida	87.5%	88.0%	87.6%
GA - Georgia	85.6%	85.8%	85.5%
HI - Hawaii	91.8%	91.5%	80.8%
IA - Iowa	68.3%	80.3%	80.8%
ID - Idaho	77.1%	70.0%	67.7%
IL - Illinois	78.3%	77.3%	76.3%
IN - Indiana	80.8%	77.8%	76.6%
KS - Kansas	83.0%	83.0%	82.3%
KY - Kentucky	89.4%	88.4%	87.7%
LA - Louisiana	75.7%	74.1%	73.8%
MA - Massachusetts	92.2%	89.7%	88.8%
MD - Maryland	87.0%	88.6%	88.7%
ME - Maine	89.4%	92.8%	92.3%
MI - Michigan	83.5%	84.6%	83.7%
MN - Minnesota	89.5%	89.7%	89.8%
MO - Missouri	85.8%	72.5%	72.1%
MS - Mississippi	72.1%	88.1%	87.0%
MT - Montana	72.3%	71.6%	66.3%
NC - North Carolina	79.8%	84.5%	83.7%
ND - North Dakota	79.5%	92.2%	93.3%
NE - Nebraska	89.8%	79.7%	78.4%
NH - New Hampshire	84.9%	90.6%	90.3%
NJ - New Jersey	85.0%	86.5%	86.2%
NM - New Mexico	96.1%	84.7%	83.9%
NV - Nevada	84.2%	80.3%	81.8%
NY - New York	91.2%	97.4%	95.6%
OH - Ohio	84.3%	83.7%	83.1%
OK - Oklahoma	70.8%	68.3%	69.4%
OR - Oregon	64.3%	64.5%	64.3%
PA - Pennsylvania	85.3%	88.7%	89.3%
RI - Rhode Island	91.5%	92.4%	93.7%
SC - South Carolina	89.6%	89.8%	88.9%
SD - South Dakota	89.3%	90.0%	88.1%
TN - Tennessee	84.2%	84.9%	81.9%
TX - Texas	70.9%	71.0%	70.2%
UT - Utah	67.4%	66.8%	64.7%
VA - Virginia	86.8%	88.6%	88.2%
VT - Vermont	88.1%	87.7%	86.4%
WA - Washington	81.2%	79.5%	79.9%
WI - Wisconsin	89.6%	81.3%	80.0%
WV - West Virginia	79.6%	89.1%	89.7%
WY - Wyoming	82.3%	82.5%	78.2%

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 dieticians, 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.



Valuation & Information Group

The Valuation & Information Group was established to provide specialized, expert valuations and services to facility operators, lenders and their advisors. The primary focus of the firm includes appraisal and market feasibility studies for a wide variety of property types in the senior housing and healthcare industry throughout the United States. Wall Street looks to V&IG for its expertise.

Eljay, LLC

Eljay, LLC provides consulting services on design, redesign and implementation of Medicaid payment systems for nursing homes. The company has also assisted numerous states in the design of revenue maximization programs through implementation of provider tax and intergovernmental transfer programs. In the last five years, the principal of the company has been involved in designing new Medicaid payment systems in 10 states.

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