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State Reimbursement Policies for Privately Operated Intermediate Care Facilities for the Mentally Retarded 1984

Prepared by

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November 1985

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I. INTRODUCTION

The Medicaid program finances a wide range of health and rehabilitative services for people with mental retardation and related disorders; but the largest share of program benefits goes for residential services in intermediate care facilities for the mentally retarded (ICF-MRs). The ICF-MR program is unique in that it is the only Medicaid benefit specifically designed for mentally retarded persons, and unlike other Medicaid services that are essentially medical in nature (at least in the sense that a physician must prescribe a plan of care and supervise its progress), the ICF-MR program has a strong habilitative or social component. Although all mentally retarded persons may technically be considered for placement in ICF-MRs, not all require the level of care and services (above the level of room and board) provided by them.

Two key themes characterize the evolution of the ICF-MR program since its enactment in 1971. First, ICF-MR expenditures have grown enormously. Between 1972 and 1982, total Medicaid expenditures grew from $6.3 billion to $29.4 billion, an increase of $23.1 billion or 367 percent.[1] During the same period, ICF-MR expenditures grew from zero (not covered) to $3.5 billion. By 1983, ICF-MR expenditures had grown to $3.6 billion accounting for nearly 12 percent of the overall growth in Medicaid expenditures since 1973.

Second, there has been a dramatic change in the philosophy and locus of residential care for mentally retarded people toward smaller, more socially integrated facilities.[2] This development, in turn, has significantly affected the ICF-MR program. For example, in 1977, large state institutions represented nearly half of the 574 certified ICF-MR

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[1] All expenditures data reported in this study come from the HCFA-2082 form which is filed annually by the states in HCFA central office, Baltimore, Maryland.

[2] All data on ICF-MR utilization come from Lakin, K.C., Hill, B.K., and Bruininks, R.H. (eds.). (1985). An analysis of Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF-MR) program. Minneapolis: University of Minnesota, Department of Educational Psychology.

facilities and 88 percent of all ICF-MR beds nationwide. As a result, the average bed size in the industry was 186. By 1982, there was a nearly fourfold increase in the number of privately owned ICF-MRs with 15 or fewer beds. Private ICF-MR facilities accounted for nearly 23 percent of all ICF-MR beds and, by 1982, the average bed size in the industry declined to 76.

Moreover, the ability of states to continue to efficiently provide ICF-MR services in large, socially isolated public institutions became increasingly challenged by the courts, consumer advocacy groups, and the academic and popular press. The convergence of these forces has led Illinois, Michigan, Minnesota, Pennsylvania, and California to close one or more institutions since 1980, and additional closures are now in progress in Florida and Maryland. These closures are putting increasing pressures on states to expand Medicaid coverage of residential care services in smaller, community-based settings.

The ability of many states to provide residential care in smaller, community-based facilities depends in part on their ability to use federal entitlements (Medicaid, Supplemental Security Income, Food Stamps, etc.) to supplement the cost of care, as well as their ability to contain the total cost of care. State rate-setting and reimbursement policies represent one of the most powerful policy tools available to assure that mentally retarded people have access to appropriate residential services, but within cost limits that states can afford.

This paper examines state methodologies for setting payment rates (reimbursing) private ICF-MR residential care[3]. Private facilities are the focus of this paper for two reasons. First, privately operated facilities are the most rapidly growing type of residential care in the ICF-MR program and now account for over 70 percent of licensed facilities. Second, publicly operated ICF-MRs use statewide uniform budgeting and do

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[3]The terms "reimbursement" and "rate setting policy" are used interchangeably in this discussion.

not usually file cost reports. As a result, their costs are more affected by the legislative appropriations process than formal reimbursement methodologies per se.[4]

The paper begins with a brief history of Medicaid ICF-MR reimbursement policy, followed by an overview of the methodology employed in the present study of state payment systems. Next, an overview of state reimbursement systems as of January, 1984 is presented, highlighting changes and innovations since that period and describing in some detail the reimbursement of residential services in five case study states. The final section of the paper explores how state rate setting policy can potentially be used to control costs, encourage efficiency, and enhance quality of care in private ICF-MR facilities. Recommendations are provided to assist states in achieving these objectives.

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[4]Legislative appropriations for ICF-MR care in state institutions are, of course, subsidized by Federal Financial Participation and audited and reviewed by the states. The point is that ICF-MR revenues do not flow directly to the facility but are treated as general revenues for state accounting purposes. Consequently, rate-setting mechanisms exert considerably less influence on operators of public facilities than of private facilities.

II. BACKGROUND ON ICF-MR REIMBURSEMENT

Prior to the enactment of the ICF-MR program in 1971, states and counties developed their own methods of reimbursing state institutions; most paid on a negotiated flat rate basis through individual appropriations by state legislatures. These rates were generally determined by state budget constraints and were not necessarily linked to the expected costs of serving a particular client population or developmental program.

In the Social Security Amendments of 1972 (Public Law 92-603), among which the ICF-MR program was originally contained until attached to another Social Security bill (authorizing lump sum death benefits) to expedite passage, there was language governing the reimbursement of all long term care facilities under Medicaid. Section 249 established the principle of "reasonable cost-related reimbursement." The law required that (1) by July 1, 1976, all states reimburse Medicaid skilled nursing care and intermediate level care on a reasonable cost basis, and (2) that methods of reimbursement be approved by the then Secretary of the Department of Health, Education, and Welfare. Reasonable cost related reimbursement was intended to cover costs incurred by facilities that were economically and efficiently operated. States were required to define allowable costs for reimbursement purposes, and facilities were required to submit annual cost reports to the states.[5]

Nevertheless, the intricacies of state reimbursement as a policy tool to shape provider behavior took a subordinate role to the need to obtain federal financial participation for the cost of care that was previously financed largely by state and local funding sources. During the first five years of program implementation, 1974 through 1978, state ICF-MR policy was almost exclusively oriented toward bringing public facilities into compliance with Federal ICF-MR standards. Substantial investments were made to meet direct care staffing requirements and life/safety and environmental standards.

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[5] Although the new law was to take effect July 1, 1976, the federal government postponed its effective date until January 1, 1978, because the final regulations were not published until July, 1976.

In the absence of historical cost data on ICF-MR operations in public institutions, some states adopted Medicare's system of reimbursement of allowable costs (defined by the Secretary of DHHS) incurred for SNF care. Other states used Medicare's allowable costs for SNF care to define their ICF-MR cost centers, but established their own ICF-MR cost limits. To aid states in establishing rates, the Health Care Financing Administration (HCFA), recognizing the differences in standards and regulations between ICF-MRs and general SNFs and ICFs,[6] released a December 1977 transmittal that enabled states to employ different cost related payment methodologies for the reimbursement of ICF-MR services.

In summary, the period of 1974 through 1978 witnessed a major emphasis on upgrading facilities to meet federal standards. The accompanying growth in per capita ICF-MR expenditures received less attention because, for the most part, states were obtaining Medicaid matching funds for care that was previously financed solely through state and local funds. States generally adapted Medicare cost-based reimbursement principles for ICF-MR care to assure adequate payment for the accelerating costs of improving staffing and programming in state institutions.

Between 1979 and 1982, however, the ICF-MR program entered a new phase of development. With the conversion of beds in existing public institutions nearly completed, both the states and the federal government began to take note of the rapidly escalating costs of ICF-MR care. At the same time, states began to expand the types of facilities certifiable as ICF-MR providers. Three factors significantly affected the ICF-MR program during this period.

1. Need to reduce the rate of increase in institutional capacity. The convergence of the principles of "normalization" and "least restrictive environments," lawsuits, and consumer advocacy pressure, forced rapid change in state policy toward residential care for mentally retarded people. As a result, releases from public institutions accelerated greatly, admissions to public institutions also declined, and the need for and development of alternative residential placements increased commensurately.

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[6] HCFA Transmittal 77-114 issued December 14, 1977.

2. Need to increase the rate of growth of residential care in community-based, social integrated settings. As the demand for residential care in small facilities increased, the private sector began to develop a variety of alternatives to institutional care in smaller, more socially integrated facilities. When faced with the potential loss of Medicaid matching funds in carrying out the social policy of deinstitutionalization, states began to look to Medicaid as source of funding of small community-based residences and new program initiatives.

3. Need to eliminate or reduce the rate of increase in Medicaid expenditures. Fiscal crises brought about by a recession, cuts in federal funds, and resistance to new taxes forced states to institute various cost control initiatives in order to control rapidly increasing Medicaid expenditures. Thus, states were forced to carefully assess the cost implications of all changes in Medicaid policy, including the coverage of residential care in community-based ICF-MR facilities.

The result of these changes in many states has been the emergence of a small but growing private sector ICF-MR industry. Between 1977 and 1982, the number of new facilities certified as ICF-MR providers grew dramatically. More that 90 percent of these new facilities were privately owned and operated. Moreover, most of this growth was in facilities with fewer than 15 beds. As a result, by 1982 states were faced with an ICF-MR program that was considerably more diverse in terms of the number, size, and type of ownership of participating facilities in the program.

The Omnibus Reconciliation Act of 1980 (Public Law 96-499) changed the Medicaid law to provide states with greater flexibility in establishing rates and methods.for paying providers of long term care services. Section 962 of the Act provided that states could pay facilities rates "which are reasonable and adequate to meet costs which must be incurred by efficiently and economically operated facilities."[7] States are still required to provide HCFA with plans describing their methodologies and standards for rate-setting. However, the states only have to provide assurances to HCFA that the rates are indeed adequate; the states' methods and standards for rate-setting do not have to be reviewed

[7] 46 Code of the Federal Register 47966 (September 30, 1981). The regulations implementing section 962 provide that states pay SNF and ICFs rates:

> "which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable state and federal laws, regulations, and quality and safety standards."

and approved prior to implementation as was the case under section 249. Further, states were given greater flexibility to adjust their rates because the regulations implementing section 962 specify that new assurances need to be submitted to HCFA only when states want to "significantly" revise their methods for determining rates. The definition of what constitutes a significant change is largely up to the states though the interpretation may well vary across HCFA regional offices. Finally, the regulations implementing Section 962 published on December 19, 1983 specify that states do not have to submit reimbursement policy changes annually as was the case under Section 249, but merely have to keep them on file if requested by HCFA. These changes have given states flexibility in establishing methods and standards that meet their specific needs.

In response to the need for increased access to community-based residential care at a reasonable cost, state reimbursement methodologies for ICF-MR services are evolving rapidly. Since 1980, 60 percent of states with a system of privately operated ICF-MR facilities have made or are making significant changes in their reimbursement methodologies. Fifteen states have made changes since July 1983. Six of these states (Alabama, Florida, Georgia, Minnesota, New York, and Ohio) reported changes effective in 1984.

Not surprisingly, states have taken diverse approaches in designing payment systems that largely reflect their different priorities and circumstances. Many states have very young and/or small community-based ICF-MR systems (e.g., Alabama, Massachusetts, Idaho, Montana, New Hampshire, New Jersey) and have initiated policies to promote growth. In contrast, other states have made changes in an attempt to slow system growth and contain program costs (i.e., New York, Minnesota, California). A few states (notably Louisiana) recently changed their systems so that they reimburse non-Medicaid and Medicaid facilities according to the same standards and methodology. Unified rate setting structures such as these could reinforce the position of ICF-MRs as a rather intensive level of residential care within a continuum of community residential alternatives. In general, as states gain more experience with community-based ICF-MR

programs, collect more facility cost data, and come to a better understanding of the types of clients and kinds of service for which the private ICF-MR model is cost-effective, they are modifying reimbursement policies to reflect equitable limits and incentives on reimbursement systems for private ICF-MR residential services within the broader continuum of care available to developmentally disabled persons.

State reimbursement policies for ICF-MR care affect both bed supply and total expenditures. Their rate setting methodologies must result in a payment that encourages providers to develop and maintain an adequate bed supply, but must also control program expenditures by encouraging efficiency and cost consciousness among providers. The following section categorizes self-reported state reimbursement methodologies across several broad dimensions that reflect these tradeoffs. Although attempts were made to analyze several features of each state's system, missing information and variation among state systems preclude a complete examination of every feature. What follows is an attempt to illustrate the diversity and complexity of ICF-MR reimbursement policy across the nation, drawing upon specific state examples where appropriate.

III. STUDY METHODOLOGY

A. Survey Instrument

The questionnaire used in the state survey (see Appendix A) was patterned after one developed for use in a study of the reimbursement practices of nursing homes and hospitals, published in March of 1983 by the National Governors' Association (Spitz & Atkinson, 1983). This was done because of the perceived similarity of reimbursement practices among long-term care services reimbursed by the Medicaid program. Generally, the areas addressed by Spitz and Atkinson corresponded to areas that are known to cause variability in the reimbursement methodologies of ICF-MR facilities. However, after consultation with Spitz, several state Medicaid directors, accountants, and ICF-MR policy analysts, certain of the original questions were deleted, changed or rearranged to increase specificity, comparability, and reliability of responses within and across states, and to reflect the unique characteristics of state ICF-MR reimbursement systems.

Questions on the final ICF-MR reimbursement survey covered the following seven areas:

1) General reimbursement design
2) Peer groupings
3) Indexing
4) Cost limits not based on indexing
5) Profits and return on equity
6) Capital reimbursements
7) Exceptions processes

Area 1 was adopted in its entirety from the Spitz and Atkinson questionnaire to initially classify each state's general system design along the three basic dimensions commonly found in the nursing home literature (degree of cost-relatedness, prospective or retrospective, and the type of ancillary services included in the per diem rate). In area 2, the survey was modified to reflect the types of peer groupings likely to be found in ICF-

MRs (e.g., client age, level of retardation) and an additional question was added to determine whether facility rates were adjusted to reflect special needs of clients hard to place due to behavioral problems. Areas 3, 6, and 7 were largely adopted from the Spitz and Atkinson survey. In area 4, a question was added to determine whether special limits were placed on top management compensation for chain or multiple homes. Finally, area 5 included a new question to determine whether efficiency allowances were permissible for facilities that spend less than their targeted or allowed expenses in certain or all cost centers.

Center staff spoke with key contacts in each state to develop a list of survey respondents familiar with the specifics of Medicaid reimbursement of ICF-MR facilities. These contacts included reimbursement experts in state Medicaid agencies and, where appropriate, state officials in departments of mental retardation. Respondents were contacted by phone and asked to participate in the survey.

Survey forms were mailed to respondents in December, 1983, accompanied by a cover letter stating the objectives of the study and clarifying the role of respondents. Active phone follow-up continued through June 1984 until a satisfactory response rate was achieved. Center staff also questioned state respondents about ambiguous responses to the questionnaires. Respondents were requested to send written documentation on reimbursement rules and standards, when available.

B. Response Rate

Questionnaires were completed and returned by 40 states and the District of Columbia. Of the remaining 10 states, 2 had private ICF-MR programs but did not return their questionnaires (Wisconsin, with approximately 700 residents in private ICF-MR facilities, and West Virginia, with 20 residents in 1982), two did not use Medicaid funding for ICF-MR services (Arizona and Wyoming), and six had no private ICF-MR program in place (Alabama, Delaware, Hawaii, Maryland, New Jersey, and Oklahoma).

The following sections present the results of the survey, summarized in Table 1.

Table 1

Summary of State Methodologies for Reimbursing
Private ICF-MR Facilities as of January 1984

State	Primary Methodology: Prospective	Prosp. w. retrospect. adjstmnts	Retrosp.	Groupings Used	Case Mix Index Used	Inflation Index Used	Cost Limits: Total Rate	Cost Centers/ Specific Costs	Return on Equity Paid	Efficiency Incentive	Capital Reimbursement: Depreciation	Interest on Fixed Assets	Interest on Working Capital	Interest on Negative Equity	Purchase Price Recognized	Incentives to not sell/ Depreciation Recapture	Lease Expense
Alabama																	
Alaska			Yes						Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Arizona																	
Arkansas			Yes								Yes	Yes	Yes		Yes		Yes
California	Yes[a]			Yes[d,e]		Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes		Yes
Colorado		Yes		Yes[f,g]		Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes		Yes
Connecticut	Yes					Yes		Yes	Yes	Yes			Yes				Yes
Delaware																	
Dist. Columbia	Yes					Yes		Yes			Yes	Yes	Yes		Yes		Yes
Florida	Yes			Yes[g]		Yes	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes	Yes
Georgia	Yes			Yes[g]		Yes		Yes		Yes	Yes	Yes			Yes	Yes	Yes
Hawaii																	
Idaho		Yes				Yes		Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Illinois	Yes			Yes[d,e]	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Indiana		Yes				Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes
Iowa	Yes					Yes		Yes		Yes	Yes	Yes	Yes	Yes	Yes		Yes
Kansas	Yes			Yes[e]		Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kentucky		Yes				Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Louisiana	Yes			Yes[e,g]			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Maine		Yes				Yes			Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Maryland																	
Massachusetts	Yes					Yes		Yes	Yes		Yes	Yes	Yes				Yes
Michigan		Yes						Yes									Yes
Minnesota	Yes					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	
Mississippi	Yes					Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes		Yes
Missouri	Yes					Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Montana		Yes					Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes		Yes
Nebraska	Yes			Yes[d,f,h]	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Nevada		Yes							Yes		Yes	Yes			Yes		Yes
New Hampshire		Yes									Yes						
New Jersey																	
New Mexico			Yes			Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New York	Yes			Yes[d,e]	Yes	Yes		Yes		Yes	Yes	Yes	Yes	Yes	Yes		Yes
North Carolina		Yes				Yes		Yes			Yes	Yes	Yes	Yes	Yes	Yes	Yes
North Dakota		Yes[c]							Yes		Yes	Yes	Yes	Yes	Yes		Yes
Ohio		Yes		Yes[e,g]	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma																	
Oregon		Yes			Yes		Yes		Yes		Yes	Yes	Yes		Yes	Yes	Yes
Pennsylvania		Yes						Yes			Yes	Yes	Yes	Yes	Yes		Yes
Rhode Island			Yes			Yes		Yes			Yes	Yes	Yes		Yes		Yes
South Carolina			Yes								Yes	Yes			Yes		Yes
South Dakota	Yes					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Tennessee	Yes[a]					Yes				Yes	Yes	Yes	Yes	Yes	Yes		Yes
Texas	Yes[b]			Yes[g]		Yes	Yes			Yes	Yes	Yes	Yes		Yes		Yes
Utah	Yes			Yes[g]		Yes	Yes	Yes		Yes	Yes	Yes	Yes				
Vermont			Yes								Yes	Yes	Yes		Yes	Yes	Yes
Virginia			Yes				Yes				Yes	Yes	Yes	Yes	Yes	Yes	Yes
Washington		Yes						Yes	Yes		Yes	Yes	Yes		Yes		Yes
West Virginia																	
Wisconsin																	
Wyoming																	

[a] Flat rate
[b] Modified flat rate
[c] Flat rate for facilities serving 8 or fewer
[d] Facility location
[e] Facility size
[f] Client level of disability
[g] Facility level of care
[h] Type of ownership

IV. FINDINGS

A. General System Design

Two general classifications of payment systems broadly reflect state approaches to ICF-MR reimbursement policy: prospective and retrospective. In prospective systems a rate is determined before it becomes effective, on the basis of the historical costs of an individual facility or group of facilities. When the same rate applies to all facilities in a similar class, it is called a uniform or flat rate system. In retrospective systems, an interim rate is established and paid to facilities during the year; an annual cost settlement at the end of the year reconciles the difference between actual allowable costs and the interim rate. Conceptually, the two payment systems are considered poles of a continuum of reimbursement systems; in practice, many state systems represent a blend of cost based approaches.

Based on the survey results, 19 states reported that rates were set prospectively or in advance of costs incurred. An additional 15 states reported that rates were set in advance of costs incurred but that adjustments were made retrospectively at the end of the year. Typically the adjustments reflected a rate that was the lesser of actual facility costs or the prospective rate. Seven states described their payment systems as retrospective, since rates were established after costs were incurred by the facility. These states required budgets or used cost reports from the previous year to assign an interim rate. A final rate was determined at the end of the reporting year on the basis of actual facility costs.

Four states (California, Texas, Utah, and Ohio) reported that they had adopted flat rate systems based on historical cost data inflated annually. Each state requires that facilities report cost data annually so that a rate can be determined prospectively based on the industry's average costs. Both California and Texas reimburse ICF-MR facilities at the 50th percentile rate of all like facilities when ordered from least to most expensive. Utah reported using a cost-based modified flat rate reimbursement system with the modified portion of the rate subject to a facility specific differential which is

primarily based on Fiscal Year 1980 property costs. All other costs, including a portion of the property costs, are averaged into a statewide payment rate based on the mean average cost reported in Fiscal Year 1980 for all privately owned ICF-MRs in the state. Ohio recently began a flat rate reimbursement system to privately operated ICF-MR facilities of eight beds or less.

Research on the advantages and disadvantages of prospective versus retrospective reimbursement has received considerable attention in the nursing home literature (Birnbaum, 1983; Holahan, 1983; Tynan, Holub, Schlenker, 1981; Pollak, 1977). Generally, there have been no consistent differences found in either levels or rates of increase in costs between the two methods. What appear to be more important to cost increases are inflation projection methods and the percentile ceilings on rates. While prospective rate setting systems are considered to contain strong cost containment incentives, the manner in which the rate is established and adjusted can result in very different reimbursement levels across state systems. Obviously, prospective systems with generous inflation adjustments and high percentile ceilings have weaker cost containment incentives than prospective systems with stringent inflation allowances and low limits. Similarly, the inherently weak cost containment incentives in retrospective systems can be offset by low percentile ceilings, administrative controls, and efficiency bonuses.

B. Services Included in Per Diem Rate

Although reasonable cost-related reimbursement is defined in federal regulations, state plans differ greatly in their definitions of routine and ancillary costs, and therefore in the services included in the calculation of facility per diem rates. Among the more significant differences reported by states are the following:

* Thirty nine percent (16 states) may include a resident's day programming outside the facility in their per diem rate;

* Eighty three percent (34 states) may include some combination of physical, speech, and/or occupational therapy services;

* Seventy nine percent (33 states) may include durable medical equipment and supplies; and

* Eighteen percent (8 states) may include prescription drugs as ancillary services in the per diem rate.

These findings suggest that in comparing per diem rates across states it is important to understand the full range of services included in the rate. Comparatively high per diems may not be specifically attributable to the relative inefficiency of ICF-MRs in any given state; rather, they may reflect a broader service mix.

C. Reimbursement Based on Peer Groupings

Some states group facilities by specific characteristics, assuming that such groupings produce similar costs and therefore lead to more efficiency and equity in rate setting methods. It is also assumed that the typical behavior of grouped facilities is desirable; that is, if the typical per diem cost for facilities within a class or group is $55.00, then $55.00 defines an acceptable standard for efficiency of operation within that classification and thus represents the maximum amount that facilities within that grouping will be reimbursed. However, a problem can arise when groupings are based on erroneous assumptions regarding the nature of variation in costs among facilities included in those groupings, and incentives may be introduced which result in facility operators overproducing along the grouping dimensions and underproducing along unrecognized dimensions.

Twelve states (29 percent of respondents) reported that private ICF-MR facilities were grouped for reimbursement purposes based on either facility, geographic, or client characteristics. Eleven states grouped facilities on two or more dimensions. The most common groupings reported by states are as follows:

* level of care (Colorado, Florida, Georgia, Louisiana, Texas, Utah, and Ohio)
* facility size (Kansas, California, Illinois, New York, Louisiana, and Ohio)
* geographic location (California, Illinois, New York, and Nebraska)
* type of ownership (i.e., profit/nonprofit, Nebraska)

Level of care is the most frequently used classification for grouping ICF-MRs for purposes of differentiating their reimbursement rates. The importance of level of care

groupings for rate differences varies, however, because of differences both in state definitions and in the number of facility categories. Most states use some combination of client characteristics and staffing requirements to define differences among ICF-MRs' level of care. States that explicitly group facilities by level of care for payment purposes generally recognize three levels of care. Louisiana groups facilities by seven levels of care.

Four examples of states' approaches to defining levels of care for reimbursement purposes in private ICF-MRs are described briefly below.

Louisiana. Louisiana's rate setting manual describes seven levels of care, though privately operated ICF-MRs are not found at all levels. Level of care criteria for ICF-MRs are based on client age; client behavior; required supervision, medical attention and treatment; and professional qualifications. Level-of-care adjustments affect the "program tier" of a facility's rate and result in seven different budget screens (ceilings). A facility's final rate is the lower of the budget screen, the inflation screen, or the budgeted facility rate.

Florida. Florida assigns one of four levels of care to privately operated ICF-MR facilities: medical, nonambulatory, residential, and institutional. Each level of care varies according to life safety and fire code regulations and the level of dependency of residents. Placement decisions within each level are based on IQ, adaptive behavior, and physical, medical, behavioral, or sensory handicaps of the client. Although four levels are used for ICF-MR placement determinations, only two levels are recognized for reimbursement purposes due to insufficient variations among costs within and across each peer grouping.

Texas. Texas is a uniform rate state where privately operated ICF-MR rates are determined by the facility size and level of care (mild to moderate, moderate to severe, or severe to profound). ICF-MR facilities are assigned clients based on their IQ, adaptive behavior (age specific), need for supervision and treatment, secondary handicaps, and required medical attention appropriate for the facility's level of care designation. All

facilities within each level of care classification are assigned a rate equal to the 50th percentile facility rate in their respective class.

Ohio. In August 1984, Ohio began grouping privately operated ICF-MR facilities of eight beds or less on the basis of level-of-care criteria. Three levels exist, with each level varying by the dependency of facility residents. One level is for facilities with fewer than two-thirds multiply-handicapped residents (multi-handicapped refers to clients with physical and/or behavioral disabilities in addition to retardation). The second level refers to facilities with two-thirds or more multiply-handicapped residents. The third level is assigned to facilities with two-thirds or more multiply-handicapped residents who require 24-hour supervision. Rate differentials apply for each of the three levels.

Cost variation based on facility characteristics is one of the few areas where empirical research exists on residential care for the mentally retarded. Bed size has been an extensively investigated facility characteristic. Generally, it has shown a surprisingly direct linear relationship with facility costs, but size effects diminish considerably when client characteristics, services provided, certification status, and level of staffing are controlled (see Lakin, Hill, & Bruininks (eds.), An Analysis of Medicaid's Intermediate Care Facility for the Mentally Retarded Program. Center for Residential and Community Services, 1985.) Cost function analyses of per diem costs of ICF-MR facilities in the CRCS 1982 facility survey suggest a U-shaped cost curve with some economies of scale noted within relatively large private facilities. The significance of this finding for the reimbursement of private ICF-MR facilities is not clear, since most states group facilities within rather narrow size groupings (e.g., 4-15 beds, 15-35 beds).

There is very little previous research analyzing facility costs by differences in client characteristics, although it is generally well demonstrated and largely self-evident that facility program costs increase along with the level of disability of program participants (e.g., Jones, Conroy, Feinstein, & Lemanowicz, 1982; Mayeda & Wai, 1975; O'Connor & Morris, 1978; Wieck & Bruininks, 1980). As expected, level of disability and associated staffing requirements (e.g., as in the ICF-MR regulations) are related to variation in

facility costs, although the specific measures and statistical importance of these variables vary widely among studies. Geographic location has also been examined, but locational factors have not generally been significant or consistent (Wieck & Bruininks, 1980). Although research on geographic location has had too few observations to adequately control for level of care and facility size, states that employ area differentials recognize greater costs of delivering residential services in high cost areas, especially urban areas.

The already limited body of research for state rate setting policy is further limited because it has not generally been focused on the cost structures of ICF-MRs. Therefore, little is known concerning the influence of facility, geographic, and level of care variables on cost differences within and across state ICF-MR systems. Nevertheless, states are using groupings as a basis for differential payment levels among ICF-MR facilities. States obviously have reasons for including or omitting certain factors from a grouping schema, but they may operate with relatively little concrete knowledge of how these factors might best be weighted in grouping. Furthermore, creating groups of facilities for reimbursement does not assure that the facilities are providing similar amounts or qualities of services, but merely that they are providing their services within relatively similar circumstances. It is possible that high and low cost providers (relative to their peer grouping) are providing a different type of service or a different quality of care not addressed by the grouping mechanism.

D. Case-Mix Adjustments

Whether states group facilities or not, they have other reimbursement policy tools at their disposal to control incentives to under or over produce services. One approach that is of growing interest among federal and state policymakers is the use of case-mix indices that explicitly recognize differences in individual resident care costs. States that use such indices assume that case-mix adjustments accurately measure resource consumption by individual residents and that the level of resource consumption is directly related to the cost of caring for these residents. It is also assumed that these measures promote appropriate care because facilities are not penalized for providing

intensive care to residents with intensive service needs and alternatively that they are not overpaid for the care of residents with less intensive needs.

Five states reported that case-mix indices were used for rate adjustments (Illinois, Nebraska, New York, Oregon, and Ohio). Payment methods based on these systems typically convert client disability, care requirements, or service intensity into monetary terms through point counts or other conversion methods. Variation in this approach generally occurs along the following dimensions:

* Comprehensiveness of the assessment tool. States report use of 3 to 20 dimensions, including adaptive/maladaptive behavior scores, I.Q. scores, notation of secondary handicaps and/or physical disabilities, functional disabilities, and age.

* Reliability of assessment tool. Client scores may be based on the judgment of one or more assessors, and may or may not be supplemented with empirically derived measurement instruments.

* Breadth of assessment. All or a subsample of facility residents may be assessed.

* Frequency of assessment. Facility residents may be assessed quarterly, semi-annually, or annually.

* Cost allocation method. Some states estimate only nursing costs, while others include all direct care staff and therapy costs.

Four of the five states also submitted detailed descriptions of their resident-related reimbursement methodologies. A discussion of these states follows.

Oregon. Oregon annually assesses all facility residents with the Resident Classification Instrument to determine facility rate ceilings for three costs: direct care supervisory staff, direct care staff, and therapy. Residents are classified by level of retardation, physically handicapping conditions (those that restrict activities of daily living), behaviors requiring habilitative intervention, training needs in the areas of functional living skills, and whether a resident is in a vocational training program or employed. Upon completion of a form with the above information noted, the resident's qualified mental retardation professional (QMRP) determines the resident's class using the following criteria (borrowed from the ICF-MR standards for minimum staffing):

Class A = children under six years of age; severely and profoundly retarded residents; severely physically handicapped residents; residents who are aggressive, assaultive, or security risks; residents who manifest severely hyperactive or psychotic-like behavior.

Class B = moderately retarded residents requiring training in functional living skills.

Class C = mild, borderline/normal residents in vocational training programs and adults in employment situation.

Each class is associated with a staff resident ratio or staffing model. Facilities are assigned rates based on their required staffing model.

Nebraska. Nebraska's ICF-MR rates for operating costs are, in part, based on each facility's resident mix. The resident mix grouping is determined by average number of residents in the facility at the end of each month during the reporting period classified according to three levels of client need. Need level is based on a standardized assessment process involving ratings in 10 areas of client adaptive and maladaptive behavior (toileting, hygiene, threatening or violent behavior, disruptive behavior, hyperactive behavior, speech, feeding, dressing, uncooperative behavior, and stereotypical behavior). Each client is assessed annually by three individuals. The average score of the three assessments is used by the Department of Social Services in a mathematical formulation which results in the identification of clients as high, moderate, or low need. Clients under six years of age and clients with severe or profound mental retardation diagnoses are included in the high need classification.

In addition to the three general categories, a special needs allowance is included to weight facilities having clients requiring the highest level or intensity of care. Staffing standards, in combination with the standard wage rates, are used to determine each facility's appropriate personnel costs in each of 19 staff categories. Respective standards are used to determine total personnel costs and are not intended to be required staffing levels for each staff category.

New York. Specific direct care and clinical staffing screens are derived using an algorithm which provides weighted values to client-specific needs. The weighted values assigned to each client-specific need reflect a correlation between the assigned

value/score and a combination of the intensity of need and the type and frequency of activity behavior and/or intervention required. The weighted values are then aggregated into four categories of disability (i.e., "none, mild, moderate, and severe") within several "need" domains. Clinical and direct care full-time staff equivalents (FTE) are derived for each of these disability levels. Variables taken into account to determine facility FTEs include facility size (several groupings), staffing model (shift, modified shift, or live-in), client level of retardation, and client information in three domains of health, life development, and personal/social behavior.

Illinois. The Illinois case-mix system for private ICF-MRs is particularly interesting because it is an adaptation of a "point system" which was originally developed for and is still used by general SNFs and ICFs. The reimbursement of fixed and variable nursing costs in large ICF-MR facilities (i.e., facilities exceeding a bed size of 15) is based on each resident's need for care and the time and type of staff required to provide that care. Residents are assessed in seven functional living areas (e.g., bathing, dressing, eating, mobility, continence, behavior, mental status). They are also evaluated in terms of the frequency and intensity of 22 service needs. Services include medical procedures and devices, specialized nursing, therapies, rehabilitation, and medication. Intensity of service is operationalized in terms of the appropriate staff skill level required to provide these services. Frequency of service is also coded. A resident's overall level of functioning is described as one to four points accumulated in each area of concern. Levels of need are determined and assigned a number of minutes of required staff time. A public health nurse reviews a 50% sample of each facility's residents at 6-month intervals.

Resident assessments are then used to calculate the average nursing cost for each facility. Costs are derived by multiplying the amount of time required for each level of service by the frequency of service, adjusted by the wage rate of the appropriate skill level required to provide the service. Other costs associated with the delivery of nursing care that are assumed to be fixed across residents (e.g., communicating with residents,

transcribing physician orders) are also added to each resident's nursing costs.

Several researchers have noted the problems that have plagued the Illinois point system during its fifteen year evolution. The point system has gone through several refinements to counter charges that it was too expensive, inconsistent, incomplete, and provided disincentives to improve resident health in nursing homes. Its effective use with mentally retarded people has also been questioned because of its primary focus on medical conditions and services more appropriate for elderly patients in SNFs and ICFs.

Ohio. The Ohio patient/resident assessment system was introduced in 1980. Like the Illinois case-mix system, it was originally introduced in SNFs and ICFs and has been adapted for use in Ohio's ICF-MR facilities of size nine or more beds. Each of approximately twenty standards or need areas is subdivided into three or four service indicators representing a frequency or usage (in hours) of services delivered. Standards or need areas are defined for behavior, mobility, medication, self care, habilitation, therapies, nursing services, and other needs. While some service indicators are described in terms of objective and unambiguous terms (e.g., "needs 50 hours of therapy"), the chosen indicator is based on the judgment of reviewers. Each service indicator is then assigned a dollar value based on the following factors:

1) Time required to deliver the service
2) A weighting factor which includes indirect costs
3) Wages for skill level required to provide the service.

Dollar values for each service indicator required by each resident are computed and summed for all patient/residents in each facility. This amount becomes the facility's reimbursement ceiling. The state pays actual facility costs to the ceiling. The costs involved in obtaining accurate, reliable, and timely resident assessment information are reported to have caused some problems with this system's effectiveness.

E. Cost Limits

Cost limits are another set of rate setting policies that states may use to reimburse appropriate, cost-effective care. The problem here, as with the use of case-mix indices, is

the difficulty in defining the quality or outcome of care. This problem is especially difficult for the reimbursement of operating expenses. If a state pays too much for operating costs it may be paying for inefficiency, a higher intensity of care than appropriate, or for more profit or non-care related costs than are considered reasonable. Similarly, if the state pays too little, it may force a reduction in the quality of care or in the amount of care available to residents in those facilities.

Thirty-two states reported using some form of cost limits to control cost increases and to define acceptable levels of efficiency in the delivery of ICF-MR care. Eighteen states (44 percent of respondents) set limits on the facility's total rate. Seven of these states set additional cost limits for every cost center included in the facility rate. Total facility rate limits range from Virginia's, defined so as not to exceed the most expensive public ICF-MR facility rate, to Mississippi's application of the 60th percentile of operating costs for all private ICF-MR facilities.

Among states that limit ICF-MR costs selectively, the specific cost centers affected vary widely. The ease with which specific cost limitations can be administered is an open question. The difficulty lies not in applying the limits themselves, but in the preliminary step of assigning and allocating costs to cost categories. The allocation problem is usually most difficult in small facilities (fewer than 16 beds) where an owner-operator typically has several different duties including administration, housekeeping, and developmental programming. Often many staff members have several sets of duties. In applying differential limits to different cost categories, states are creating clear incentives for providers to allocate costs to the categories with the broadest limits. Since cost allocation in these smaller facilities is more problematic, there exists much more room for gaming the limits. Most commonly mentioned limits were those for the administrative cost center or administrator's salary. Fourteen states mentioned that specific limits were placed on management compensation for chain or multiple home operations. Few states selectively targeted cost ceilings specifically related to resident well being (e.g., food, nursing, therapies). It appears that most states have not considered

it necessary to selectively set higher limits or ceilings as incentives to encourage homes to deliver minimum amounts of direct care and habilitation.

Most states indicated that the use of cost limits has encouraged cost containment in the industry. However, in the absence of cost-function analysis and limited knowledge concerning the relationship between specific program costs and quality of care or outcomes, many states have been forced to use less refined methods of establishing limits and ceilings.

The most common approach to setting limits is to base limits on the historic cost experience of the industry, although the use of the industry's average cost experience as a measure of efficiency has a number of problems. More expensive homes may have residents who are more impaired and who have need of a greater array of services, more elaborate equipment, or a more highly professional staffing component. Conversely, the more expensive facility could also have inefficient administrative and/or program practices, be overstaffed, or have excessive profits.

If historically derived cost limits persist over time, there is nothing to encourage inefficient facilities (which are benefiting) to modify their method of operation. Furthermore, historic cost limits without adjustment for client needs make it difficult for facilities to assume responsibility for the increasingly handicapped residents who remain in public institutions and are now returning to the community.

Many of the states that cap total operating costs have indicated that they recognize these problems and, as a result, are considering moving away from all-inclusive total rate limits. Some states are opting for limiting individual cost centers or specific cost centers to specific dollar amounts or to percentages of the costs of facility groups (based on size, location, level of care, etc.). A few states, in the absence of any ICF-MR specific cost limits, draw upon federal Medicare nursing home guidelines in Health Insurance Manual 15. The trend in more mature ICF-MR state systems has been to set more stringent limits on all cost centers, particularly the administrative and property cost centers.

F. Inflation Adjustments

Inflation adjustments are used to project costs from a base year to some future rate period. With states' increased use of historic cost data and concomitant lengthening of time for establishing a revised base for rate determination, the choice of indices to periodically adjust rates forward can promote greater or lessor cost containment. The selection of inflation indices has very important cost implications for the ICF-MR program. Costs in private ICF-MRs maintaining operation between 1977-1982 increased at a compounded annual rate of 12%, a rate slightly higher than the comparable rate of increase in acute care hospital rooms (U.S. Bureau of Labor Statistics, 1978, 1982).

Based on our survey results, nine states (22 percent of respondents) reported using inflation adjustments to adjust overall facility rates. Fourteen states (34 percent of respondents) used indices to inflate facility operating costs. Most of these states used general indices that are largely independent of the ICF-MR sector and, consequently, unlikely to be significantly influenced by its behavior. The most commonly used indices are elements of the Consumer Price Index (CPI) in combination with area specific wage indices. Several states modify this approach by weighting one or more cost centers or by applying different indices to specific cost centers (Texas, for example, reported the use of twelve different indices). Among the other general indices most commonly reported to inflate all or portions of facility expenses are the Producer Price Index, Implicit Price Deflator for Residential Consumption Index, HCFA Nursing Home Price Index, and the Gross National Product (GNP) Deflator. Fourteen states reported that no general indices are used to inflate facility costs over time.

Very little is known concerning the relationship between various indices and the actual rates of change in the costs of private ICF-MRs. Nevertheless, the choice of index implies very different assumptions about inflationary trends within the industry. For example, CPI rates of change between 1979 and 1982 were one to four percentage points higher than the GNP deflator and as much as 3.6 percentage points higher than the HCFA Nursing Home Price Index (Spitz & Atkinson, 1982, p. 18). As a result, the CPI,

the GNP deflator, and the HCFA Nursing Home Price Index may be increasing faster or slower than the actual rate of increase in prices that ICF-MRs face, and lead to inappropriate payments in either case.

Several states have responded to these problems by developing indices based on historical cost trends in state ICF-MR facilities. ICF-MR specific indices are particularly evident for certain operating expenses such as administrative cost centers. This approach also has problems because it creates an index that is directly affected by industry behavior which may, particularly in states with small private ICF-MR industries, represent inherent incentives to overproduce or raise prices along these indicators.

G. Return on Investment

The increasing presence of private capital in the ICF-MR program presents an additional design issue for state reimbursement policymaking--whether or not to recognize a rate of return on private investment. Federal regulations do not require states to pay a return on investment to privately operated ICF-MRs. Nevertheless, a profit-motivated entrepreneur will invest in an ICF-MR facility only if return on investment exceeds the return in alternative investments; if not, the individual will invest capital elsewhere. It is less likely that non-profit agencies are as sensitive to cash return on investment.

Nineteen states (46 percent of respondents) reported that a return on equity was paid to ICF-MR providers. Illinois and Connecticut paid a return on equity to both for-profit and nonprofit facilities. Eleven other states indicated that the return on equity applied only to for-profit providers; however, in at least three of these states (Massachusetts, South Dakota, North Dakota), for profit facilities were nonexistent at the time of the survey. Rates of return were variously described as a percentage of average equity (10-12 percent) or specific dollar amounts, that is, between $1 and $2 per resident per day.

The decision to pay a return, and the level of return established, depends upon the state's assessment of the adequacy of the ICF-MR bed supply and the attractiveness of the overall ICF-MR rate of payment to private investors. Eleven states recognized

proprietary ownership of ICF-MRs but did not recognize a return on investment. They generally noted that the overall rate was considered sufficient to encourage an adequate supply of privately owned and operated ICF-MR beds. Most states that discourage proprietary ownership of ICF-MRs do so through state licensure laws and certificate of need laws.

H. Efficiency Incentives

Another approach states have taken to encourage cost containment is through the use of efficiency incentives which allow providers to keep all or a portion of the difference between their actual costs and their targeted or retrospectively adjusted rate. Twenty-four states (59 percent of respondents) reported the use of efficiency incentives. Generally, to receive an efficiency bonus, a facility's cost must be below some state established maximum. If facilities are not allowed to keep the entire difference, or a fixed portion of the difference, the amount they receive increases as their savings increase up to some state established maximum. Kansas, for example, has a sliding scale efficiency incentive which amounts to 10 cents per resident per day for facilities at 95 percent of the target rate, and increases up to 50 cents per resident per day for facilities below 55 percent of the target rate.

Some states modify this approach by varying efficiency incentives by individual cost centers, based on a concern that cost reductions may affect the overall quality of care rather than the cost-effectiveness with which a desired quality of care is provided. For example, a state may not want to create an incentive to provide less direct resident care, but may be very conscious of the need to build incentives to contain energy costs. Colorado is an example of a state that applies efficiency rewards only to the administrative cost center. Georgia, in contrast, has variable incentive bonuses for each operating cost center up to a total maximum profit allowance of $1.49 per resident per day.

Due to state fiscal constraints and the recent cost increases in states' ICF-MR programs, efficiency incentives are becoming increasingly popular in state rate setting

methodologies. The long-run effectiveness of these methods in controlling costs in prospective rate-setting states may be diminished, however, because of the widespread practice of rebasing the facility's following year rate on the facility's cost experience in the prior year. The facility that receives an efficiency bonus can be, in effect, penalized for cost containment efforts in the current year because future year rates will be lower.

I. Capital Reimbursement

Because state reimbursement policy largely determines the return on investment available to owners and operators of ICF-MRs, private sector investment is heavily influenced by approaches to capital cost reimbursement. The objective for state policymakers is to design a system that avoids reimbursing ICF-MR owners more than is necessary for capital expenses while, at the same time, assuring adequate access by persons needing services. In a cost related reimbursement system establishing a fair price for capital involves such decisions as determining the value of the facility for depreciation purposes, specifying acceptable interest rates and expenses, and the recognition and treatment of facility sales.

Virtually all states reimburse depreciation (Connecticut and Michigan do not), interest for fixed asset acquisition (Connecticut, Michigan, and New Hampshire do not), working capital interest expense (Georgia, Michigan, Mississippi, Nevada, New Hampshire, and South Carolina do not), and the purchase price of the facility when it is sold (Connecticut, Michigan, New Hampshire, Indiana, Massachusetts, Minnesota, and Utah do not).

As a result of the financial scandals in the nursing home industry in the early 1970s, many states have established policies to restrict provider control over capital cost manipulations.[8] Indirect limits exist in the few flat rate systems that include the value of property in determining the uniform rate (e.g., Texas). States directly control provider manipulation by limiting the value of the facility, by establishing ceilings on allowable interest rates or expenses, by limiting gains on facility sales, or by placing a per-bed dollar limit on capital reimbursement.

All jurisdictions except the District of Columbia value a new facility at its historic cost, either from the date of construction or from the date of last sale. States may freeze this value over the life of the facility or update it periodically. Construction indices (e.g., the Dodge Construction Index) are used in some states as the mechanism for updating a facility's value.

States that recognize facility sales and use of the purchase price of facility for purposes of reimbursement most commonly limit a facility's value by the market value (9 states), the depreciation-replacement cost value (4 states), or the lower of some combination of the market value, depreciation-replacement cost value, and/or appraised value (13 states). Utah does not reimburse the purchase price but instead reimburses a weighted amount which incorporates a historic value equal to the property reimbursement of like facilities on March 27, 1981 plus the facility's value in the year of acquisition. Colorado, in contrast, uses a historic cap.

Seven states reported that dollar limits were placed on per-bed investment. As of July 1983, most states limited investments to approximately $25,000. Dollar limits ranged from a low of $20,100 in Indiana to a high of $29,100 in Minnesota. These states usually adjust the per-bed limit to reflect changes in market conditions or construction costs.

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[8]More recently, Congress has enacted policies to also restrict capital cost manipulations. Section 2314 of the Deficit Reduction Act applies new capital cost limits to long-term care facilities. The value of a facility for depreciation purposes is now limited to the lower of the purchase price or the value of the acquisition price of the owner of record on July 18, 1984. This policy limits the available depreciation to a new owner, especially if the facility in question was purchased by the existing owner several years prior to 1984. The law was effective on October 1, 1984 and applies to the owner of record on July 18, 1984. Regulations implementing this provision are currently being drafted by HCFA.

States also take a variety of approaches to establishing and limiting allowable interest charges. Most states recognize interest expenses for fixed asset acquisition and working capital. Nineteen states also recognize facility interest expense attributed to negative equity. About half of the respondents to the survey (19 states) reimburse actual interest expense at the prevailing market rate. Of these, three states establish the aggregate amount of interest expense that is allowable and the other fourteen states reimburse interest expenses up to a limit. Limits are most often established as specific percentages (ranging from 11 percent to 13 percent) or as percentile ceiling representing the average or median interest rate of all like facilities in a previous year.

Several states have also instituted policies to discourage sales and/or to limit a seller's gain from the sale of his/her facility. The most popular approach is the use of a depreciation-recapture provision, a method by which states require compensation for all or a portion of reimbursed depreciation. Generally, this is an amount to be paid to the state by the new owner. Fourteen states use depreciation recapture provisions with the majority of these states decreasing the amount of depreciation replacement over time to encourage longer periods of ownership. Indiana and Nebraska are examples of states that discourage property transactions by limiting a change in facility value for sales purposes (every eight and five years respectively). This is done independently of whether or not property transactions occur over this period. Finally, as was mentioned earlier, seven states do not recognize the sale of a home for capital investment purposes.

J. State Case Studies

State reimbursement methodologies are best viewed in terms of state priorities, policies, and goals of the entire residential system for mentally retarded people. Center staff contacted survey respondents and other previously established key contacts in several states to answer specific questions regarding incomplete responses to questionnaire items as well as to supply additional information on each state's residential care system. Long and often frequent conversations were initiated by staff to request and discuss information about the past and future development of residential services,

reasons for most recent changes in the reimbursement methodology, the development of non-Medicaid alternative residential care, and current state policy initiatives, litigation, and moratoriums on bed construction. As a result of these discussions, six states-California, Illinois, Minnesota, New York, Pennsylvania, and Texas—were selected for a more indepth review of rate setting practices.

Table 2 presents the total number of mentally retarded persons residing in ICF-MR facilities, the percentage of ICF-MR residents who live in privately operated ICF-MR facilities, and the cumulative number/percentage of the nation's total number of ICF-MR residents represented by these states. The percentage of ICF-MR recipients in privately operated facilities ranges from a low of 17 percent in New York and Pennsylvania to a high of 65 percent in Minnesota. As a group, these states serve nearly half of the nation's ICF-MR clients and account for more than 65 percent of ICF-MR expenditures nationwide. As a result, their reimbursement policies and rate-setting methodologies have a significant impact on federal spending for ICF-MR care.

Table 2

ICF-MR Residents on June 30, 1982
U.S. Total = 138,738

State	No. of ICF-MR Res.	% in Priv. Op. ICF-MRs	Cum. No. of ICF-MR Res.	Cum. % of U.S. Total ICF-MR Res.
New York	15,577	17	15,577	11%
Texas	13,959	26	29,536	21%
California	9,726	25	39,262	28%
Pennsylvania	8,598	17	47,860	35%
Illinois	7,834	47	55,694	40%
Minnesota	6,899	65	62,593	45%

Table 3 presents data on each state's use of privately operated ICF-MRs of various bed sizes. Seventy percent of New York's residents of privately operated ICF-MRs and 54% of Minnesota's residents of such facilities live in facilities with 15 or fewer beds. In

contrast, none of California's residents and only 2% of Illinois' clients in privately operated ICF-MRs live in small residences. Almost three quarters of residents in privately operated ICF-MRs in California and Illinois and two-thirds of Pennsylvania's residents live in facilities with bed sizes between 76 to 300. Finally, 16 percent of New York's privately operated ICF-MR residents and 13 percent of Illinois' residents still live in privately owned ICF-MRs with more than 300 beds. Thus, these states vary considerably in the composition of privately owned facilities that are participating as ICF-MR providers.

Table 3

Number and Percent (in parenthesis) of Residents in Privately Operated ICF-MR Facilities by Facility Size

State	1-6	7-15	16-75	76-300	301+	Total
NY	332(12)	1,567(58)	239(9)	112(4)	435(16)	2,685
MN	652(15)	1,760(39)	1,366(30)	704(16)	0	4,482
PA	75(5)	199(14)	244(17)	952(65)	0	1,470
TX	0	610(17)	1,229(34)	1,744(49)	0	3,583
IL	0	64(2)	492(14)	2,608(72)	480(13)	3,644
CA	0	0	609(25)	1,841(75)	0	2,450

Table 4 illustrates the percentage of mentally retarded residents in long-term care who reside in ICF-MRs and the number of facilities licensed to provide residential services to mentally retarded people in each of six facility types (most ICF-MR facilities would be represented under group home types). Immediately it can be seen that Texas and Minnesota appear to offer few, if any, residential alternatives to the ICF-MR for mentally retarded persons. Alternatively, New York and California provide a greater diversity of residential options, particularly through the use of family or foster care settings. Similarly, Pennsylvania has developed a broad range of semi-independent living alternatives and Illinois also utilizes a system of personal care homes and foster care homes. The availability of a broader continuum of residential settings for the mentally retarded people is important for state rate-setting policy because it offers substitute placement options to ICF-MR care and provides an intricate set of financing choices due

to the multitude of non-Medicaid funding sources involved—SSI payments, HUD grants, family contributions, and other state and local funds.

Table 4

Number of Residential Facilities and Proportion of Residents in ICF-MR Beds in 1982

State	Spec. foster	Small grp. home	Large grp. home	Semi-Ind. living	Board & care	Per. care	Spec. nurs.	% Res. in ICF-MR pub. & pri.
CA	1,729	740	152	9	64	127	32	36
PA	237	803	65	56	1	5	9	55
NY	1,556	690	66	23	5	40	15	62
IL	91	72	89	18	5	20	26	61
TX	0	112	70	6	0	1	7	94
MN	2	251	44	14	0	1	6	98

Finally, the reimbursement of ICF-MR care also reflects the maturity of the state's ICF-MR program within the total continuum of residential care for mentally retarded persons. Mature ICF-MR systems have fully developed the ICF-MR component of their residential care system and, as a result, are expected to have different policy emphases than states in the early phases of expanding bed capacity of privately operated facilities. Mature states are less concerned with growth incentives and more concerned with stabilizing the level and quality of the bed supply in the state. They are also likely to become more concerned with cost containment and the efficiency with which care is delivered. As we shall see, many of the case study states reflect these changes in policy emphasis as their community-based ICF-MR programs have grown.

1. New York

Between 1977 and 1982, New York state experienced a five percent decrease in its residential population. In 1982, 62 percent, or 15,577 persons resided in ICF-MRs. Of these, 83 percent—12,892 persons-lived in government facilities. In 1977, 70 percent (18,601 beds) of all beds were ICF-MR certified. However, ICF-MRs represented only 14 percent of all long-term care facilities for mentally retarded people in 1977.

Table 5

Change in Proportion of Beds ICF-MR Certified

New York: 1977-1982

	Tot. Res.	Tot. ICF-MR Res.	% ICF-MR
1977	26,550	18,601	70%
1982	25,317	15,577	62%
Net change	-1,233	-3,024	-12%

As a result of deinstitutionalization efforts and the closing of Willowbrook state hospital, the number of public ICF-MR beds decreased by 5,500 over the past five years. The number of private nonprofit community ICF-MR beds increased dramatically over this period, going from approximately 200 in 1977 to nearly 2,700 in 1982.

In 1979 New York had no ICF-MR facilities with fewer than 30 beds. An ambitious program began in 1980 to create small ICF-MR facilities. Currently, most ICF-MRs coming into the system are small facilities, comprised of 15 beds or fewer. However, by 1982, small ICF-MRs still represented less than ten percent of all beds in the state.

Reimbursement for ICF-MR care was initially a budget-based system; the state agency would take a request to the state legislature who would then determine the appropriate budget for the agency to run the system. This budget was then allocated to each facility as the agency saw fit. In 1982, a new rate-setting system for ICF-MR care was developed. New York now assigns facility rates prospectively based on historic cost data which are adjusted annually for inflation. Screens and cost limits are used to limit costs in four cost categories: administration, support, clinical, and direct care. Currently, the screens are set at the median facility cost plus five percent in each cost category. Groupings are used for rate ceiling determination based on location (New York City, surrounding counties, the rest of the state) and facility bed size (3-5, 6-9, 10-14, 15-19, 20-24, and 25-30). Strong efficiency incentives are available to facility operators in

that if they do not spend up to the current rate, they keep the entire difference.

New York facilities are both leased and owned. No return on equity exists. Unless otherwise approved by the Commissioner, any increase in costs created by the sale or purchase of a facility is not allowed for purposes of reimbursement. All property transactions and leases are reviewed by OMRDD, the Division of Budget, and state agency real property personnel. No proprietary ICF-MRs exist in New York, but not because of statutory prohibition. One rate setting expert described the lack of anticipated profitability to be a possible cause.

Straight line depreciation is allowed over 25 years, based on the value of the facility at the date of construction or date of last sale. The state establishes a funded depreciation account and pays into it for the facility. Interest expense attributed to negative equity and working capital is reimbursed up to a ceiling that varies by bed size. The actual interest expense incurred for fixed asset acquisition is reimbursed at the prevailing rate.

In 1984, the state took several initiatives to tighten reimbursement for ICF-MR care. First, the state decided to index rates forward biannually rather than annually. In addition, limits based on certain support and clinical costs (notably fringe benefits) were set at one percent higher than each facility's previous year costs rather than the median industry cost plus five percent. New York further refined its system by incorporating a case-mix adjustment to the rate system (see earlier discussion).

Several respondents felt that the new reimbursement reforms instituted since 1982 have enhanced both cost containment and program goals. Rate increases from August 1982 to March 1985 for facilities which have not undergone any change in program structure totaled 8.8% (less than 3 percent annually). In contrast, during the same period, the official New York State Department of Health trending factors totaled 21.8% or 7.3% annually.

Several respondents noted the fiscal and programmatic advantages that community-based ICF-MRs have over non-Medicaid residential alternatives. These advantages

include the constancy of the funding source, the favorable federal Medicaid match, state assistance given to ICF-MR operators during the start up phase, and the availability of lease funding by the state. These advantages are particularly evident in New York City where low reimbursement rates are making it difficult to recruit providers for residential alternatives such as family care homes. New York's OMRDD is currently examining the feasibility of increasing rates to encourage a broader continuum of residential alternatives for mentally retarded people who live in the city.

2. Texas

Texas served nearly 15,000 mentally retarded people in its long-term care system in 1982. Almost 14,000 of these residents--94 percent of all placements—were in ICF-MRs. State institutions/schools and other government operated facilities made up 10,376 (74 percent) of the states ICF-MR beds, while private for-profit and private nonprofit facilities accounted for another 2,523 and 1,060 beds, respectively. The largest number of community facilities serve between seven and 15 clients; however, in 1982, the Texas Board of Human Resources passed a six bed or less rule which no longer allowed ICF-MR operators to expand bed size past six nor allowed potential providers to build facilities with more than six beds.

The table below provides data on the growth of Medicaid participation among mentally retarded people in Texas' residential care system. Between 1977 and 1982, while the total number of residential placements declined slightly, the number of ICF-MR placements grew by 27 percent. Almost two-thirds of this growth was in private for-profit facilities.

Table 6

Change in Proportion of Beds ICF-MR Certified

Texas: 1977-1982

	Tot. Res.	Tot. ICF-MR Res.	% ICF-MR
1977	15,763	10,486	67%
1982	14,906	13,959	94%
Net Change	-857	+3,413	+27%

Texas originally paid for ICF-MR care on a facility-specific retrospective cost basis; each home was paid for the costs of the care they provided their residents. As a result of the rapid growth of the ICF-MR program Texas changed its reimbursement system in 1981 and adopted a uniform rate structure that was adjusted annually by the sum of the median costs in four ICF-MR cost centers—patient care, dietary, support, and administrative. Twelve indices, including the nonprofessional wage index, the implicit price deflator for personal consumption expenditures, and portions of the Consumer Price Index are applied to operating costs to develop an annual rate of increase or decrease for all facilities in the system. During the most recent rate year, for example, a 7 percent inflation factor was applied to the median costs in each cost center. Providers whose costs fell below the median could keep the difference. Providers with costs above the median would only be reimbursed up to the median cost limit.

Texas also considers client characteristics in setting rates for ICF-MRs. Private ICF-MR facilities are grouped for rate determination based on facility Class I, IV, or VI. These classes reflect the severity of retardation, adaptive behavior limitations, and secondary physical or behavioral problems of clients served. Texas has published Level of Care Criteria to be used as guidelines for client placement in ICF-MR facilities of each class. No further allowances are made for hard-to-place clients.

Straightline depreciation of property costs is allowed based on a useful facility life of 40 years. When sold, a facility's purchase price is recognized with no limitations

except that imposed by the flat rate system. No depreciation-recapture provision exists. All interest expense for fixed asset acquisition and working capital is reimbursed within the confines of the flat rate system, as well. Lease expenses are allowed for purposes of reimbursement; however, no limits or requirements for minimal duration exist.

Texas is not under any court order to deinstitutionalize; however, there currently exists a plan to implement waivered services and place institutionalized persons in community facilities. Texas is using a comprehensive services model based on the Nebraska ENCOR Model. Few non-Medicaid funds are spent to develop residential programs, nor are there plans to do so. Those non-Medicaid facilities that do exist are generally large group homes funded through multiple sources and operated through a regional mental health/mental retardation center or state school outreach program.

3. Pennsylvania

In 1982, 55% of Pennsylvania's approximately 15,500 mentally retarded residents of long-term care facilities resided in ICF-MR facilities (represents 6% of facilities). Eighty-three percent of all ICF-MR residents lived in one of Pennsylvania's state-operated facilities. The remaining 17% resided in small, for the most part nonprofit, community facilities. While the number of long-term residential care beds for mentally retarded people declined by approximately 7% from 1977 to 1982, the number of residents living in ICF-MR facilities of all sizes increased by 34% during that period. The sharpest increase, nearly 5-fold, occurred in the number of small (size 1-6 and 7-15) community ICF-MR beds.

Table 7

Change in Proportion of Beds ICF-MR Certified

Pennsylvania: 1977-1982

	Tot. Res.	Tot. ICF-MR Res.	% ICF-MR
1977	16,705	6,436	39%
1982	15,567	8,598	55%
Net Change	-1,138	+2,162	+16%

The current reimbursement methodology for private (community) ICF-MRs has been in effect since 1980. Previous to changes occurring at that time, community ICF-MRs were reimbursed in the same manner as state ICF-MR facilities. Reimbursement now is based on actual facility costs limited by an approved budget submitted by providers prior to the current rate year. Facilities are not grouped for rate or cost ceiling determination.

No indexing of costs occurs. Limits are used to control the administrative cost center (13% of net total budget) and salaries and benefits of staff (wage is limited to that of workers in similar positions). Currently, operators are allowed no profit allowance, return on equity or efficiency incentive (profits are made only as part of administrative cost center).

The state reimburses all actual interest expense attributed to negative equity and working capital interest. It also allows straightline depreciation and recognizes the purchase price of a facility for purposes of reimbursement when a facility is sold. A proposed system will limit the purchase price by the fair market value. No depreciation-recapture provision exists. The state ended construction of new facilities in 1980 due to the high cost of construction, so all facilities coming into the system are rehabilitated. Lease expenses are also allowed for purposes of reimbursement but are subject to a fair-rental appraisal. A rate exception process exists for special client or service needs.

In addition to ICF-MR facilities, Pennsylvania has encouraged the growth of small community living alternatives. Almost 45 percent of Pennsylvania's mentally retarded

population reside in non-Medicaid residential living alternatives. Non-Medicaid community living alternatives (CLAs) are reimbursed in one of two ways based on the decision of county mental health/mental retardation administrators. Unit of service reimbursement is a payment made per unit of service delivery (resident day) regardless of cost or quality. Within this system, there exists an incentive to contain costs only if the fee for service is reasonable, based on competitive constraints, and quality is regulated. Pennsylvania is introducing provisions into the system to deal with cost containment and quality, making the system more viable. Program funding reimbursement of non-Medicaid facilities also exists. Providers negotiate a budget in advance based on actual costs. A settle-up occurs for under or overpayment. Neither "unit of service" nor "program funding" results in payment to providers for therapies, day programs, or doctor/hospital expense, though some facilities are allowed to include transportation costs to and from a day program and 24-hour nursing services in their residential rate. Neither system places limits on costs, indexes costs, allows explicit profit or return on equity. The "unit of service" methodology does allow providers to keep any money not spent. Interest expense and lease expense are reimbursed. Depreciation of a facility is not recognized for purposes of reimbursement, nor are facility sales. States reimburse working capital interest expense when state grant payments are not made in a timely manner. No exceptions process exists to deal with special client or service needs.

The growth of community residential services for mentally retarded people has been a result of much litigation beginning with Halderman vs. Pennhurst (1974) and culminating with a series of consent decrees mandating the improvement of institutional environments and care, as well as the development of quality treatment environments in the community. As part of its efforts to deinstitutionalize, Pennsylvania has applied for six waivers under Section 2176 of P.L. 97-35 of the Omnibus Budget Reconciliation Act of 1981 to provide noninstitutional long-term care services in the community. Two of the waivers are currently in effect and affect nearly 600 persons.

Over the past decade, mental retardation expenditures in Pennsylvania have almost quadrupled, rising from $126.7 million in fiscal year 1971-1972 to $486.6 million in fiscal year 1981-1982. Outlays for the operation of state residential centers have increased by 191 percent over this same period (from $100 million to $291 million, respectively). The cost-related budget review system for reimbursing ICF-MRs has been attributed by some as contributing to this cost spiraling by allowing relatively generous incremental rate increases to the "most persuasive" providers. The state is now considering changes in its reimbursement rule for ICF-MR care to moderate these inflationary aspects of the budget review system. Essentially, the proposed system will apply an annual inflation factor to facility-specific costs but provide profit incentives for efficient providers.

4. Illinois

Eighteen percent of Illinois' 321 residential facilities for mentally retarded people (61% of residents) were certified ICF-MR in 1982 (57 facilities). Fourteen of the ICF-MRs were public institutions housing 4,190 individuals; the remaining 43 were privately operated and housed 3,644 people. Only 16 small (size 15 or less) ICF-MRs were operational in 1982, though 20 more were under construction. Most ICF-MR facilities in Illinois ranged in bed size from 100-150. The 264 non-Medicaid residential facilities included foster care, residential schools, community living facilities, and supervised apartments.

Between 1977 and 1982, the percentage of mentally retarded people residing in group homes, size 1-15, increased from 0.5% to 3.3%, and those in large institutions, size 16 and over, decreased from 81% to 75% of total residents. Although the total number of mentally retarded persons in residential facilities in Illinois decreased slightly between 1977 and 1982, the number of ICF-MR beds increased by 2,993 (2,012 in publicly-operated facilities, 981 in privately operated facilities).

Table 8

Change in Proportion of Beds ICF-MR Certified

Illinois: 1977-1982

	Tot. Res.	Tot. ICF-MR Res.	% ICF-MR
1977	13,398	4,841	36%
1982	12,888	7,834	61%
Net Change	-510	+2,993	+25%

The current ICF-MR reimbursement system is a prospective payment system that groups facilities into 11 geographical Health and Service Areas. All ICF-MRs with 15 or fewer residents are grouped separately from larger ICF-MR facilities for the purposes of rate determination; however, the thrust of ICF-MR services has been, until recently, to provide care in large facilities. Costs are inflated annually by the Dodge Construction Index for capital costs; CPI components for are used to index wages, utilities, and supplies, and the producer price index is used for food. A field audit is conducted on 20% of the facilities each year, a desk audit on the remainder. Estimates of how many adjustments occurred due to the audit were unavailable.

Cost center percentiles for each geographical group are calculated each year from cost reports submitted by individual facilities. Reimbursement is limited to the 50th percentile for all cost centers except support costs which are reimbursed up to the 60th percentile and property costs which are based on historic cost updated by the Dodge Construction Index. If a facility's support costs are at or above the 50th percentile but below the 60th, the facility will be reimbursed at actual costs plus 50% of the difference between its costs and the 60th percentile.

Providers are also allowed additional amounts if annual licensure surveys show their facilities meet certain standards. This bonus is related to a facility's quality of care as measured by an absence of survey violations and a top score in the "quality of care incentive survey". Limits on top managers' salary costs are set at the 90th percentile of

updated salaries paid to nonowner administrators for homes of that size and location group.

Providers are allowed to include physical therapy, speech therapy, occupational therapy, transportation, and nursing services in the residential rate. Physician/hospital and day programs outside the living unit are billed separately. Program and nursing costs are grouped separately for ICF-MRs serving fewer than 16 clients.

A point assessment of needs is employed in Illinois to determine reimbursement rates for clients with special program or nursing needs. The assessment was developed for geriatric facilities which are grouped with ICF-MRs for rate setting purposes. Because the assessment deals primarily with medical needs and is not felt to be successful at measuring nonmedical needs such as behavior problems, it is not generally applicable to the mentally retarded population unless they are medically involved.

Straightline depreciation on fixed assets is allowed for purposes of reimbursement based on historic cost (latest sale or construction prior to July 1, 1977). This cost is updated annually using the Dodge Construction Index. If a sale occurs, the undepreciated basis of the seller multiplied by the construction cost index is considered the value of the home. Therefore, the new owner would receive essentially the same rate as the old owner. Interest for fixed asset acquisition is reimbursed at the prevailing rate to a ceiling of 125% of the prevailing mortgage rate at the time of the loan. Two months of working capital is also reimbursed.

The Illinois Department of Mental Health/Mental Retardation has recently licensed non-Medicaid group homes with eight beds or less. These group homes will be partially funded by the Medicaid 2176 waiver for community services. Eighteen community residential alternatives (CRAs) presently exist; they serve 110 residents. Most facilities of this type are nonprofit operations that serve a population quite similar to the population of small ICF-MRs. Waiver funds are also being used for the Home Individualized Program, a residential program which houses two children or adults in homes.

The reimbursement system described in response to our questionnaire was effective as of January 1, 1982. At the end of 1982, Illinois froze ICF-MR rates to contain costs; this freeze was effective until July of 1984. State officials felt that this action would not cause major budgetary problems for providers because of an increased efficiency incentive and "slack in the system". The rate freeze did not act as a deterrent to bed construction either, as several ICF-MRs, size 15 or less, were started during that period.

5. California

In 1982, California's residential system for mentally retarded people was composed of 27,000 people. Approximately 10,000 of these individuals occupied ICF-MR certified beds (1% of facilities). Seventy-five percent of ICF-MR beds were located in large state-operated facilities. The remaining 2,500 beds were found in the community as large private for-profit or large private nonprofit ICF-MR facilities.

Table 9

Change in Proportion of Beds ICF-MR Certified

California: 1977-1982

	Tot. Res.	Tot. ICF-MR Res.	% ICF-MR
1977	26,179	0	0%
1982	27,066	9,726	36%
Net change	+887	+9,726	+36%

The total system grew by three percent from 1977 to 1982. In addition to state institutions becoming ICF-MR certified, all growth in the private ICF-MR industry occurred since 1977. Private ICF-MR facilities were generally larger than 32 persons, and most were in the "76-150 residents" size range. In other words, California has not used the Medicaid system to supply small, home-like environments to its mentally retarded population. Nearly 65% of all mentally retarded people living in residential facilities resided in non-Medicaid family homes or small group residences. A scattering of personal care homes, board and care homes, and non-Medicaid nursing homes are

available to this population, as well.

The non-Medicaid reimbursement system is loosely controlled. It is a flat rate system based on cost reports (supposed to be annual, but is not) of facilities of certain types and sizes and geographic locations. One auditor thought that the in-the-field auditing, when it occurred, was done on a one percent sample basis. Inflationary increases were sometimes applied—not regularly—and depended on the legislature—not an index.

ICF-MR facilities are also reimbursed using a flat rate system. Rates are decided prospectively based on annual cost report data. ICF-MR facility cost reports are arrayed within several groupings of size and geographic location. The median cost in each group is chosen as the rate after the adjustment for inflation is made on each cost category. The median rate is an overall rate. Classification of expenses among cost centers is done according to California reporting standards. Indexing is done frequently (monthly) and based on the California CPI and U.S. Producers Price Index.

Approximately 15% of facilities are audited annually in the field. Auditing is important in flat rate cost-based systems because of the incentive to increase "book" costs through disguising profits as costs without increasing real costs. Auditing in California usually results in an additional rate adjustment (downward) of three percent. The nursing home accounting guidelines (HIM15) are used to limit certain costs, particularly administrator salaries and leaseback arrangements.

Several state respondents indicated that the current system provides the potential for property manipulations by providers. New homes are valued at historic cost (date of last sale), and the purchase price of a facility is recognized (limited by the assessed value) when sales occur. The actual interest expense to acquire fixed assets is reimbursed at the prevailing rate. The weakness in this system is that no depreciation recapture provision exists. This provides incentives to owners to leverage their investment, renovate the facility (even if renovation is unnecessary) and sell at a higher price. Still, with the scrutiny of in-field auditing and the flat rate system, many officials felt that, overall, capital costs are controlled. Annual rate increases since the 1980-1981 revisions of the

reimbursement methodology have been around two percent per year.

Leasing may be the preferred method of operation for ICF-MRs in California. Except for reasonableness, there are no limits on lease payments and no requirements that leases be of a minimum duration. State officials were unable to provide more detailed information on the extent and costs of leasing ICF-MRs in the community.

Some persons at the state level feel that non-Medicaid facilities are far easier to operate because they require little in terms of provider accountability or cost reporting. On the other hand, the rate may not always be adequate, particularly for the small provider. California is seeing the buying up of independently-operated Medicaid facilities, creating large chain operations. California's ICF-MR facilities can really be characterized, however, as nursing homes. Many of the particulars on reimbursement of ICF-MRs come from the federal nursing home guidelines. Trafficking was cynically mentioned as a possible problem; however, it was felt that the current flat-rate system curbs these problems. Though there are undoubtedly some providers who make large profits, overall, system-wide costs have been contained.

6. Minnesota

In Minnesota, the mentally retarded population of state hospitals declined to approximately 2,400 at the end of 1982 from a high of 6,100 in 1963 (Office of the Legislative Auditor, 1983). Prompted by the Welsch Consent Decree (1980), the state has committed itself to reduce further the number of state hospital residents to 1,850 by 1987.

While the population of state hospitals continues to decline, the total number of mentally retarded people in small (primarily size 1-6 and 7-15) community ICF-MR facilities increased steadily causing the total number of persons in all long-term care facilities (both Medicaid and non-Medicaid) to have increased, as well, from 6,182 in 1977 to 7,069 in 1982.

Table 10

Change in Proportion of Beds ICF-MR Certified

Minnesota: 1977-1982

	Tot. Res.	Tot. ICF-MR Res.	% ICF-MR
1977	6,182	5,268	85%
1982	7,069	6,899	98%
Net Change	+887	+1,631	+13%

The 6,899 persons living in over 300 ICF-MR facilities (97% of all long-term care facilities for mentally retarded people) represent a far greater state percentage than the national average of 59% of residents and 12% of facilities. Approximately 55% of Minnesota's ICF-MR residents of privately operated facilities live in for-profit facilities. About 20 providers out of a total of 150 own facilities with a capacity of nearly one-half of statewide capacity. The largest provider operates 27 facilities with a capacity of 520. The current reimbursement methodology does not limit (or limits are easily bypassed) the number of homes (and/or beds) one provider can own and/or operate.

Though it is estimated that 10% to 20% of current ICF-MR residents could live in Minnesota's semi-independent living facilities, these and other alternatives to ICF-MR facilities are not widely available. Alternatives, though far less expensive overall, are more expensive to local governments. The home and community-based waiver authority enacted in 1981, however, may allow the states to eliminate some of the fiscal and administrative disincentives that have discouraged the development of less restrictive and less expensive services at county and state levels. Minnesota is currently operating with a waiver to develop non-ICF-MR residences for its institutionalized population.

In Minnesota, the federal government pays approximately 52% of Medicaid-funded services, while the state government pays 45% and local government pays 4.8% (State Health Planning & Development Agency, 1982). Private ICF-MR services have become a growing part of the state Medicaid budget-in 1982 they accounted for nearly the same percentage of Medicaid expenditures as state-operated facilities (9% and 11%,

respectively). In 1984, as many states are undeniably pursuing major priorities in community services development, only Minnesota, Nebraska, and Colorado have achieved spending parity (all services) between the public and private service sectors. Several other states, notably Florida, Rhode Island, Montana, New Hampshire, Vermont, Ohio, and Michigan, will achieve spending parity in the near future (Expenditure Analysis Project, 1985).

Recent reports have recommended that the Minnesota Department of Human Services increase the availability of residential alternatives to community ICF-MRs, encourage facilities to serve more dependent clients, and limit development of new group homes. There is currently a moratorium on the development of new ICF-MR beds. Revisions in Minnesota's reimbursement rule for ICF-MR facilities were designed to deal with the other priorities. The old reimbursement methodology was based on a prospective per diem established by the Department of Public Welfare after examining each facility's reported historic costs and predictable cost changes reported each year by providers. Higher uniform rates were routinely requested and granted. Although the rule required consideration of licensing and program requirements in setting rates, it did not link rates to residential characteristics or program quality and discouraged providers from making the changes needed to serve more dependent clients. Recent caps imposed on annual per diem rate increases have not allowed providers to cover costs of added staff-enriched programs or improved physical facilities needed for large numbers of state hospital admissions with behavioral disorders. Instead, reimbursement rates were set on a cost plus profit basis.

Certain provisions of the old rule made it relatively easy for providers to develop new facilities. The rule did not require a minimum capital investment, did not limit reimbursable interest rates on debt, and did not limit the initial per diem rate. In fact, after a first rate year, a provider typically sought and received a retrospective settle-up rate that resulted in a revised per diem that was 38% higher than the rate seen during the review process and 22% higher than the interim rate. It also paid an earnings

allowance based on presumed equity or on minimum cost of capital with allowance for each resident day and all disallowed interest expense, bearing no relationship to a fair return on actual capital invested. It discouraged provider investment and drove up costs. (When facilities are heavily debt financed, as many are in Minnesota, property costs increase, and the flexibility to deal with possible reductions in occupancy or Medicaid reimbursement is limited.)

Minnesota's previous system provided both a cap (10% until June 30, 1983) and, recently, a temporary reduction in reimbursement to Medicaid providers. Both were effective ways of limiting the state Medicaid budget, but because rate caps affected facility revenue across the board, they may have hurt an efficient provider more than an inefficient one and cause heavily-indebted facilities to face negative cash flows.

Minnesota made major changes in its reimbursement rule effective in January of 1984. A temporary injunction against it brought by a judge at the request of the state's ICF-MR operators was denied.

The new rule provides cost-containment incentives while promoting sound management practices. For instance, in the area of operating costs, the new rule indexes costs using independent indicators of cost changes (CPI) rather than a facility's own projections. The new rule establishes a series of limits on top management compensations. It also provides an efficiency incentive (100% of savings) to reward efficient providers rather than asking providers to return all unused operating funds; however, the base for next year is adjusted down by 50% of the efficiency savings. The new rule further limits interest rates, expense, and indebtedness to encourage sound management by discouraging refinancing at high interest rates while rewarding refinancing at low interest rates. The new rule requires providers to fund depreciation and gives an allowance for capital loan reductions, thereby improving the stability of the industry. Reimbursement for working capital interest expense is being phased out under the rationale that a mature facility should have accumulated sufficient cash reserve to obviate the need for short term borrowing. Leasing expense has been limited to the costs

of ownership; again providing incentives for sound management practices. The state legislature has imposed an overall rate limit of five percent increase over the last year's incurred costs. The new rule also controls the cost of services provided by related organizations in order to prevent inflation of costs which may result from transactions which are not conducted at arms length.

V. Conclusions and Recommendations

A. Policy Implications

State approaches to the payment for ICF-MR care in private facilities reflect an explicit or implicit set of objectives and consequences for the cost, accessibility, and quality of residential care for mentally retarded persons. Reimbursement mechanisms that fail to encourage efficiency often can lead to excessive profits and/or a greater level of expenditure than is necessary for the quality of care desired. While the impact of ICF-MR reimbursement policy on the quality of care is more indirect, reimbursement levels must be sufficient to enable reasonably efficient facilities to meet the necessary costs of care or the result will often be a lower level of quality than is acceptable to the state or the community. Inadequate reimbursement levels also affect accessibility to care because operators may refuse to admit heavy care clients or may not expand the bed supply to meet increased needs for ICF-MR placements.

Although reimbursement policy alone cannot achieve all these objectives, the incentives inherent in individual state payment systems will likely represent a powerful influence on states' ability to achieve their aims. This section examines some of the more significant incentives inherent in state systems and summarizes the implications of these incentives for containing costs and modifying system growth while, at the same time, enhancing the quality of care in state private ICF-MR programs.

At the outset of this analysis, it is important to recognize that the goals of cost, access, and quality often conflict, and that the aspects of a particular system that appear to be deficiencies under one set of objectives may contain many advantages under another. Also, a complete analysis of the efficacy of state policy in each of these areas must examine particular state reimbursement systems in the context of the strengths and weaknesses of other policy instruments, such as certificate of need programs and standards for quality assurance and enforcement.

1. Cost Control and Efficiency.

Table 11 provides a summary of the general system design of state ICF-MR payment mechanisms, as well as the types of peer groupings and reimbursement ceilings employed by states. As is evident from this chart, a major finding of the survey was the considerable number of states that have adopted prospective payment schemes for reimbursing ICF-MR care. It appears that most state programs have accepted the premise that prospective payment should generally result in lower costs than retrospective payment. Incentives are most strongly in the direction of cost containment in the four states with prospectively determined uniform or flat rate systems. These states pay facilities a set rate regardless of their cost experience or client mix. Flat rate payment systems also have strong incentives toward efficiency since the facilities above the ceiling will have to lower costs or go out of business, and facilities below the ceiling will earn profits on the difference between the rate and their own costs.

The ability of variable rate prospective systems to control costs is largely influenced by state policy toward establishing the reimbursement rate. One feature that has been argued to influence the effect of established rates on individual providers is whether the prospective payment system groups facilities for the purpose of determining the rate (Pollak, 1977). Peer groupings, because they take the control over payment levels away from individual providers, are generally considered to provide clear incentives for cost control among high cost operators, who must either reduce their costs or operate at a loss.

High cost facilities in states with retrospective adjustments to the prospective payment system probably face weaker incentives to control costs, because they do not know where the final ceiling will be relative to their peers. Similarly, facilities below the ceiling know they will be paid their costs and, thus, these facilities also lack incentives for efficiency and cost control in the cost centers subject to year-end adjustment. Again, peer groupings serve to mitigate against cost increasing incentives because uncertainty about the final adjusted rate may make facilities more cautious.

Table 11

General System Design of State ICF-MR
Payment Mechanisms as of January 1984

		Prospective Facility-Specific	Prospective with Peer-Groupings	Retrospective Facility-Specific
Type of Reimbursement Ceiling	No ceiling on facility costs	ME, NV, NH, ND, TN		AK, AR, SC, VT
	Ceiling on overall costs	MO, OR		VA
	Ceilings for Specific Cost Centers	CT, DC, ID, IA, MA, MI, NC, PA, WA	IL, NY, OH	RI
	Overall ceilings and ceilings for Specific Cost Centers	IN, KY, MN, MS, MT, SD	CO, FL, GA, KS, LA, NE	NM
	Uniform Rate		CA, OH*, TX, UT	

*Uniform rate for facilities serving 8 or fewer

Grouping facilities to set reimbursement rates does not always encourage cost containment, however. Grouping facilities prior to establishing rates will typically work to the advantage of higher cost facilities since the facilities in the higher cost groupings will have some costs recognized that would not have been recognized without grouping. Groupings based on size, for example, are typically considered to work to the advantage of smaller facilities that will have a greater percentage of costs recognized. In fact, several of the states surveyed that grouped facilities by size selected to implement such groupings not as a cost-saving device, but to stimulate and support the development of small community-based ICF-MRs.

For the majority of states with prospective payment systems, as well as for all of the seven states with retrospective payment systems, the actual rates faced by facilities were reported to be tied to each facility's own cost experience. Facility specific reimbursement systems, irrespective of design, are generally expected to have fewer incentives for cost control and efficiency because facilities can more directly influence future rates. As Holahan has observed for such systems in the nursing home industry:

> ...a home can let its costs rise above the target, lose money in the current year, but establish a higher base for the next year's rate. Losses in the current year are a type of investment yielding higher revenue streams in further years. (Holahan, 1983, p. 24)

The cost generating incentives are even more pronounced in retrospective facility-specific payment systems because if costs exceed the interim rate, the facility can receive all or part of the difference, in addition to establishing a higher base for the next year's base. All of the seven states that reported using retrospective payment mechanisms for ICF-MRs employ facility-specific payment schemes.

2. Adjustments to Operating Costs.

Table 11 also illustrates that a number of states have established specific cost ceilings to augment the cost containment features of their basic payment system. As was described earlier, the cost containment incentives in state systems often depend as much on the adjustments to the system as on the general system design itself.

Only nine states recognize no percentile ceilings on facility costs. Here the general incentives inherent in basic system design become less relevant since under both prospective and retrospective arrangements states with no percentile ceilings use facility-specific payment methods and limit each facility by its own past cost experience.

The states also vary in terms of whether percentile ceilings apply to all costs or just specific cost centers. Only two states (Missouri and Oregon) employ a uniform ceiling for all cost centers. These systems have the advantage, similar to flat rate systems, that a high cost facility can spend, as it chooses, within the overall rate to bring its overall costs within the target ceilings. Most states that use uniform percentile ceilings, however, employ additional ceilings or screens for various individual cost centers to enable them to exercise greater control over spending within the facility, especially, as already noted, for management fees and salaries. This approach offers less discretion to the high cost facility for cost reallocation, but assures greater compliance with state policy objectives concerning the resources allocated for direct care and administration.

For states that reported specific percentile ceilings, ceilings on individual cost centers ranged from the 50th percentile (e.g., Illinois) to the 100th percentile (e.g., Colorado). Obviously, the lower the percentile ceiling, the fewer costs that will be recognized by the state, and the greater cost containment incentives in the system. However, if the ceilings are set too low, they can overwhelm other incentives in the payment system and affect the quality of care in the facility. This is particularly likely for variable prospective payment systems with uniform ceilings on total costs; if the ceiling is set so low that most or all of the facilities in the state are at or above the limit, the system becomes, in effect, a statewide flat rate system.

Twenty-seven states also employed inflation adjustments to modify the cost-containment features of private ICF-MRs over time. As was described earlier, the cost incentives systemwide will depend largely on the choice of index or indices. Moreover, the behavior of high cost facilities will also depend on the method of rebasing; that is, whether costs are inflated based on the target rate or on actual costs. If the facility's

costs adjusted for inflation is its rate, the cost containment incentives are diminished; facilities that have actual costs below the target rate are penalized for being efficient in the current year because future rates projected on current year performance will be lower. Alternatively, if a facility's costs exceed the rate, the facility will be rewarded for inefficiency in the future because subsequent adjustments to the rate will be higher. Most states reported that ICF-MR payment systems inflate facility rates based on actual costs.

If the established rate becomes the base for adjusting next year's costs, however, the incentives change. A high cost facility that reduces its cost structure to come in below the established rate will be rewarded in the current year and in future years as well. Similarly a facility that continues to operate inefficiently will continue to be under pressure to reduce costs in future years, because subsequent rates will be based on the current rate, not the facilities' actual costs.

3. Quality and Access Implications.

The preceding section summarized the general incentives inherent in state ICF-MR systems to modify growth and foster cost containment. Potential savings accruing from such incentives can result in (1) increased efficiency, (2) changes in resident or service mix, or (3) reduced quality of care. Providing a certain level of reimbursement does not necessarily guarantee the provision of the level of quality deemed desirable by the state. This section examines the general incentives provided for in state payment systems to enhance access to and quality of ICF-MR services.

Under uniform or flat rate systems, the facility retains payments in excess of its costs. Because every facility within the system receives the same payment for every resident, facility revenues are unaffected if the facility provides lower quality to achieve savings. Texas and Ohio have attempted to ameliorate these incentives by establishing peer groupings based on client characteristics and corresponding staffing requirements. Such groupings enable these two states to better target clients by categorizing homes into more homogeneous groupings providing similar services to

comparable clients.

In general, however, reimbursement schemes that are independent of facility costs are generally considered to have less flexibility to maintain quality with cost reductions, especially where facilities are allowed to keep the difference between actual costs and the established rates. Most studies in the general nursing home literature suggest that in such systems, pressures to enhance quality will have to come outside the payment systems if minimum quality standards are to be maintained under facility independent systems.

Most experts agree that facility-specific reimbursement systems provide the most flexibility to maintain quality, especially when the facility's actual costs become the basis for next year's rate. These systems permit homes which seek to provide more or better services to do so without financial penalty. Many of the prospective facility-specific payment systems for ICF-MRs protect against cutbacks in quality from cost-reductions by (1) providing a retrospective adjustment to the established rate, and (2) inflating next year's rate by actual facility costs instead of the prior year's rate.

States can still enhance the incentives to provide quality care in payment mechanisms with strong cost containment incentives by establishing multiple payment screens or ceilings on various cost centers, and then setting higher percentile ceilings in areas that they believe to be more closely related to quality care (e.g., direct care staff).

Most states address quality of care issues primarily through mechanisms outside of rate-setting policy. The five states that reported using case-mix adjustments to compensate facilities for the costs of caring for residents with different levels of impairment are exceptions. Facilities in each of these systems are provided maximum payment amounts for patient care costs based on client assessments. In general, the higher the level of impairment, the higher the payment amount. Thus, there are no clear incentives in these systems to lower the quality of care in the face of cost reductions since the facility will still be compensated for varying care requirements of residents. Moreover, case-mix systems also mitigate against facilities denying access to severely impaired clients on purely economic grounds.

The efficacy of case-mix adjustments in enhancing quality of care depends, in part, on the quality of the assessment instrument. Needs assessments that emphasize the medical-nursing dimensions of care planning and service delivery may misrepresent the developmental care requirements of most residents and provide incentives to allocate resources in a manner quite independent from habilitative needs. Medically oriented needs assessment may in fact provide perverse incentives if facilities are inadvertently rewarded for greater frequency of medication administration, for example. Thus, states such as Illinois and Ohio that have adapted pre-existing case-mix systems for general nursing homes should exercise considerable effort to assure that assessment instruments are indeed appropriate for the quite different care requirements of developmentally disabled persons in ICF-MRs.

Patient-related reimbursement systems that emphasize physician, nursing, medication administration, and other high cost inputs may also be inflationary if facilities have few incentives to be efficient. Ohio, for example, has few incentives to be efficient in the delivery of care because their final rate is adjusted retrospectively to equal actual costs, if their cost experience in the current year was less than the established rate. Illinois, in contrast, allows facilities to keep the difference between their actual patient care costs and the maximum allowable case-mix adjusted rate as profit.

Finally, only one state (Illinois) reported utilizing more direct linkages between quality and reimbursement policy, such as making efficiency incentives contingent upon the lack of compliance deficiencies. Also, no state indicated that their resident-related payment system was outcome oriented or rewarded facilities financially according to the presence of client growth or transition to less restrictive settings.

B. Recommendations

States demonstrate broad diversity in private ICF-MR reimbursement policies. States differ in their approach toward ICF-MR reimbursement because their goals and objectives differ with respect to such factors as the desired distribution and amount of

ICF-MR beds in private facilities; the target rate of growth in beds; characteristics of residents; type of facility considered appropriate for participation in their ICF-MR program; the expected growth in state expenditures for ICF-MR care; and the projected growth and availability of substitutes and complementary services within the state's continuum of care for mentally retarded people. Nevertheless, a review of state methodologies reveals several policy options that states should consider to enhance their reimbursement system for ICF-MR care in private residential settings:

1. Grouping facilities for payment purposes should include ICF-MR client characteristics in the grouping mechanism to assure that different levels of client impairment will be recognized in the rate-setting mechanism. This approach will ensure that facilities will not be encouraged to cut back on quality if cost reductions are necessary. It should also facilitate the placement of profoundly retarded residents in community settings. If employing client characteristics in the grouping mechanism is not desirable to states, those with grouping schemes should minimally consider additional adjustments that recognize the costs of treating clients with varying impairment levels (e.g., case-mix adjustments).

2. States should attempt/be encouraged to move away from uniform cost limits to multiple screens on cost centers within an overall cap on total costs. This approach will enable states to exert greater influence over resource allocation within the facility while, at the same time, providing flexibility to raise or lower screens on specific cost centers to reflect changing policy objectives regarding ICF-MR cost containment and quality control. Screens could be established to set minimums as well as maximums within different cost centers.

3. States should attempt modest rewards for efficiency of operation through adjustments to prospectively determined payment systems based on the current established rate, not actual costs. This policy will provide both long and short run incentives for efficiency in high cost facilities.

4. Concerns about the effect of efficiency incentives on quality of care can be avoided through incentives on nonservice areas such as administration. This option requires, of course, rigid cost allocation rules to minimize the possibility of facilities manipulating their books. Another option would be to make efficiency incentive payments conditional upon the lack of compliance deficiencies in state or federal certification surveys.

5. Inflation adjustments should be reflective of costs incurred by privately operated ICF-MRs and vet not subject to manipulation by facilities. States should carefully assess the cost implications of the variety of composite indices now in use for adjusting ICF-MR costs. In particular, elements of the Consumer Price Index may understate inflation in the ICF-MR service sector unless adjustments are made to account for the specialized needs of severely and profoundly retarded ICF-MR residents. If states use client characteristics in grouping facilities for reimbursement purposes, different indices may be appropriate to differentiate cost trends among peer groupings. At the same time, these adjustments should not be so service-specific that they are easily manipulable by a few facilities.

6. States expanding SNF and ICF case-mix adjustments to ICF-MR payment policy should carefully examine the appropriateness of these methodologies. The type of habilitative care and treatment provided for mentally retarded persons in private residential facilities is substantially different than nursing home care, and instruments used for case-mix adjustments must obtain and properly weigh those client data that are directly related to variations in the cost of providing appropriate habilitation. In particular, the medical orientation of the nursing home assessment instruments often reflects a different treatment philosophy and desired allocation of direct care resources than is needed to meet the habilitation needs and care requirements provided to ICF-MR residents.

7. States with capital reimbursement problems may want to consider a fee-for-service capital system. States have taken a relatively sophisticated approach in reimbursing

capital-related expenses. However, those states that do experience problems in establishing the purchase or listing price of facilities should consider moving to a fee-for-capital arrangement. Establishing capital reimbursement based on one fee or several modified fees based on such criteria as facility age and facility size will reduce the opportunity for trafficking and lessen the need to monitor private transactions in the market. States can also selectively control capital costs through selective cost screening. Among the cost centers to be considered for selective cost screening are (1) the value of the home, (2) allowable interest expense, (3) depreciation allowances, and (4) sale/price of the facility.

8. States should evaluate ICF-MR reimbursement incentives in the context of the broader continuum of residential care services available or desired for mentally retarded persons. ICF-MR is only one level in a range of residential care models appropriate for facilitating development and capacity for independent living of mentally retarded persons in community settings. Medicaid reimbursement policy should reflect the desirability of functions for ICF-MR facilities within the residential care system to assure that ICF-MR payment incentives enhance rather than inhibit client movement toward greater levels of independence, self-care, and integration in community settings.

VI. Appendices

A. References

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APPENDIX B

REIMBURSEMENT QUESTIONNAIRE

Questions on this form ask for Information about the following areas of reimbursement:

I. General Reimbursement Practices
II. Reimbursement Based on Facility/Client Characteristics
III. Indexing Inflation/Costs
IV. Cost Limits Not Based on Indexes
V. Profits and Return on Equity
VI. Capital Reimbursement
VII. Exceptions Process

*Please respond to questions only as they apply to_____residential facilities for mentally retarded people. Mark any question that does not apply with "NA".

I. General Reimbursement Practices

A. Responses on this survey form apply to a reimbursement methodology effective as of._____

Date

B. Is facility reimbursement best described as (check one):

_____Cost related, based on actual costs of the specific facility (Answer C, skip D)

_____Cost related, based on average costs of some/all facilities (Answer C, skip 0)

_____Legislated flat rate based on factors such as state/county budget and number of clients (Skip to D)

_____Negotiated flat rate decided at county or regional level (Skip to D)

_____Other_____> Describe: (Skip to D)

C. Which of the following best describes the method of rate setting used for cost related reimbursement (check one)?:

_____Prospective; rates set in advance of costs incurred

_____Retrospective; rates set after costs incurred

_____Prospective with retrospective adjustments

_____Other > Describe:

D. Are any of the following considered when determining a legislated or negotiated flat rate (check all that apply):

_____Cost of capital (e.g., depreciation. interest on capital asset loans)

_____Operating expenses (e.g., salaries for direct care workers)

_____Client characteristics (e.g., hard to place clients, age of clients)

_____Facility characteristics (e.g., location, profit or nonprofit)

Other———> Describe:

E. Are facilities permitted to include any of the following services in their residential rate? Check all that apply

	All residents		Some residents		Billed
	Some fac.	All fac.	Some fac.	All fac.	separately
Physical therapy	—	—	—	—	—
Speech therapy	—	—	—	—	—
Occupational therapy	—	—	—	—	—
Day program outside living unit	—	—	—	—	—
Transport to/from day program	—	—	—	—	—
24 hour nursing	—	—	—	—	—
Doctor/hospital expenses	—	—	—	—	—
Other —> Describe.					

II. Reimbursement Based on Faci1ity/Cllent Characteristics

A. Are facilities grouped (for rate or cost celling determination) based on any facility or client characteristics? No. Yes.---> What are groupings based on (check all that apply)?:

_____Facility location (e.g., urban vs. rural)

_____Facility size (e.g., 15 or less, 15+)

_____Client age (e.g., children vs. adults)

_____Client level of disability (e.g., severe/profound vs. moderate/mild)

_____Facility level of care (e.g., state designation/certification within type)

_____Profit/nonprofit

_____Ownership (e.g., corporate vs. single family)

Other, Describe:

B. Is the reimbursement system adjusted using a case-mix index (i.e., an aggregate score/measure characterizing a facility based on a cluster of resident characteristics or resident service needs)? No. Yes. —> Please attach the regulations or a description of that process to this survey form.

C. Does the rate setting structure make special allowances for facilities serving one or more hard to place clients (i.e., as defined by case manager)? No. Yes. —> Describe.

III. Indexing Inflation/Costs
(indices include but are not limited to the Consumer Price Index, GNP-Deflator, state designed composite index)

A. In establishing the reimbursement rate, is an index used to adjust the overall facility rate for inflation (i.e., includes depredation, interest, and profit if these costs are allowed for purposes of reimbursement)? No, (if No, skip to 8). Yes. —> Name the Index.

1. Are increases in certain costs unrestrained by the index (pass-throughs) and incorporated 1n their entirety into rates? No. Yes. Which costs:

_____

_____

_____

B. Is an Index used to adjust total operating costs for inflation (excluding depredation, interest, and profit-allowances)? No. (If no, skip to C) Yes. —> Name the Index:

1. Are increases in certain operating costs unrestrained by the Index (pass-throughs) and incorporated in their entirety into rates? No. Yes. —> Which costs:

_____

_____

_____

C. Are indices only used to inflate specific cost categories (e.g., construction costs, food costs)? No. Yes. —> List each cost category and Index used:

_____

_____

_____

IV. Cost Limits Not Based on Indexes (Cost limits, ceilings, or caps reflect a maximum increase of allowable reimbursement based on facility/industry costs)

A. Do you place limits on a facility's total rate? No. Yes. —> Describe:

B. Do you place limits on allowable reimbursement for any costs other than depreciation and interest? No. (if No, skip to Section V). Yes. --->

1. Are limits placed on cost centers/categories (e.g., administrative costs, kitchen costs, ancillary services)? No. Yes. —> Which cost centers: -----> Is the limit (Check one):

a percentile (describe)	a mean average	a mean & percentage of mean (describe)	Other (describe)

a. If facilities are grouped based on resident or facility characteristics (see Section II), are the limits described above different for facilities 1n different groups? No. Yes. ——> Describe:

2. Are limits placed on specific costs (e.g., top manager's salary, food costs, speech therapy)? No. Yes. ————> Which specific costs?————> Is the limit:

a percentile (describe)	a mean average	a mean & percentage of mean (describe)	Other (describe)

a. If facilities are grouped based on resident or facility characteristics (see Section II), are the limits described above different for facilities 1n different groups? No. Yes. ——> Describe:

3. Are limits placed on management fees, home office fees, top management compensation in the case of "chain" or multiple home operations? N/A. No. Yes. —> Describe:

V. Profits and Return on Equity

A. Is there an explicit profit component in the reimbursement system? No. Yes. —> Which of the following best describes how profits are determined (check one)?:

_____Fixed profit allowance per resident day (describe):

_____Variable profit allowance per resident day up to a maximum (describe):

B. Is a return on equity paid that is different from the profit component above: No. (if No, skip to C) Yes. —>

1. To which facilities is the return on equity applied (check all that apply)?:

_____Not-for-profit facilities_____For-profit facilities

2. What is the rate of return and capital base used for equity computations?:

C. If a facility is efficient and does not spend up to its established rate, does it keep the difference between its actual expenditure and established rate? No. Yes.

VI. Capital Reimbursement

A. Is depreciation allowed for purposes of reimbursement? No. (if No, skip to B) Yes. --->

1. Is depreciation straightline? No. Yes.

2. Is accelerated depreciation permitted? No. Yes. —> What is the maximum depreciation allowed?_____

3. Is the facility required to establish a funded depredation account to help meet principal payments when such payments exceed depreciation? No. Yes. —> Describe:

a. If No, as part of the facility's property reimbursement does the state establish a funded depreciation account and pay into it for the facility? No. Yes,

4. How 1s the value of the facility recognized by the state (check one):

_____Historic costs.---> From which date are costs set (check one):

_____ Date of construction

_____Date of last sale

_____Other. —> Describe:

Replacement costs

_____Market value

a. Must the buyer and seller be "unrelated"? No. Yes. Define "unrelated":

b. Are there dollar limits placed on market transactions? No. Yes. —> What are the limits:_____

_____Other. —> Describe:

5. Does the state place a dollar maximum on the investment in a bed which it is willing to pay for? No. Yes. —> What was the maximum on July 1, 1983:_____

6. What is the useful life of a new facility (check all that apply)?:

_____15 years_____40 years

_____30 years_____Other. —> Describe:

_____35 years

B. Is interest incurred for fixed asset acquisition allowed for purposes of reimbursement? No. (1f No, skip to C) Yes.——> Does the state (check one):

_____Establish the interest rate it will recognize for reimbursement (e.g., impute a flat rate to all facilities)

_____Reimburse the actual interest expenses incurred by a facility -—>

Are rates set according to (check one):

_____prevailing rates_____Other —> Describe:

_____Prevailing rate to ceiling (describe cei1ing)

1, If the facility has debts in excess of the book value of the capital assets (negative equity), does the state reimburse the facility interest expenses attributed to the negative equity? No. Yes. —-> (Check one)

_____All interest expenses are reimbursed

_____Interest expenses to a celling are reimbursed (what 1s the celling):_____

C. Does the state reimburse working capital interest expenses? No. Yes. —-> Describe any limits:

D. If property costs are reimbursed using depreciation and interest, 1s the purchase price of a facility recognized for establishing the basis of reimbursement? No. If No, skip to E) Yes.——>

1. How is the value of the home limited (check one):

_____Income value_____Depreciated replacement costs? —> Describe:

_____Assessed value

_____Market value_____Other —> Describe:

2. If a sale occurs, is there a depreciation recapture provision? No. Yes. —> Describe:

3. Are there reimbursement incentives for an owner not to sell his facility? No. Yes. ---> Describe:

E. Are lease expenses recognized as allowable costs for reimbursement purposes? No. (1f No, skip to E3) Yes. —>

1. Does the state set a celling on lease payments? No. Yes. —> What is the ceiling; how 1s 1t determined?:

2. Does the state require that the lease be of a minimum duration? No. Yes. —> What is that minimum?:

3. If lease expenses are not allowed for reimbursement purposes, how are operators of leased facilities reimbursed? ——> Describe:

F. If depreciation and interest or lease expenses are not allowed for purposes of reimbursement, how is capital financed ——> Describe:

VII. Exceptions Process

A. Can a facility apply for an exception (increase) to an established reimbursement rate if such an exception 1s based on extraordinary client characteristics/services needs? Yes. No.

B. Which state agency/office hears appeals for exceptions to a reimbursement rate?

C. How many facilities applied for an exception in the most recent rate year?

D. How many were granted an exception in the most recent rate year?

VIII. Has the reimbursement method described above successfully controlled costs while promoting program goals? Please comment: