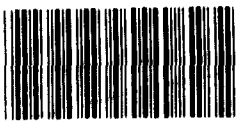
UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548



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STATEMENT OF

GARRY MCDANIELS

DEPUTY DIRECTOR, INSTITUTE FOR PROGRAM EVALUATION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

UNITED STATES HOUSE OF

REPRESENTATIVES

ON

MEDICAID AND NURSING HOME CARE ACROSS THE STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

We are pleased to be here today to talk about our study on Medicaid and nursing home care that was conducted at the Chairman's request. The report is currently being reviewed by officials in HHS and will be available to the public in the near future.

As you know, the role that Medicaid plays in providing nursing home care across the States is important because no overall national policy addressing long-term care, including nursing home services, exists. Medicaid has become the nation's primary payer of nursing home care. Medicare and private insurance support only a negligible proportion of nursing home services and the

catastrophic costs of long-term institutional care often exceed the financial resources of the elderly persons who are the prime users of nursing home services. Within the Medicaid program, expenditures for nursing home care represent the largest single expenditure category. The Medicaid program thus constitutes the chief vehicle through which the Federal government and the States share the substantial responsibility of insuring that adequate nursing home care is available to people who need but are unable to pay for it.

NURSING HOME CARE IS AN ESSENTIAL AND COSTLY COMPONENT OF LONG-TERM CARE

Even when a wide array of community-based long-term care services are available, many disabled or chronically ill elderly persons will still need to enter nursing homes. The elderly population in general is increasing rapidly and demographic trends suggest that the population at-risk of needing nursing home care may be increasing especially fast. An increase in future demand for nursing home care can, therefore, also be expected.

This expected growth in demand for nursing home services must be considered in the context of demand growth in these services over the past 20 years. In 1960, expenditures for nursing home care comprised only 2.1 percent (an estimated $500 million) of total personal health care expenditures. By 1981, nursing home services accounted for 9.5 percent of the total personal health bill, having more than quadrupled their share and

totaling over $24 billion dollars. Thus the past growth in demand, the projected increase in the population likely to need nursing home care, and the catastrophic cost to an individual of long-term care services, together point to an issue likely to be of increasing national concern.

MEDICAID IS THE MAJOR PAYER OF NURSING HOME CARE

In 1979, the latest year for which a breakdown is available, Medicare, the health insurance program which covers almost all elderly and some disabled individuals, paid for 2 percent of all nursing home care. Medicare, however, is designed to provide only acute, short-term care coverage. Private resources financed less than half (47 percent) and private insurers and other payers paid 1.4 percent of the national bill for nursing home care. Medicaid paid for approximately 45 percent of all nursing home expenditures (see Figure 1).

Medicaid is a Federally supported and State administered assistance program in which the Federal government currently pays from 50 to 77 percent of State costs for providing medical care to certain low income individuals and families. When Medicaid was authorized in 1965, by Title XIX of the Social Security Act, the legislation mandated no specific method of reimbursement and no direct control over the population admitted to nursing homes. As a result, States' control over eligibility criteria, bed supply, and reimbursement policy has resulted in a loosely-knit system of Medicaid nursing home programs which vary across the States.

STATES AND THE FEDERAL GOVERNMENT ARE TRYING TO CONTROL MEDICAID NURSING HOME SPENDING

Nursing home expenditures accounted for 35 percent ($7.2 billion) of all Medicaid dollars (approximately $20.6 billion) in fiscal year 1979; they also increased at an average annual rate of 14.5 percent from 1976 to 1980--a slightly faster growth rate than the rest of Medicaid (see Figure 2).

Currently, States are trying to reduce the rate of increase in their Medicaid nursing home expenditures because: (1) the rate at which these expenditures had been rising in the past, (2) the reduction in the Federal contribution to Medicaid as passed in the 1981 Omnibus Budget Reconciliation Act, and (3) fiscal pressure on States due to inflation, the recession, and reduced revenues as a result of cutbacks in other Federal aid and State tax limitations. To contain costs, States are using nursing home bed supply and/or reimbursement policies to slow the growth in their Medicaid programs.

STUDY OBJECTIVES AND METHODOLOGY

As the role of Medicaid in the financing of nursing home care has expanded, gaps in the understanding of the program's operations from a national perspective--what services are provided and with what frequency, quality, and efficiency--have become increasingly serious. There is also concern over the impact of State efforts to control nursing home spending at a time when the demographic trends indicate the care needs of the elderly population to be increasing rather than diminishing.

The Chairman of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked us to assess the current role of Medicaid in nursing home care across the States. The objective of our study was to provide information on several aspects of this program, including characteristics of nursing home residents, State program expenditures, bed supply, and reimbursement policies.

To conduct our study, an extensive review of the literature was made in conjunction with interviews of knowledgeable individuals in Federal and State organizations, universities, research organizations and the nursing home industry. We collected information for the period 1976 to 1980 through a mail and telephone survey to Medicaid officials in 49 States and the District of Columbia to obtain information on nursing home beds, reimbursement payment systems and rates, patient days, and reimbursement policy for Medicaid-eligible individuals waiting in hospitals for nursing home placement.

We also examined characteristics of nursing home residents by utilizing data provided by the Minnesota Department of Health. This data base contained information on almost all Medicaid nursing home patients in the State between 1976 and 1979. In order to analyze variation in State Medicaid nursing home spending, we relied on annual State Medicaid data provided by the Department of Health and Human Services for the fiscal years 1976 through 1980.

THE GROWING ELDERLY POPULATION MAY HAVE GREATER NURSING HOME CARE NEEDS

Most nursing home residents have been identified as chron-

ically ill, functionally dependent and/or mentally impaired; they frequently have very long stays (an estimated average of 2.5 years). Residents with long stays are also more likely to be female, unmarried, diagnosed as having mental illness, senility, or other chronic conditions and supported by Medicaid. In addition, we found that national surveys and one State survey of Medicaid patients suggest that nursing home residents, as well as new admissions to nursing homes, have become functionally more impaired over the past decade and may have more intensive care needs (see Figure 3).

Our review of the characteristics leading to nursing home use indicates that the at-risk population will grow faster than the overall elderly population in the future. While increased community-based services and preadmission screening programs may prevent or postpone entry into nursing homes for some portion of the at-risk population, this should at the same time result in higher dependency levels and care needs of the elderly who do enter nursing homes.

STATE SPENDING IN 1980 FOR MEDICAID NURSING HOME SERVICES PER ELDERLY RESIDENT RANGED FROM $34 TO $272

While the above trends suggest that nursing home costs will be subjected to increasingly heavy upward pressures, at the same time, Medicaid expenditures for nursing home care are already of major concern to the States and the Federal government because they have increased at a high rate in the past. Virtually all States have problems financing Medicaid nursing home care. How

much they spend for this service, however, varies substantially (see Figures 4 and 5).

We used Medicaid nursing home expenditures as the best available proxy for examining variation in State Medicaid nursing home services because data were unavailable to compare Medicaid nursing home utilization differences across States.

While all elderly are not likely to use nursing home care equally across the States because there may be different factors affecting their demand for it, our analysis indicates that some States clearly spend more Medicaid nursing home dollars per elderly resident than other States. Even when 1980 State and local expenditures are adjusted for differences in nursing home wages, the State spending the most ($272) for nursing home services per elderly resident spent eight times as much as the State spending the least ($34) (see Figure 6).

There is also a great deal of variation in the proportion of State fiscal resources (as measured by tax capacity and State income) directed to nursing home services. State spending for nursing home services is not a function of available resources, but rather a reflection of State policies which allocate resources differently. For example, some States which are relatively poor in terms of tax capacity, are among those spending the most on nursing home services per elderly resident.

The Federal medical assistance percentage is intended to compensate for disparities in State fiscal resources (as measured by per capita income) but is not targeted at individual types of services. However, it does result in relative in-

creases in spending for nursing home services in some poorer States. Our analysis found that adding the Federal contribution to each State's spending per elderly resident reduced overall State nursing home spending variation by 8 percent.

STATE NURSING HOME BED SUPPLY PER ELDERLY RESIDENT RANGED FROM A LOW OF 22 BEDS TO A HIGH OF 94

Nursing home bed supply, controlled largely by the States, is important because it helps to determine: (1) how many individuals gain admission to a nursing home, and (2) the level of State and Federal expenditures for nursing home care. Our survey data indicated that nursing home bed supply increased more slowly (2.9 percent annually) between 1976 and 1980 when compared to an average yearly growth rate of 8.1 percent between 1963 and 1973. There was also a wide range across States in bed/population ratios in 1980 from a low of 22 beds per 1,000 elderly persons in Florida to a high of 94 in Wisconsin (see Figures 7 and 8).

The slowing rate of nursing home bed growth and the wide variation in bed/population ratios raise questions as to how elderly residents in each State are affected by these factors. It is not possible to determine the number of nursing home beds that are required because need is so difficult to define and measure. And, while the research has shown that some persons who are in nursing homes could be served more appropriately in other settings, the relationship between State bed supply and the avoidable use of nursing home care is unknown.

One measure thought to indicate nursing home need or use was the dependency characteristics of State populations. These were examined in relation to State bed/population ratios. Only about half the members of a group identified as highly likely to use nursing home care--those individuals aged 75 or older, unmarried, and dependent in toileting and eating--were in nursing home beds in the 9 States and the District of Columbia with the lowest bed/population ratios. Over 90 percent of the persons with these same characteristics, however, were in nursing homes in the 10 States with the highest bed/population ratios. This may indicate that there is an inadequate supply of beds (or inadequate access to beds) in the low bed States or an overuse of nursing home services in high bed States, or most likely, a combination of both.

STATES ARE TRYING TO LIMIT THEIR BED SUPPLY BECAUSE OF ITS EFFECT ON MEDICAID EXPENDITURES

Regardless of whether States currently have a high or low bed/population ratio, several are trying to control their supply because of its effect on expenditures (see Figure 9). These events are occurring despite indications that nursing home occupancy rates are high nationally and that the annual growth rate in bed supply has not kept pace in recent years with the annual growth rate in the population of heaviest users of nursing home care (those 85 and older), (see Figure 10).

Some States have used their certificate of need reviews to limit bed supply. For example, five States, which varied in the

ratio of nursing home beds per 1,000 elderly residents from a high of 94 to a low of 31, recently imposed moratoriums on the construction of new nursing home beds. The research has not identified whether these and other actions to limit bed supply reduce unnecessary care or instead make it more difficult for individuals who need these services to obtain them.

MOST STATE REIMBURSEMENT SYSTEMS ARE NOT DESIGNED TO PAY FOR THE COST OF EACH PATIENT'S CARE NEEDS

State reimbursement systems can be characterized by their wide diversity. Two broad categories of reimbursement, uniform rate and facility-specific rate systems, have evolved. The results of the systems developed by the States are a wide range of reimbursement methodologies with many unique components that make comparisons difficult, and a wide range of reimbursement rates for ostensibly similar services across the States. Because most State reimbursement systems are not designed to pay for the cost of each patients' care needs, and because they also establish ceilings or limits to the allowed payment rate, there is a disincentive for nursing homes to admit costly, heavy care Medicaid patients.

Since 1980, many States have changed or revised their reimbursement systems in an effort to contain costs. These actions do not necessarily mean that the quality of care has been or will be adversely affected. Cost controls may produce more efficient care delivery. However, at the same time they require that States assure, through appropriate mechanisms, that quality of nursing home care is maintained.

The assurance of quality nursing home care is particularly important at this time because our study findings suggest that nursing home patients have become more dependent over time and may require potentially more costly services. It is critical that utilization review and survey and certification procedures for nursing homes be adequate to insure that facilities meet the health and safety requirements of the law. Quality however, has been difficult to define and designing the appropriate incentives to guarantee quality has been problematic.

PROBLEMS EXIST IN MEDICAID PATIENTS' ACCESS TO CARE

Patient characteristics and care needs, combined with State Medicaid nursing home reimbursement and bed supply policies, have contributed to an apparent access problem for some Medicaid and potentially Medicaid-eligible patients in need of nursing home care. Limited data are available, however, to assess the extent to which access problems exist, how they compare across States, or how effective State as well as Federal laws and regulations have been in alleviating access problems.

One measure of the access difficulties Medicaid patients currently experience is that many wait in hospitals (often paid for at the higher acute care rate) because they could not gain access to a nursing home. It is estimated that Medicaid and Medicare pay for between 1 and 9.2 million days annually of inpatient hospital care when the patients require nursing home care instead. (These patient days are referred to as hospital backup days.) Data, however, on the magnitude and costs of this hospital care are poor because neither Medicaid nor Medicare can

identify most of these patients. The care requirements of these patients and the inadequacy of the Medicaid nursing home reimbursement rate in covering the cost of their care, are considered among the most important reasons for this problem.

ATTEMPTS TO REDUCE HOSPITAL BACKUP MAY BE EXPENSIVE

Recent legislative changes have been made to Medicare hospital reimbursement to strengthen hospital incentives to discharge patients sooner. Further tension in the long-term care system may result if hospitals attempt to discharge these patients but nursing homes refuse to admit them, possibly leading to increased problems for patients who wait in hospitals for nursing home beds.

Attempted solutions to this problem are complex and their effectiveness is yet to be determined. These attempts include providing reimbursement incentives to nursing homes to admit hospital backup patients, expanding nursing home bed supply, and using excess hospital capacity for long-term care. All three proposals would increase Medicaid expenditures.

Although the use of excess hospital capacity, the third proposal, would alleviate the need for new nursing home beds, hospitals may be reluctant to use their excess capacity for long-term care, hospital-based nursing home rates may be relatively high, and there is limited information on the quality of long-term care that hospitals provide. In addition, other hospitals with high occupancy rates and little excess capacity could use this argument to create additional pressure to expand. Because there is a general consensus that there are

enough hospital beds nationally, hospital expansion could lead to unnecessary increases in health expenditures.

CONCLUDING OBSERVATIONS

In conclusion, observations drawn from this study have focused on broad program objectives of Medicaid's nursing home program as well as research questions concerning the specific components of each State's program. We note that:

1. As indicated by our data on bed supply trends, nursing home bed supply is unlikely to increase rapidly (given current State incentives to prevent this). This suggests that improvements are needed in the efficiency with which Medicaid nursing home services are used across the States. Such efficiency involves assuring that:

   --those elderly individuals in need of long-term care are assisted to remain in the community as long as possible and economically feasible, and

   --those individuals most in need of skilled and intermediate levels of nursing home services are able to receive them.

2. Preadmission screening by Medicaid, expanded use of community-based long-term care services, and other factors should contribute to the trend of a nursing home population with potentially increasing dependencies and care requirements identified in this study. Reimbursement systems and other incentive mechanisms need to be developed which will insure both the accommodation of this changing population with expensive heavy care needs and cost-effective quality care delivery.

3. Adequate utilization review and survey and certification procedures are also critically important given an increasingly dependent nursing home population and current State efforts to limit the growth of Medicaid spending.

The following research issues are particularly important for addressing some of the current problems in the delivery of Medicaid's nursing home care. These issues emerge from the difficulties we encountered in attempting to examine these problems in this study.

1. Information is needed to identify whether State and Federal efforts in using the Medicaid Home and Community

Care Waiver provision, preadmission screening, and other activities are sufficient to assure that individuals who could be served appropriately at less cost in their own homes or other settings are able to avoid nursing home admission.

2. Because the number of nursing home beds has a direct impact on State and Federal Medicaid expenditures for nursing home care, additional information could help to address conflicting findings related to the wide range of bed supply across States and determine whether this variation is justified.

3. There is currently inadequate research information available to identify the best way to provide:

   --incentives to nursing homes to admit patients with extensive care requirements, and

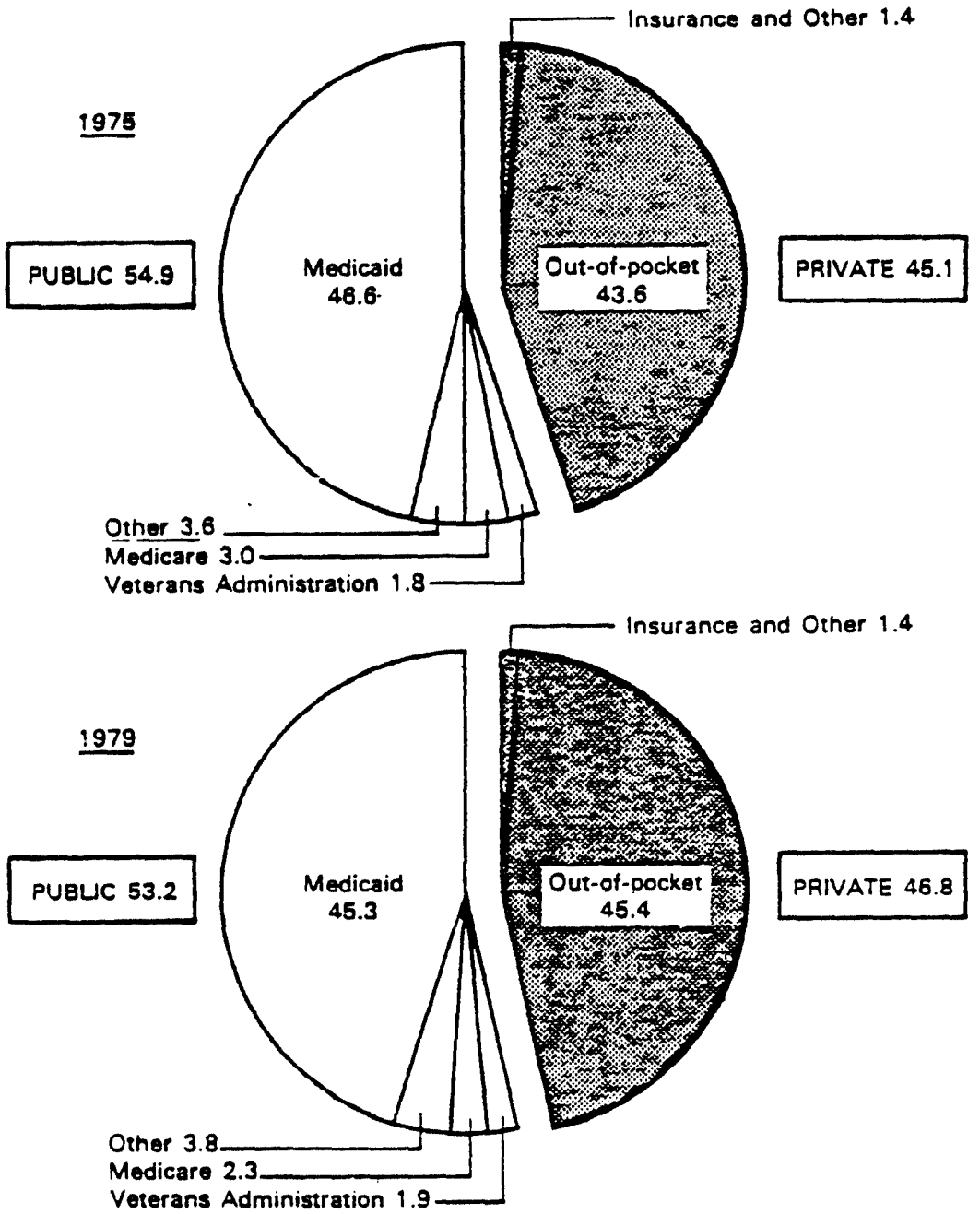
   --adequate controls to insure that if Medicaid's reimbursement rates are raised to cover the cost of heavy care patients, the patient actually receives the needed services at an acceptable level of quality.

4. Information on the number and characteristics of hospitalized patients awaiting nursing home beds would help to establish whether one or some combination of approaches to providing long-term care services (e.g., in hospitals, nursing homes, or at home with home health care) to these individuals is most cost-effective.

5. There are serious information gaps on the most basic components of Medicaid's support of nursing home care which caused major problems in our efforts to assess the program across the States. Data currently available on patient days, expenditures, beds, level of care, persons served and their characteristics, care needs and costs associated with these care needs are generally outdated, unreliable and/or unavailable.

Figure 1

PERCENTAGE DISTRIBUTION OF NURSING HOME EXPENDITURES FISCAL YEARS 1975 AND 1979[a]



Source: HCFA, HHS Long-Term Care: Background and Future Directions, (Washington, D.C.: January 1981), p. 15, and unpublished HCFA data.

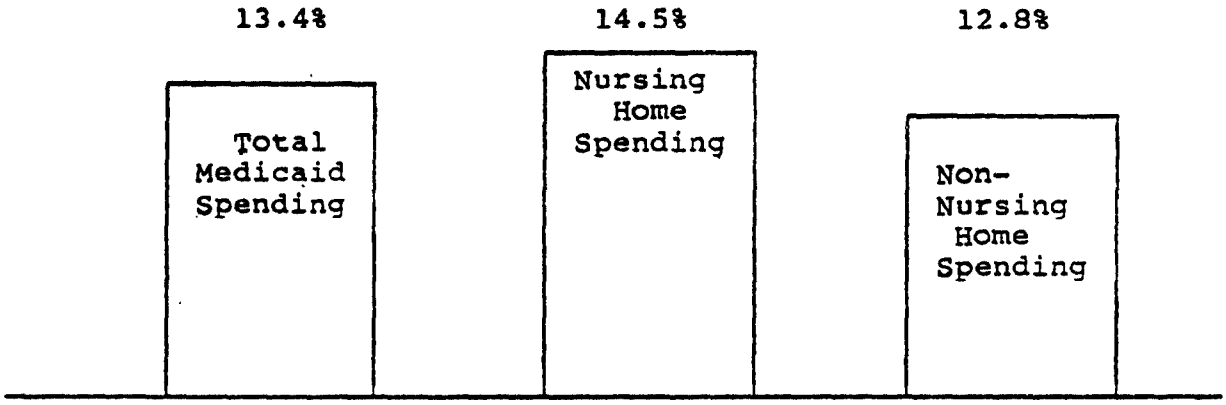
[a] Figures may not add to 100 because of rounding.

Figure 2

Medicaid Expenditures for Nursing Home Services and Percentage of Total Medicaid Expenditures a/ Fiscal Years 1976-1980, (dollars in billions)

	1976	1977	1978	1979	1980
Expenditures	$4.7	$5.3	$6.2	$7.2	$7.9
Percentage of Total Medicaid	33.3	33.0	34.6	35.0	34.2

Annual Growth in Medicaid Program Expenditures, Fiscal Years 1976-80 b/



Source: HCFA, HHS, Bureau of Data Management and Strategy, Division of Medicaid Cost Estimates, Medicaid State Tables, (Washington, D.C., 1976-80).

a/Expenditures for Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands are excluded. Expenditures for intermediate care facilities for the mentally retarded (ICF-MR) are included within nursing home expenditures in the following States in the years indicated: Ala., Ark., Calif. (1976-79); Conn., Fla. (1976); Hawaii (1977-79); Ill., Maine, Md. (1976-80); Mo. (1976); Mont. (1980); Nev. (1976-77); N.H. (1976-79); N.J. (1977); Wash. (1967); W.Va. (1979). The analysis presented in the text adjusts for ICF-MR expenditures unless otherwise indicated.

b/Expenditures for Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands are excluded. Expenditures for intermediate care facilities for the mentally retarded are included within nursing home expenditures in twelve States: Ala., Ark., Calif., Conn., Fla., Ill., Maine, Md., Mo., Nev., N.H., Wash.

Figure 3

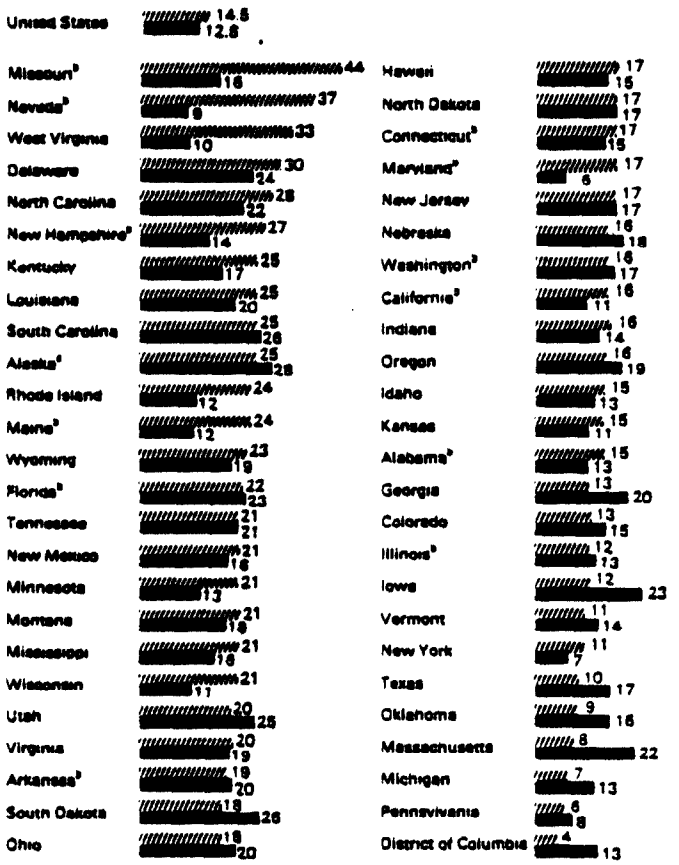
Percentage Distribution of Nursing Home Patients in 1973-74 and 1977 Dependent in Activities of Daily Living

	1973-74	1977
Activity		
Bathing	70.7	86.3
Dressing	58.9	69.4
Toileting	52.7	52.5
Transferring	51.6	66.1
Continence	33.8	45.3
Eating	17.6	32.6
Index of Dependency		
Not dependent	23.5	9.6
Dependent in one activity	12.7	12.4
Dependent in bathing and one other activity	8.4	12.2
Dependent in bathing, dressing, and one other activity	4.5	8.5
Dependent in bathing, dressing, toileting, and one other activity	14.3	9.6
Dependent in bathing, dressing, toileting, transferring, and one other activity	16.0	15.6
Dependent in all six activities	14.4	23.3
Other combinations of dependencies	6.2	8.9

Sources: (1973-74) National Center for Health Statistics, Department of Health, Education and Welfare, "Nursing home Costs - 1972, United States: National Nursing Home Survey, August 1973 - April 1974," Vital and Health Statistics, Series 13, No. 38, November 1979, p. 6.
(1977) National Center for Health Statistics, Department of Health and Human Services, "The National Nursing Home Survey, 1977 Summary for the United States," Vital and Health Statistics, Series 13, No. 43, June 1980, p. 45.

Figure 4

AVERAGE ANNUAL GROWTH IN MEDICAID NURSING HOME AND NON-NURSING HOME EXPENDITURES FOR THE NATION AND BY STATE, FISCAL YEARS 1976-1980[a]



Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Division of Medicaid Cost Estimates, Medicaid State Tables (Washington, D.C., 1976-80).

[a] Ranked by growth in nursing home expenditures.

[b] Expenditures for intermediate care facilities for the mentally retarded (ICF-MR) are included within nursing home expenditures. This may affect average growth rates presented for these states.

[c] The growth rate of Alaskan expenditures is based on 1976 and 1979 data because 1980 data was not reported.

Figure 5

Percentage of State Medicaid Programs Spent on Nursing Home (ICF and SNF) Services, Fiscal Year 1980

			Utah			
			Mississippi			
			New York			
			Louisiana			
			Tennessee	So. Dakota		
			Ohio	Montana		
			Missouri	Minnesota		
			Georgia	Alabama		
			Florida	Connecticut		
			Virginia	Idaho		
			So. Carolina	Texas		
			Kansas	Alaska c/		
		Delaware	Hawaii	Maine a/		
		Michigan	Kentucky	Nebraska		
		Pennsylvania	Rhode Island	Colorado		
		Illinois a/	Vermont	Arkansas		
		Massachusetts	Oregon	Iowa	Wyoming	
		New Mexico	No. Carolina	Nevada	No. Dakota	
		Maryland b/	New Jersey	Oklahoma	Wisconsin	
Dist. of Col.		California	W. Virginia	Washington	Indiana	New Hampshire
0-9%	10-19%	20-29%	30-39%	40-49%	50-59%	60-69%

(Columns are ordered by percentage; low [bottom] to high [top])

a/1980 expenditures have been adjusted, using 1981 preliminary data, to remove expenditures for intermediate care facilities for the mentally retarded.

b/1980 expenditures have been adjusted, using 1982 preliminary data, to remove expenditures for intermediate care facilities for the mentally retarded.

c/HCFA substituted 1979 data for 1980 data because Alaska did not report 1980 data.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Medicaid State Tables, Bureau of Data Management and Strategy, Division of Medicaid Cost Estimates.

Figure 6

Medicaid Nursing Home Expenditures per Elderly Resident, 1980
(Ranked by State Expenditures Per Elderly)

	State and Local Expenditures per Elderly Resident	State and Local Expenditures per Elderly Resident Adjusted for Nursing Home Wages	Total Expenditures per Elderly Resident	Total Expenditures Per Elderly Resident Adjusted for Nursing Home Wages
Alaska a/	$486	$263	$972	$526
New York	382	252	764	504
Wisconsin	270	272	642	651
Minnesota	255	213	574	616
Connecticut	222	213	444	425
Hawaii	212	171	424	342
Massachusetts	181	196	374	400
Rhode Island	178	202	422	478
New Hampshire	166	164	427	423
Michigan	162	175	323	349
Washington	155	158	311	316
Colorado	144	156	308	333
Nevada	138	113	276	226
Indiana	135	147	316	348
Texas	131	154	314	370
New Jersey	131	120	263	240
Illinois b/	127	134	255	270
Montana	126	122	352	341
California	125	122	251	245
North Dakota	123	139	318	361
Maine b/	123	139	403	455
Wyoming	115	103	230	205
Louisiana	115	134	368	435
Delaware	113	128	225	255
Ohio	108	117	242	262
Dist. of Col.	108	97	215	196
Virginia	106	109	244	252
Iowa	105	134	242	309
Georgia	105	117	317	353
Vermont	105	110	332	349
Kansas	104	130	224	279
Oklahoma	104	124	286	342
Maryland c/	100	98	201	197
Nebraska	97	110	228	258
South Dakota	93	115	297	367
Utah	90	97	281	302
South Carolina	90	89	310	309
Arkansas	84	95	309	349
Idaho	84	101	245	295
Oregon	83	91	187	205
Pennsylvania	82	72	184	162
Alabama	81	94	281	328
Tennessee	78	86	256	284
Kentucky	77	84	241	263
North Carolina	68	75	211	233
Missouri	64	74	161	186
Mississippi	61	70	271	311
New Mexico	46	50	149	161
West Virginia	42	45	130	139
Florida	33	34	81	83

a/Alaska data represent 1979 data.

b/1980 expenditures have been adjusted using 1981 preliminary data to remove expenditures for intermediate care faciities for the mentallly retarded.

c/1980 expenditures have been adjusted using 1982 preliminary data to remove expenditures for intermediate care facilities for the mentally retarded.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Bureau of Data Management and Strategy, Division of Medicaid Cost Estimates, Medicaid State Tables, U.S. Department of Labor, Bureau of Labor Statistics, unpublished data from the Establishment Survey 202.

Figure 7

Nursing Home Beds per 1000 Aged 65 and Older, 1976-1980, and Average Annual Growth Rate, 1976-1980

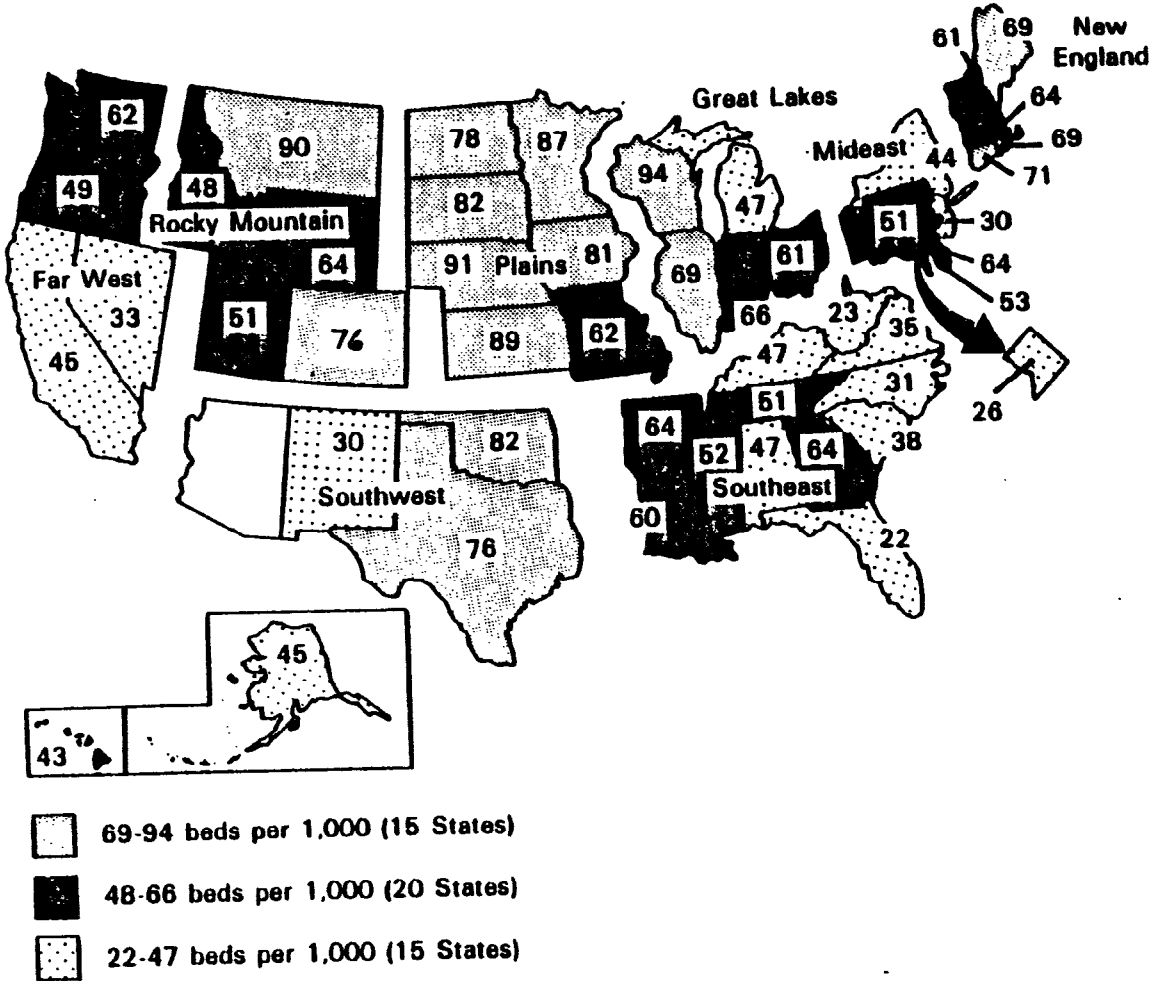
STATE	'76	'77	'78	'79	'80	Avg. Annual Growth Rate		'76	'77	'78	'79	'80	Avg. Annual Growth Rate
U.S.:	54.4	54.9	54.9	54.7	54.2	0.0							
Number of States:	(45)	(48)	(49)	(50)	(48)								
U.S. Estimated Bed/Pop. Ratios for 50 States	53.9	54.3	54.5	54.7	54.4	0.0							
Alabama	48	48	49	48	47	-0.5	Montana	93	94	90	92	90	-0.8
Alaska	51	51	64	64	45	-3.1	Nebraska	96	97	93	93	91	-1.3
Arkansas	69	66	66	65	64	-1.9	Nevada	18	37	36	34	33	16.4
California	51	50	48	46	45	-3.1	New Hampshire	*	61	60	59	61	0.0
Colorado	82	81	78	76	*	-2.5	New Jersey	30	31	30	30	30	0.0
Connecticut	69	72	69	72	71	0.7	New Mexico	34	33	33	35	30	-3.1
Delaware	*	56	54	62	64	4.6	New York	46	46	46	45	44	-1.1
Dist Columbia	30	26	26	26	26	-3.5	North Carolina	27	28	29	31	31	3.5
Florida	23	23	22	22	22	-1.1	North Dakota	76	77	76	75	78	0.7
Georgia	68	66	65	65	64	-1.5	Ohio 1/	57	58	60	60	61	1.7
Hawaii	29	39	43	45	43	10.3	Oklahoma	79	78	79	78	82	0.9
Idaho	52	52	50	48	48	-2.0	Oregon	*	51	50	50	49	-1.3
Illinois	69	68	70	71	69	0.0	Pennsylvania 1/	47	48	49	50	51	2.1
Indiana	61	61	61	67	66	2.0	Rhode Island	62	68	71	72	69	2.7
Iowa	74	76	77	78	81	2.3	South Carolina	34	35	37	38	38	2.8
Kansas	85	85	89	85	89	1.2	South Dakota	81	79	80	83	82	0.3
Kentucky	28	34	43	46	47	13.8	Tennessee	47	48	47	49	51	2.1
Louisiana	55	59	59	61	60	2.2	Texas	77	79	79	79	76	-0.3
Maine	63	66	66	68	69	2.3	Utah	48	46	56	53	51	1.5
Maryland	*	*	48	52	53	5.1	Vermont	57	57	53	52	*	-3.0
Massachusetts 1/	62	65	65	65	64	0.8	Virginia	30	33	33	35	35	3.9
Michigan	49	49	49	48	47	-1.0	Washington	72	70	69	65	62	-3.7
Minnesota	85	85	87	87	87	0.6	W. Virginia	*	*	*	23	23	0.0
Mississippi	45	46	49	52	52	3.7	Wisconsin	94	93	91	90	94	0.0
Missouri	54	54	55	56	62	3.5	Wyoming	65	64	64	65	64	-0.4

1/Massachusetts and Pennsylvania data include ICF-MR beds. Ohio data include rest home beds.

Note: Growth rates were caculated on rounded figures and may inflate the actual rate of growth.

Figure 8

NURSING HOME BEDS PER 1,000 AGED 65 AND OLDER, 1980[a]



[a] Data for Colorado and Vermont are for 1979. Arizona data were not collected in the survey.

Figure 9

State Spending for Medicaid Nursing Home Care and State Bed/Population Ratios, 1980

Medicaid Nursing Home Expenditures Per Elderly Resident, Adjusted for State Cost of Living Differences

Beds per 1,000 Aged 65 and Older	$83 - 309	$311 - 651
22 - 60	California District of Columbia Florida Idaho Kentucky Maryland Nevada New Jersey New Mexico North Carolina Oregon Pennsylvania South Carolina Tennessee Utah Virginia West Virginia	Alabama Alaska a/ Hawaii Louisiana Michigan Mississippi New York Vermont b/
61 - 94	Delaware Illinois Iowa Kansas Nebraska Missouri Ohio Wyoming	Arkansas Colorado b/ Connecticut Georgia Indiana Maine Massachusetts Minnesota Montana New Hamphire North Dakota Oklahoma Rhode Island South Dakota Texas Washington Wisconsin

Source: GAO State survey and U.S. Department of Health and Human Services, Health Care Financing Administration, Bureau of Data Management and Strategy, Division of Medicaid Cost Estimates, Medicaid State Tables.

a/Fiscal year 1979 data are substituted for missing 1980 expenditure data.
b/1979 data are substituted for missing 1980 nursing home bed data.

Figure 10

Percent Distribution of the Elderly by Age Groups, 1980, and Average Annual Growth Rates for Selected Periods

STATE	Percentage 65-74	Percentage 75-84	Percentage 85+	Average Annual Growth in 65+ 1976-1979	Average Annual Growth in 75+ 1976-1979	Average Annual growth in 85+ 1975-1979
UNITED STATES	61.0	30.2	8.8	2.4	2.7	4.5
Alabama	63.2	29.1	7.7	2.8	3.3	3.3
Alaska	66.7	25.0	8.3	3.6	0.0	0.0
Arkansas	61.5	30.1	8.3	2.6	3.2	4.3
California	60.9	30.0	9.0	3.0	3.1	4.9
Colorado	60.3	30.0	9.7	3.1	3.0	4.9
Connecticut	58.9	29.8	9.9	2.5	2.3	4.9
Delaware	62.7	28.8	8.5	3.1	1.6	5.7
Dist. of Col.	62.2	29.7	8.1	0.9	1.2	3.9
Florida	62.8	30.3	6.9	5.0	5.9	8.5
Georgia	64.0	28.2	7.5	3.3	3.3	4.4
Hawaii	64.5	27.6	7.9	5.3	7.7	5.7
Idaho	61.7	28.7	8.5	4.0	3.1	3.4
Illinois	60.3	30.5	9.1	1.3	1.7	3.9
Indiana	60.0	30.9	9.2	1.6	2.0	3.6
Iowa	55.5	33.1	11.6	1.1	1.2	3.1
Kansas	56.5	32.4	10.8	1.4	1.6	3.4
Kentucky	60.7	30.7	8.5	1.7	2.1	3.2
Louisiana	63.1	29.5	7.4	2.2	3.1	4.5
Maine	58.2	31.9	9.9	1.8	2.6	4.3
Maryland	62.4	28.5	8.3	2.8	3.3	5.3
Massachusetts	58.2	31.6	10.2	1.5	1.7	3.8
Michigan	61.1	30.0	9.0	2.1	2.4	4.9
Minnesota	56.3	32.7	11.0	1.7	2.1	5.0
Mississippi	62.3	29.8	8.3	2.1	2.8	4.9
Missouri	58.8	31.8	9.4	1.3	2.0	3.2
Montana	61.2	28.2	10.6	2.5	1.6	3.0
Nebraska	55.3	33.0	11.7	1.2	1.5	3.4

Figure 10
(Continued)

Percent Distribution of the Elderly by Age Groups, 1980, and Average Annual Growth Rates for Selected Periods

STATE	Percentage 65-74	Percentage 75-84	Percentage 85+	Average Annual Growth in 65+ 1976-1979	Average Annual Growth in 75+ 1976-1979	Average Annual Growth in 85+ 1975-1979
Nevada	69.7	24.2	6.1	9.1	8.7	7.5
New Hampshire	60.2	31.1	9.7	2.5	2.8	3.0
New Jersey	61.7	29.9	8.4	2.3	2.3	5.1
New Mexico	64.7	27.6	7.8	5.1	5.9	6.5
New York	59.8	31.2	8.9	0.9	1.5	4.3
No. Carolina	64.3	28.2	7.5	3.7	4.0	5.3
No. Dakota	58.8	31.3	10.0	2.2	2.2	3.4
Ohio	60.5	30.3	9.2	1.6	1.7	3.9
Oklahoma	59.8	31.1	9.0	2.1	2.7	4.2
Oregon	61.1	29.7	9.2	3.3	3.1	5.0
Pennsylvania	61.7	29.8	8.5	2.0	2.1	3.9
Rhode Island	59.8	30.7	9.4	2.0	2.2	5.1
So. Carolina	66.2	27.2	7.0	4.0	4.0	4.4
So. Dakota	56.0	33.0	11.0	1.5	1.8	5.7
Tennessee	62.4	29.5	7.9	2.8	3.4	4.2
Texas	61.8	30.1	8.7	3.0	3.7	4.7
Utah	62.4	30.3	8.3	3.7	3.7	6.5
Vermont	53.4	31.0	10.3	1.9	3.1	4.7
Virginia	63.0	28.9	8.1	3.2	3.1	4.3
Washington	61.0	32.9	9.5	3.4	3.1	4.2
West Virginia	61.8	29.8	8.0	1.7	1.6	2.8
Wisconsin	58.5	31.6	9.9	2.0	2.5	4.6
Wyoming	67.6	29.7	8.1	1.9	-11.5	0

Sources: 1976-1979 State populations: Bureau of the Census, Department of Commerce, "Estimates of the population of States, by age: July 1, 1971 to 1979," Current Population Reports, Population Estimates and Projections, Series P-25, No. 875, January 1980;
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1975, 1976, and 1979 age cohorts: unpublished data generated in accordance with: Bureau of the Census, Department of Commerce, "Methodology for experimental estimates of the population of counties by age and sex: July 1, 1975," Current Population Reports, Special Studies, Series P-23, No. 143, May 1980.