A Report on Shortfalls in Medicaid Funding for Nursing Home Care

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REPORT HIGHLIGHTS

- The average shortfall in Medicaid nursing home reimbursement was projected to be $17.33 per Medicaid patient day in 2010. The actual shortfall in 2010 will likely be somewhat higher, in that historically, actual cost increases have outpaced projected inflationary increases for nursing homes.

- Un-reimbursed nursing home Medicaid allowable costs were estimated at over $5.6 billion in 2010.

- The Medicaid reimbursement outlook for 2011 is bleak. It is worse than any other year in which this annual report has been compiled due to unprecedented state budget deficits and expiration of federal stimulus funds as of July 1, 2011.

- The actual daily reimbursement shortfall for 2008 was estimated at $16.79 per Medicaid patient day. The 2008 shortfall is greater than the 2007 actual shortfall of $15.97[1] (per last year's report) and has increased by over 85% between 1999 and 2008.

- In 2010, for every dollar of allowable cost incurred for a Medicaid patient, the Medicaid program reimbursed, on average, approximately 91 cents.

- States continue to rely heavily upon provider taxes to fund nursing home reimbursement. However, new or expanded provider tax programs were most often used to mitigate rate reductions, or at best, to fund inflationary increases that states were unable to as a result of budget deficits.

- States continue to redirect more of their long term care budgets to non-institutional services. This heightened competition among long term care programs for limited state resources, combined with sagging state economies, has slowed the rate of growth in Medicaid rate increases. This negative trend has gotten worse in 2011. Most states have provided minimal rate increases, if any, as state revenues have been slow to rebound and because of the reduction in higher temporary *American Recovery & Reinvestment Act of 2009 (ARRA)* federal match rates (FMAP) as of January 1 and April 1, 2011 and their expiration as of July 1, 2011.

- Medicare cross-subsidization of Medicaid continues to play an important role in sustaining nursing home care. However, Medicare margins are not enough to compensate for the increasing Medicaid shortfalls. The shortfall for the two programs combined is estimated at $2.5 billion for 2010.

[1] The 2007 and projected 2009 shortfall figures in last year's report were understated. The 2007 cost report data from New York inadvertently omitted nursing administration costs and excluded non-allowable pharmacy costs thrice. Correcting for these omissions increases the 2007 shortfall from $14.00 ppd to $15.97 ppd and the projected 2009 shortfall from $14.17 ppd to $16.18.

MEDICAID 2008 AND PROJECTED 2010 NURSING HOME SHORTFALL STUDY OVERVIEW

Eljay, LLC (Eljay), was engaged by the American Health Care Association (AHCA) to work with its state affiliates and other sources to compile information on the shortfall between Medicaid reimbursement and allowable Medicaid costs in as many states as feasible.[2] This year's compilation, like the previous eight, identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available, which in most states was 2008. In a few states, cost reports for providers with year ends in 2009 were available and used. Similar to last year's study, a shortfall for the current year (2010) is projected by trending the 2008 costs (or 2009, if available) to the current year and comparing them to current Medicaid rates.

Methodology

Overall, data were obtained from 39 states for 2008 (or 2009, if available) and represented over 86% of the Medicaid patient days in the country. The data from over 70% of the states reporting in 2008 were based upon audited or desk-reviewed cost reports, or some blend of both. As-filed Medicaid cost reports or Medicare cost reports were used for the remaining states.[3]

As previously indicated, in addition to determining the shortfall in Medicaid funding in 2008, Eljay projected the shortfall in Medicaid reimbursement for the current year by comparing current year rates to 2008 allowable costs (or 2009, if available) trended to the current year. The trending factor used in projecting 2008 costs to the current rate year was the Medicare Skilled Nursing Facility Market Basket Index (Market Basket), the same inflation index used by most states to inflate costs for rate setting purposes and by the Centers for Medicare & Medicaid Services (CMS) in setting Medicare rate increases. In addition, the trended costs were increased by the cost of any new or expanded provider tax programs if that cost was not already included in the base year's cost reports. Historically, allowable Medicaid costs have increased annually by a greater percentage than the Market Basket, meaning that once actual 2010 cost data become available, the actual shortfall for 2010 will likely be higher than what is projected in this report. For example, the October 2008 report projected a per diem shortfall of $12.48 for

[2] The President of Eljay, LLC is a retired partner of BDO Seidman, LLP (BDO) and formerly their National Director of Long Term Care Services. Both this year's study and the seven conducted in prior years were compiled under his management and review. BDO performed the compilation for the first five years with both BDO and Eljay collaborating on the report in year six.

[3] As-filed Medicaid cost reports or Medicare cost reports were the only available reports in a few states where rates were not based upon the most current cost report. In this situation, the state may not have audited the cost reports since it was not used in the rate setting process. These cost reports, however, already exclude non-allowable costs per cost report instructions although additional adjustments would typically be made if audited by the state agency or its contractor.

2008. When calculated using actual allowable cost data for that year, the actual per diem shortfall was $16.79, over 34% higher than originally projected.[4]

Estimated Medicaid Shortfall: 2008

The estimated average shortfall in Medicaid reimbursement increased per Medicaid patient day from $15.97[1] in 2007 to $16.79 in 2008; a 5.1% increase. For every dollar of allowable cost incurred for a Medicaid patient in 2008, Medicaid programs reimbursed, on average, approximately 91 cents. The 2008 shortfall compilation incorporates data from 39 states. When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing facilities was estimated to be almost $5.5 billion.

Projected Medicaid Shortfall: 2010[5]

Between 2008 and 2010, overall Medicaid rates increased by 4.9%, fairly comparable to Market Basket inflationary projections for the same time period. The estimated 2010 projected shortfall climbed slightly to $17.33.[6] We estimate that, on average, in 2010, state Medicaid programs continued to reimburse approximately 91% of projected allowable costs incurred on behalf of Medicaid patients, still the lowest percentage achieved since 2003.

The 2010 shortfall compilation incorporates data from 40 states.[7],[8] When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing facilities was projected at over $5.6 billion. Taken together, in the years that we have compiled this study, the shortfall in Medicaid nursing home funding has increased 91.4%, from $9.05 per patient day in 1999 to a projected $17.33 in 2010.

[4] If we incorporated the corrected 2007 cost data for New York in projecting the 2008 national shortfall (see footnote 1), the projected 2008 shortfall increases to $14.07. The actual national shortfall for 2008 of $16.79 is still 19% higher.

[5] No determination of the Medicaid shortfall could be made for 2009, since 2009 cost reports were unavailable in all but a few states. The 2010 Medicaid shortfall is a projection based upon trending the most recently available cost reports to 2010 and comparing these trended costs to current rates.

[6] This shortfall projection, based upon trending 2008 (or 2009 if available) allowable costs to 2010 by the SNF Market Basket for comparison to 2010 rates is conservative. The actual 2010 shortfall will likely be greater once actual 2010 allowable cost data becomes available in that historically, allowable costs have increased annually by a greater percentage than the Market Basket.

[7] In New Jersey, the state agency provided 2008 and 2010 rate data but no cost data has been provided since 2006. As such, we projected a 2008 and 2010 shortfall for New Jersey by projecting 2006 cost report data to 2008 and 2010 and comparing these projected costs to 2008 and 2010 rates.

[8] In New Hampshire, the state Medicaid contractor provided shortfall data only for the current year. Thus, a 2010 shortfall was determined, but a 2008 shortfall could not, due to missing data.

The charts on pages 19 – 22 reflect the per diem shortfall and the fiscal impact of the shortfall in each state by year. Figures I and II on pages 4 and 5 reflect the shortfall per Medicaid day and the percentage of costs covered by the rates in each year since inception of the study.

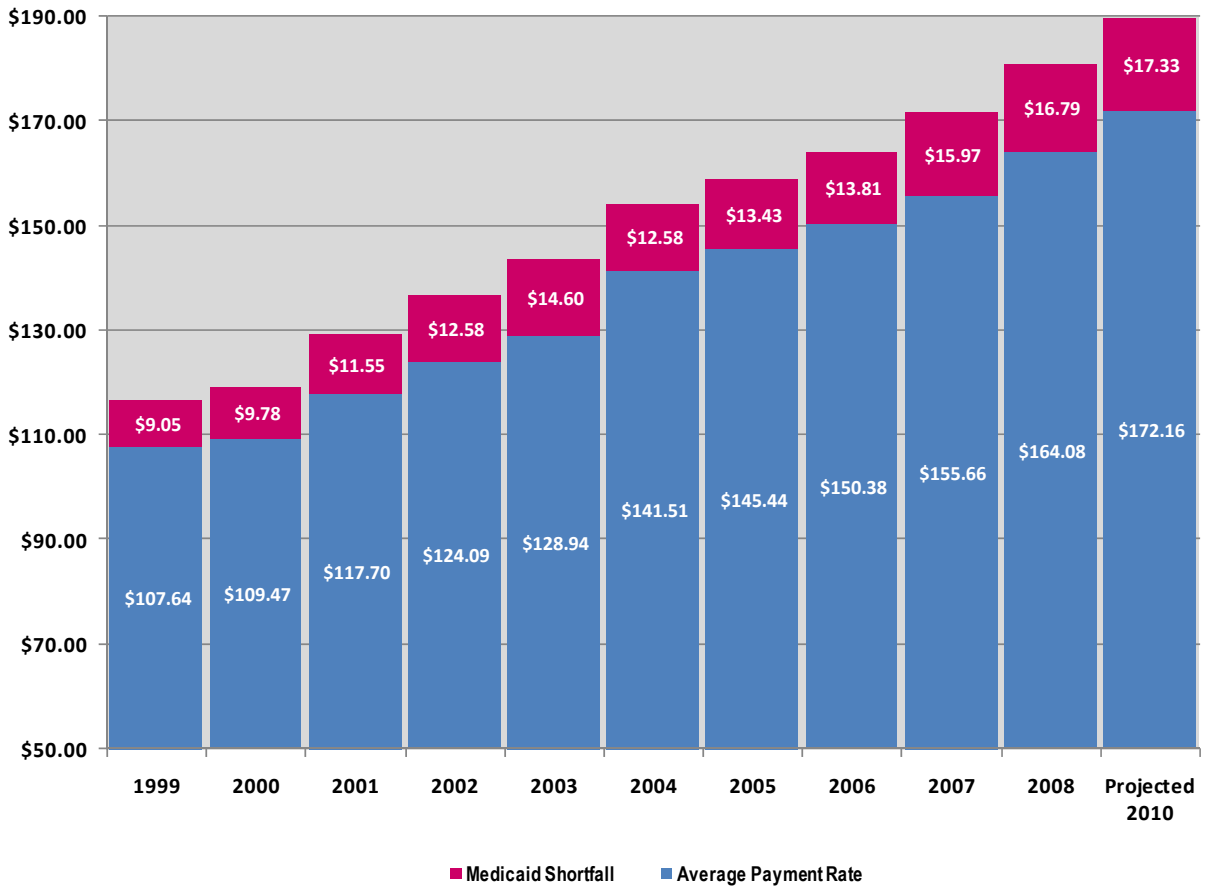
Medicaid Allowable Costs Compared to Total Costs

If all costs of operations were considered—not just Medicaid allowable costs—the shortfall would be significantly greater. Allowable costs include only those costs recognized by the Medicaid state agency as directly or indirectly related to patient care and typically exclude necessary operating costs including, but not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of facilities, and out-of-state travel. Based upon historical analysis of non-allowable costs in states where such detail was available and Eljay's experience over the past 36 years of preparing and analyzing cost reports, these legitimate business costs typically constitute 2% to 3% of total costs. A 2% disallowance of legitimate business costs is equivalent to additional unreimbursed cost of approximately $3.79 per day based upon total projected 2010 Medicaid allowable costs of $189.49 per day. This would increase the projected 2010 Medicaid shortfall to just over $21 per patient day.

FIGURE I

Shortfall Per Medicaid Patient Day

All States in Each Year [1,2]



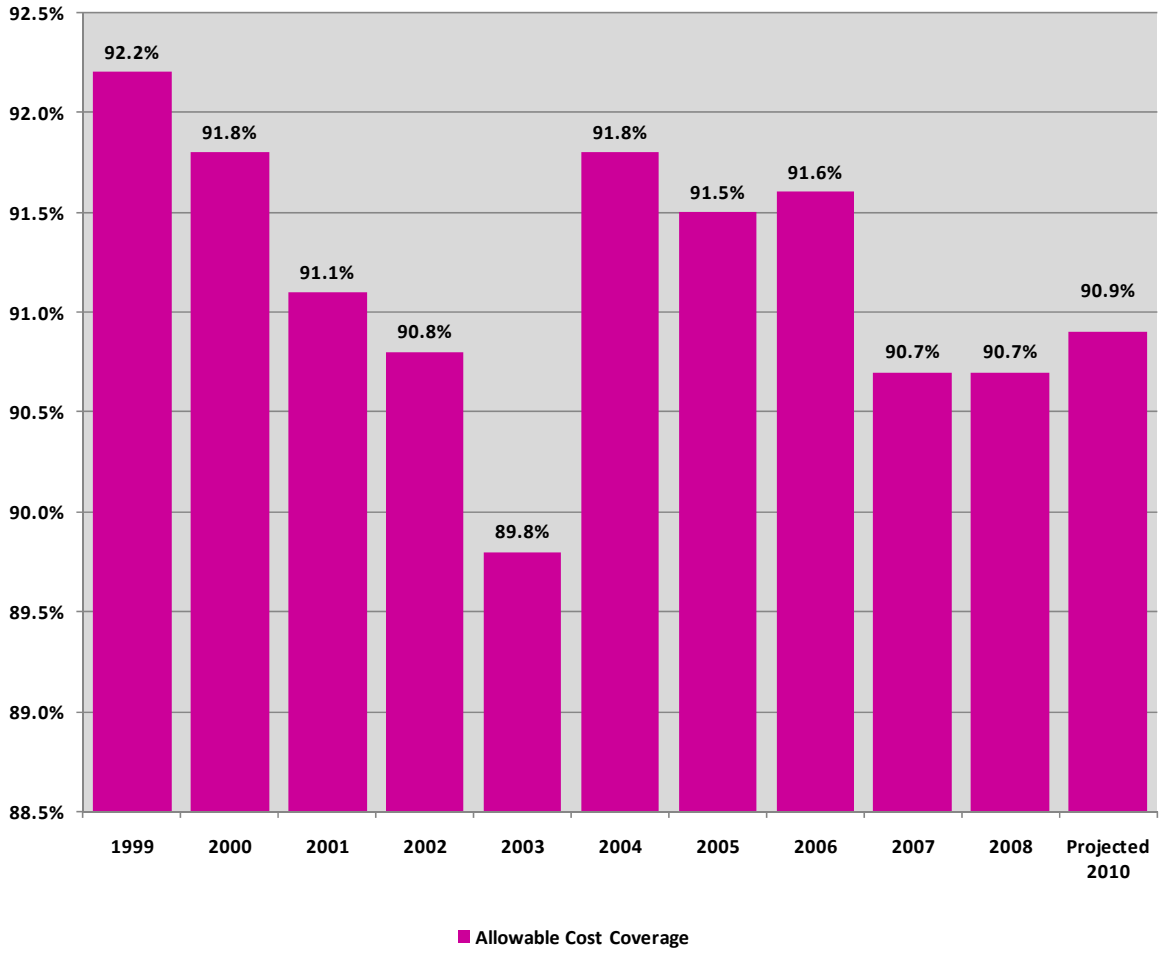
[1] No determination of the Medicaid shortfall could be made for 2009 since cost reports for 2009 were unavailable in all but 9 states. The 2010 Medicaid shortfall is a projection based upon trending the most recently available (2008) cost reports to 2010 and comparing these trended costs to current rates.

[2] The 2007 shortfall per Medicaid patient day reflects the correction for New York (see Footnote 1).

FIGURE II

Percentage of Costs Covered by the Rates

All States in Each Year [1]



[1] The 2007 cost coverage percentage reflects the correction for New York.

TABLE I

State-by-State Comparison of Rates & Costs

State	Rate 08	Cost 08	Difference 08
Arizona	$ 162.07	$ 169.03	$ (6.96)
California	$ 156.56	$ 168.04	$ (11.48)
Colorado	$ 186.87	$ 196.80	$ (9.93)
Connecticut	$ 218.11	$ 231.30	$ (13.19)
Delaware	$ 207.24	$ 224.91	$ (17.67)
Florida	$ 180.05	$ 195.62	$ (15.57)
Georgia	$ 133.48	$ 141.62	$ (8.14)
Hawaii	$ 223.68	$ 231.77	$ (8.09)
Idaho	$ 175.19	$ 173.77	$ 1.42
Illinois	$ 112.20	$ 134.69	$ (22.49)
Indiana	$ 148.57	$ 155.65	$ (7.08)
Iowa	$ 121.18	$ 136.38	$ (15.20)
Kansas	$ 132.45	$ 149.04	$ (16.59)
Maine	$ 172.67	$ 189.33	$ (16.66)
Maryland	$ 213.27	$ 214.76	$ (1.49)
Massachusetts	$ 191.30	$ 214.08	$ (22.78)
Michigan	$ 187.31	$ 191.56	$ (4.25)
Minnesota	$ 154.24	$ 178.99	$ (24.75)
Missouri	$ 122.35	$ 141.73	$ (19.38)
Montana	$ 162.67	$ 172.41	$ (9.74)
Nebraska	$ 140.84	$ 160.88	$ (20.04)
Nevada	$ 173.49	$ 184.01	$ (10.52)
New Jersey	$ 204.96	$ 230.09	$ (25.13)
New York	$ 214.19	$ 253.39	$ (39.20)
North Dakota	$ 171.66	$ 174.80	$ (3.14)
Ohio	$ 166.07	$ 177.06	$ (10.99)
Oklahoma	$ 128.07	$ 136.15	$ (8.08)
Oregon	$ 206.83	$ 213.20	$ (6.37)
Pennsylvania	$ 197.61	$ 212.38	$ (14.77)
South Carolina	$ 148.05	$ 154.13	$ (6.08)
South Dakota	$ 123.51	$ 138.58	$ (15.07)
Tennessee	$ 141.56	$ 146.22	$ (4.66)
Texas	$ 111.89	$ 126.20	$ (14.31)
Utah	$ 156.82	$ 173.47	$ (16.65)
Vermont	$ 181.96	$ 195.05	$ (13.09)
Virginia	$ 143.17	$ 151.90	$ (8.73)
Washington[1]	$ 159.07	$ 183.59	$ (24.52)
Wisconsin	$ 140.87	$ 172.02	$ (31.15)
Wyoming	$ 151.76	$ 178.66	$ (26.90)

[1]The shortfall for the state of Washington only represents a comparison of the operating cost to operating rate. Accurate allowable property cost data were not available, so the comparison excludes property costs and the property component of the rate.

TABLE I (continued)

State-by-State Comparison of Rates & Costs

State	Rate 10	Projected Cost 10	Projected Difference 10
Arizona	$ 166.99	$ 175.66	$ (8.67)
California	$ 164.65	$ 176.21	$ (11.56)
Colorado	$ 188.76	$ 199.08	$ (10.32)
Connecticut	$ 221.38	$ 240.58	$ (19.20)
Delaware	$ 206.36	$ 229.22	$ (22.86)
Florida	$ 202.66	$ 205.05	$ (2.39)
Georgia	$ 139.84	$ 148.46	$ (8.62)
Hawaii	$ 231.67	$ 238.19	$ (6.52)
Idaho	$ 193.56	$ 185.59	$ 7.97
Illinois	$ 117.57	$ 139.52	$ (21.95)
Indiana	$ 151.78	$ 162.44	$ (10.66)
Iowa	$ 139.23	$ 146.26	$ (7.03)
Kansas	$ 132.41	$ 154.02	$ (21.61)
Maine	$ 178.11	$ 196.38	$ (18.27)
Maryland	$ 212.89	$ 224.62	$ (11.73)
Massachusetts	$ 196.09	$ 227.31	$ (31.22)
Michigan	$ 205.54	$ 206.07	$ (0.53)
Minnesota	$ 162.91	$ 187.61	$ (24.70)
Missouri	$ 132.69	$ 149.03	$ (16.34)
Montana	$ 167.43	$ 177.18	$ (9.75)
Nebraska	$ 143.37	$ 163.96	$ (20.59)
Nevada	$ 183.01	$ 197.91	$ (14.90)
New Hampshire	$ 195.21	$ 226.46	$ (31.25)
New Jersey	$ 204.96	$ 234.25	$ (29.29)
New York	$ 216.50	$ 264.45	$ (47.95)
North Dakota	$ 194.36	$ 192.00	$ 2.36
Ohio	$ 177.45	$ 191.10	$ (13.65)
Oklahoma	$ 128.89	$ 138.74	$ (9.85)
Oregon	$ 217.14	$ 220.90	$ (3.76)
Pennsylvania	$ 205.96	$ 221.09	$ (15.13)
South Carolina	$ 154.12	$ 157.14	$ (3.02)
South Dakota	$ 128.76	$ 144.15	$ (15.39)
Tennessee	$ 144.63	$ 151.26	$ (6.63)
Texas	$ 126.29	$ 130.76	$ (4.47)
Utah	$ 161.54	$ 177.79	$ (16.25)
Vermont	$ 182.56	$ 198.11	$ (15.55)
Virginia	$ 143.60	$ 158.44	$ (14.84)
Washington[1]	$ 161.03	$ 189.21	$ (28.18)
Wisconsin	$ 154.56	$ 181.10	$ (26.54)
Wyoming	$ 164.03	$ 187.70	$ (23.67)

[1]The shortfall for the state of Washington only represents a comparison of the operating cost to operating rate. Accurate allowable property cost data were not available so the comparison excludes property costs and the property component of the rate.

NURSING HOME REIMBURSEMENT TRENDS

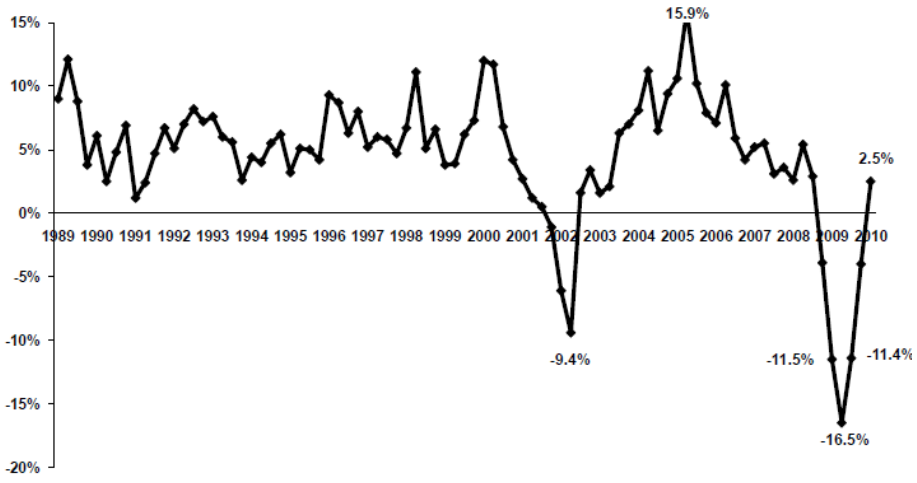
In 2008, providers continued to see steady rate increases. The impact of the recession did not impact Medicaid rates in most states until state fiscal years 2010 or 2011. Rates and costs both increased, on average over 5% from 2007 to 2008. However, allowable cost coverage (the percentage of allowable costs covered by the rates) remained just under 91%, the lowest since 2003.

As addressed in the next section of this report, provider taxes were an important element in attaining reasonable rate increases in many states in 2008. Colorado and Maryland implemented new nursing facility tax programs in 2008, while Florida did so in early 2009. Many of the remaining 29 states and the District of Columbia that already had such tax programs, increased provider taxes in 2008 and 2009 to support Medicaid rate increases.

However, as reflected in Figure III, state tax revenues declined steadily from 2005 to 2008 and then plunged in 2009. At the same time, Medicaid enrollment and spending experienced significant growth since 2006, peaking at an 8.8% increase in 2010 (Figure IV).

FIGURE III

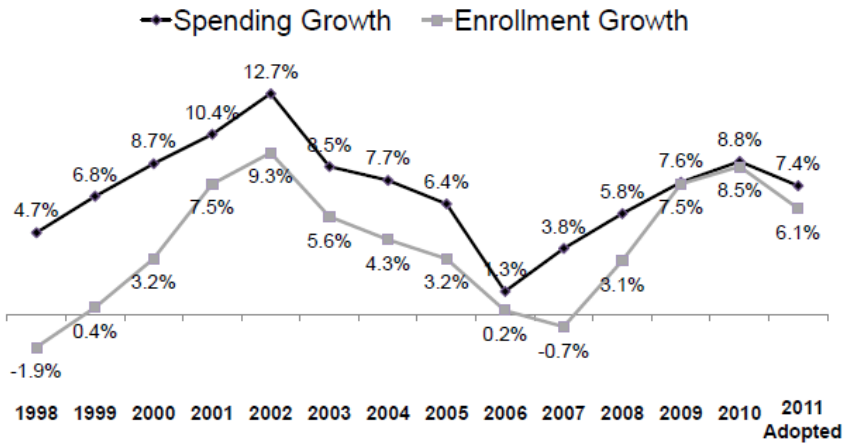
State Tax Revenue, 1999 – 2010



SOURCE: Percent change in quarterly state tax revenue, US Census Bureau

FIGURE IV

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2011



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.
SOURCE: Enrollment Data for 1998-2009: *Medicaid Enrollment in 50 States,* KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2010 and FY 2011 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

If not for the relief provided by the enhanced federal matching funds (Federal Medical Assistance Percentage or FMAP) as a result of the *American Recovery & Reinvestment Act of 2009 (ARRA)*, states would not have survived this deadly combination of higher spending and steep revenue declines. In fact, according to a September 2010 survey report by the Kaiser Commission on Medicaid and the Uninsured on state Medicaid budget trends, the *ARRA* enhanced FMAP funds actually reduced the state costs for Medicaid. The average decline in state general fund spending for Medicaid was 10.9% and 7.1% in FY 2009 and FY 2010, respectively.

However, even with *ARRA* funding enhancements, states incurred cumulative budget deficits exceeding $129 billion in 2010, and deficits in 2011 are projected at $144 billion.[9] This has resulted in a decline in Medicaid rate increases over the past few years, which are addressed later in this report.

[9] 07/15/10 Report from Center on Budget and Policy Priorities

PROVIDER TAXES, INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES AS FUNDING SOURCES FOR RATE INCREASES

Provider taxes continue to be a major funding source for rate increases in many states. Between FY 2004 and FY 2010, many states implemented or expanded provider tax programs, using the proceeds and corresponding federal matching funds to increase Medicaid rates to nursing homes. Prior to FY 2004, 20 states assessed provider taxes on nursing homes. In FY 2010, 37 states and the District of Columbia have implemented nursing home tax programs. Total tax collections exceed $4 billion. Overall, provider taxes on nursing homes generate over $5.5 billion in matching federal funds. In states with such programs, these taxes are used to reimburse an average of $19 per patient day in allowable Medicaid nursing home costs.

Since 2008, five states (Colorado, Florida, Idaho, Iowa, and Kansas) enacted new provider tax programs. All but nine of the remaining 32 states with provider tax programs increased these taxes in the past two years. How provider tax funds are used has changed dramatically as a result of massive state budget deficits. Most new or expanded tax programs no longer serve to enhance rate increases from the state that would reduce the shortfall between rates and allowable Medicaid costs (as was common in the 12 states implementing new provider tax programs in 2004). Instead, such programs help to mitigate rate freezes or rate reductions. In other words, without the new tax or tax increases, providers would have either received no rate increase or a rate reduction, which is why new tax programs were enacted in Florida, Idaho, Iowa, and Kansas. Even with existing tax programs, many states are using a greater portion of these funds to reduce the overall state budget deficit rather than to enhance rates.

A perfect example of how states are using provider taxes to fund budget deficits can be found in reviewing the enhanced federal match program on Medicaid expenditures through the end of FY 2011 under *ARRA*. Provider taxes that are used as the state share of Medicaid expenditures are eligible for the higher match rates. As a result of the higher federal match rates, states could have used existing provider tax dollars to increase rates to providers. Alternatively, states could have lowered the provider tax rates without having to reduce Medicaid rates due to the higher federal match on the taxes. However, most states with existing nursing facility provider tax programs did neither. Instead states used the savings, representing the difference between existing provider tax revenues and the tax revenues needed to sustain existing rates based upon the higher match rates, to reduce state budget deficits.

As the recession continues, nursing home provider taxes cannot continue to be counted on as a major catalyst for insuring rate increases except in those remaining 13 states that have yet to implement a provider tax program. States with existing programs can only increase the provider tax rate to the federal maximum of 5.5% of nursing facility revenues; this federal limit will climb to a maximum of 6% on October 1, 2011. We estimate that 23 of the 37 states and the District of Columbia are at, or close to, the 5.5% limit in FY 2011.

Besides provider taxes, a number of states also use Intergovernmental Transfers (also known as IGTs) and Certified Public Expenditures to generate additional federal funds to support state services, including long term care services. In May 2007, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule, which in effect, required that the federal dollars generated from these programs remain with the public facilities that are incurring Medicaid shortfalls. The federal dollars could no longer be used to help subsidize state budgets or to increase rates to non-public providers. New limits also reduced the federal dollars that could be generated from these programs. In 2008 and again in 2009, Congress placed a moratorium on this rule, delaying implementation until July 2010. Congress has since requested that CMS not finalize this rule knowing implementation would certainly increase the pressure on state budgets as more Medicaid expenditures would be financed with state funds. Finalization and enactment of the proposed rule could negatively impact nursing home reimbursement rates and increase the shortfall between reimbursement and allowable Medicaid costs.

REDIRECTION IN MEDICAID LONG TERM CARE EXPENDITURES

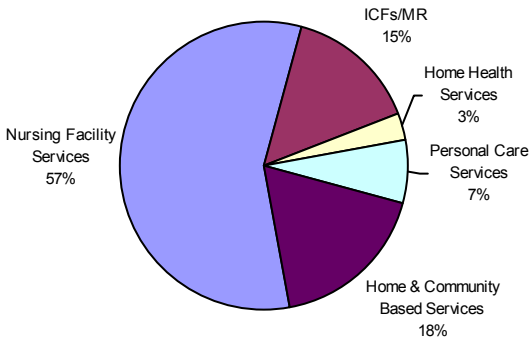
Even though states continue to rebalance their limited resources, redirecting more resources to home and community-based services (HCBS) programs, the percentage of long term care expenditures spent on nursing facility services did not significantly change from 2009 to 2010. A good part of this was due to the difficult financial conditions in the states, which curtailed rebalancing efforts. However, as reflected in Figure V, in the last decade, the percentage of Medicaid long term care expenditures spent on nursing facility services declined from 57% to 43%, a reduction of 24.5%. At the same time, the percentage spent on HCBS has climbed 72%.

FIGURE V

Medicaid Long Term Care Expenditures

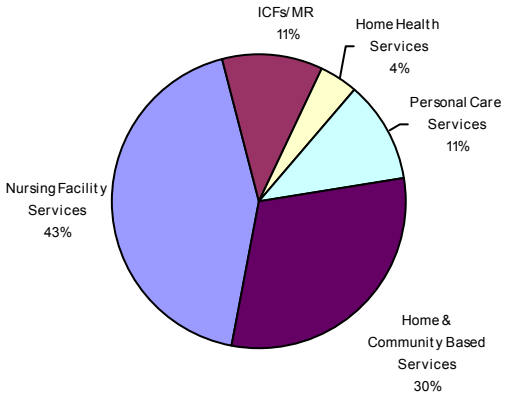
2000

Total LTC Expenditures
$69.5 Billion



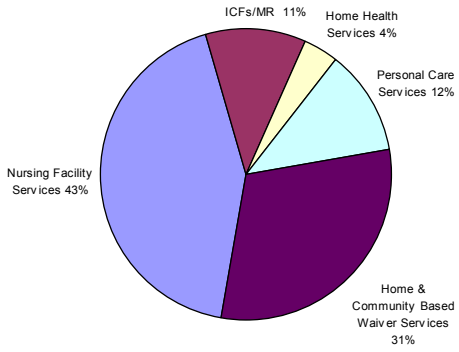
2009

Total LTC Expenditures
$116.7 Billion



2010

Total LTC Expenditures
$120.6 Billion



Source: CMS Medicaid Statement of Expenditures (CMS-64) 2000; CMS Medicaid Program Budget Report (CMS-37), August 2009 and 2010, annual estimate, 2010.

In terms of dollars, expenditures for nursing facility services have only increased $12.2 billion between 2000 and 2010—a compounded annual growth rate of only 2.7%. During the same period, expenditures for HCBS have tripled, climbing $24.9 billion. Figure VI reflects the percentage change and annual rate of growth in Medicaid expenditures by program between 2000 and 2010. It clearly demonstrates that even with Medicaid rates keeping pace with nursing home inflation for most of the decade; nursing home expenditure growth has been extremely modest due to declining nursing home occupancy.

FIGURE VI

Long Term Care Medicaid Expenditures Growth

Expenditures (in billions)	2000	2010	% Change	Annual Rate of Growth
NF	$ 39.6	$ 51.8	30.8%	2.70%
ICFs-MR	$ 10.4	$ 13.3	27.9%	2.30%
HCBS	$ 12.5	$ 37.4	199.2%	11.60%
PC and Home Health	$ 7.0	$ 18.1	158.6%	10.00%
Total	$ 69.5	$ 120.6	67.9%	5.70%

The September 2010 Kaiser Commission report referenced earlier indicates that states may be postponing additional rebalancing efforts due to difficult state fiscal conditions. The number of states adopting new or expanded HCBS waivers dropped to 23 in FY 2010 and 22 in FY 2011 compared to 27 in FY 2009 and 38 in FY 2008.

Limited state resources in the past few years have considerably dampened long term care expenditure growth for not only non-institutional programs, but institutional services as well. As addressed on page 2 of this report, even with enhanced federal matching funds and new and expanded provider tax programs, nursing home rates only climbed 4.9% from 2008 to 2010, and in FY 2011, rate freezes appear to be the norm. This downward pressure on future nursing home rate increases comes at a time when the functional, medical and psycho-social needs of new admissions are higher as increasing percentages of less disabled recipients are cared for in non-institutional settings.

THE ROLE OF MEDICARE IN SUBSIDIZING MEDICAID SHORTFALLS

Medicare continues to play an important role in the cross-subsidization of Medicaid deficits. According to the Medicare Payment Advisory Commission (MedPAC), the average margin on Medicare payment to freestanding nursing homes in 2008 was 16.5%,[10] while our analysis indicates a 10.2% shortfall on Medicaid payment for that year (weighted average 2008 shortfall of $16.79 divided by weighted average Medicaid rate of $164.08). The weighted average 2008 margin from the two government funded programs combined is a negative 0.7% (see Figure VII).

Figure VII
Combined Medicare/Medicaid Shortfall for 2008

Payer	2008 Average Rate	Days in Millions	Revenue in Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	$ 412.42	72.5	$ 29.90	16.5%	$ 4.93
Medicaid	$ 164.08	327.2	$ 53.69	(10.2%)	$ (5.50)
					$ (0.57)

Net Medicare/Medicaid Shortfall as a Percentage of Revenue	(.7%)

Sources: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using 2008 SNF claims data. Medicare margin percentage derived from March 2010 Medicare Payment Advisory Commission Report to Congress. Medicaid rates, days and margins derived from this report.

We also estimated a combined shortfall for 2010 which would take into account the October 1, 2009 reduction in Medicare Part A payments to skilled nursing facilities (SNFs) of approximately $1.05 billion annually to prospectively correct for unexpected overpayments to SNFs as a result of changes in the nursing weights that occurred as part of the FY 2006 SNF Prospective Payment System (PPS) refinement. Figure VIII reflects the impact of this Medicare rate reduction, which increases the shortfall from the two government funded programs combined to a negative 2.9%[11] (see Figure VIII). The combination of declining Medicare margins and greater

[10] March 2010 Medicare Payment Advisory Commission Report to Congress.
[11] Together Medicare and Medicaid represent approximately 80 percent of nursing facility residents. If other payer sources were included (e.g., private pay, private insurance, managed care, etc.), overall margins in 2008 would likely have been close to zero or slightly positive.

Medicaid shortfalls (as addressed in the next section of this report) could have serious adverse financial and quality implications.

Figure VIII
Estimated Combined Medicare/Medicaid Shortfall for 2010

Payer	2010 Average Rate	Days in Millions	Revenue in Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	$ 422.07	72.5	$ 30.60	10.3%	$ 3.15
Medicaid	$ 172.16	325.2	$ 55.99	(10.1%)	$ (5.65)
			$ 86.59		$ (2.50)
			Net Medicare/Medicaid Shortfall as a Percentage of Revenue		(2.9%)

Sources: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using 2008 SNF claims data. Medicare 2010 projected margin percentage derived from March 2010 Medicare Payment Advisory Commission Report to Congress. March 2010. Medicaid rates, days and margins derived from this report.

NURSING HOME REIMBURSEMENT OUTLOOK FOR 2011 AND 2012

According to the September 2010 Kaiser Commission report, *Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*, states were still in the midst of the worst economic downturn since the Great Depression at the end of FY 2010 and heading into FY 2011. While Congress extended FMAP enhancement funds through June 2011 (although funding enhancement was scaled back from $24 billion to $16.1 billion), more than half of the states assumed a full extension of *ARRA* funds in drafting their 2011 budgets. Of the states that assumed a full extension of *ARRA* funds in their fiscal year budgets, the annual budgeted growth in state Medicaid spending was 5.3%, which compares to an average projected growth of 25.6% in states that did not assume an extension of such funds. As a result, many states will have to make mid-year budget adjustments that could adversely impact Medicaid rates.

Looking forward to 2012, the Kaiser Commission report suggests that –even though tax revenues are again slowly increasing (i.e., the first quarter of 2010 was 2.5% higher than the comparable quarter in 2009) – state economic recovery remains a few years away. The state cost of Medicaid in FY 2012 will be one quarter to a third higher in FY 2011 simply due to the expiration of enhanced FMAP without considering other factors such as changes in eligibility, enrollment, utilization and rates.

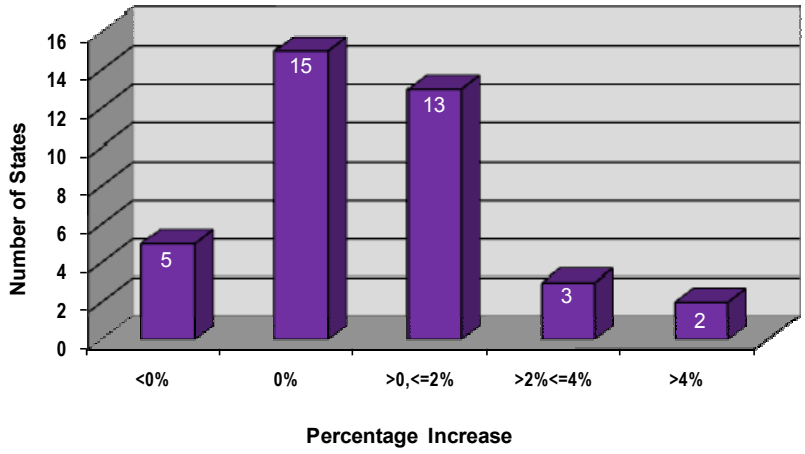
Also looming is comprehensive health reform. States will face key challenges with major cost implications that include implementing the expansion of Medicaid eligibility; transitioning to a new income eligibility methodology; setting up Health Insurance Exchanges; and redesigning systems to accommodate the changes.

The impact of the recession on nursing home Medicaid rate increases has been felt in the past two years even with expansion of provider tax programs; increases in tax rates in existing programs; and *ARRA* enhanced FMAP. While rates increased just over 5% from 2007 to 2008, rates only increased 4.9% in the two year period from 2008 to 2010.

The drop-off in rate increases really hit home in FY 2011. As part of our data gathering, we requested FY 2011 provider rates from the AHCA state affiliates, or at a minimum, the average change in Medicaid rates between FY 2010 and FY 2011. The Medicaid day-weighted average increase for the 38 states reporting was only one half of one percent. As reflected in Figure IX, more than half of the states reported either no rate increases or a rate decrease for FY 2011.

FIGURE IX

Projected 2011 Percentage Increase in Medicaid Rates



Even if nursing home costs conservatively increase at the same pace as the forecasted annual Market Basket (approximately 2% per year), the shortfall will likely increase to at least $21.12 per Medicaid patient day in FY 2011, ballooning 53% since 2006. The percentage of cost

covered by the Medicaid rates would drop to 89%, the lowest cost coverage percentage since we initiated this study.

SUMMARY

Between 2004 and 2008, Medicaid rate increases have reasonably kept pace with nursing home cost increases due to a healthy economy and enactment or increases in provider taxes in numerous states. As a result, cost coverage (the percent of allowable cost covered by the rate) remained relatively stable, hovering around 91%.

Even in 2009 and 2010, as state revenues declined considerably and Medicaid spending increased, the combination of new and expanded provider tax programs and enhanced federal matching funds under *ARRA* resulted in inflationary rate increases for nursing homes in most states in these years. The rate increases of course were much lower than in prior years.

Unfortunately, FY 2011 looks bad. State revenues are not increasing as quickly as anticipated and higher state budget deficits are projected. The enhanced federal matching FMAP funds provided under *ARRA* expire as of June 30, 2011. Most states now have a provider tax program and the taxes these programs currently generate are at or near federal limits. States are reporting little or no rate increases for nursing homes in FY 2011, with the average of only one half of one percent (0.5%).

FY 2012 could be even worse if economic recovery is slow, as is being predicted. The state cost of Medicaid in FY 2012 will be one quarter to a third higher in FY 2011 simply due to the expiration of enhanced FMAP without considering other factors such as changes in eligibility, enrollment, utilization and rates. As a result, there is little expectation of inflationary rate increases for nursing homes in most states in FY 2012.

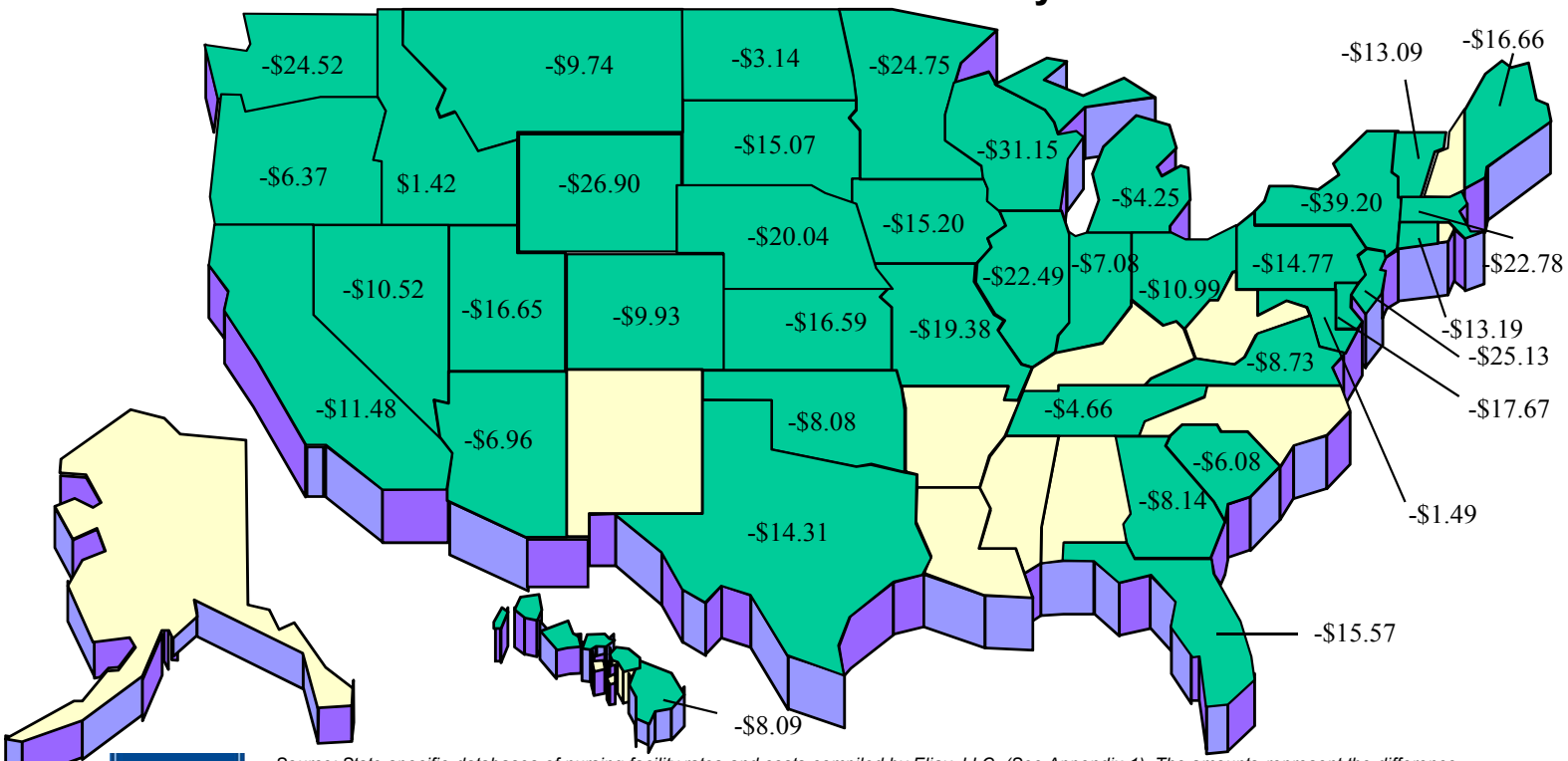
Medicaid nursing home rate setting will undergo significant changes in the coming years. Greater emphasis will likely be placed on value-based purchasing: achieving efficiency, economy and quality of care. Nursing home providers will need to meet expectations in all three areas to be successful. With a sluggish economy and limited state resources, the solution for many states may be a re-allocation of Medicaid funds to those providers who can accomplish all three objectives.

Charts

CHART 1

In 2008, on Average, the Shortfall in Medicaid Reimbursement Was $16.79 Per Medicaid Patient Day

Average Disparity By State Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs

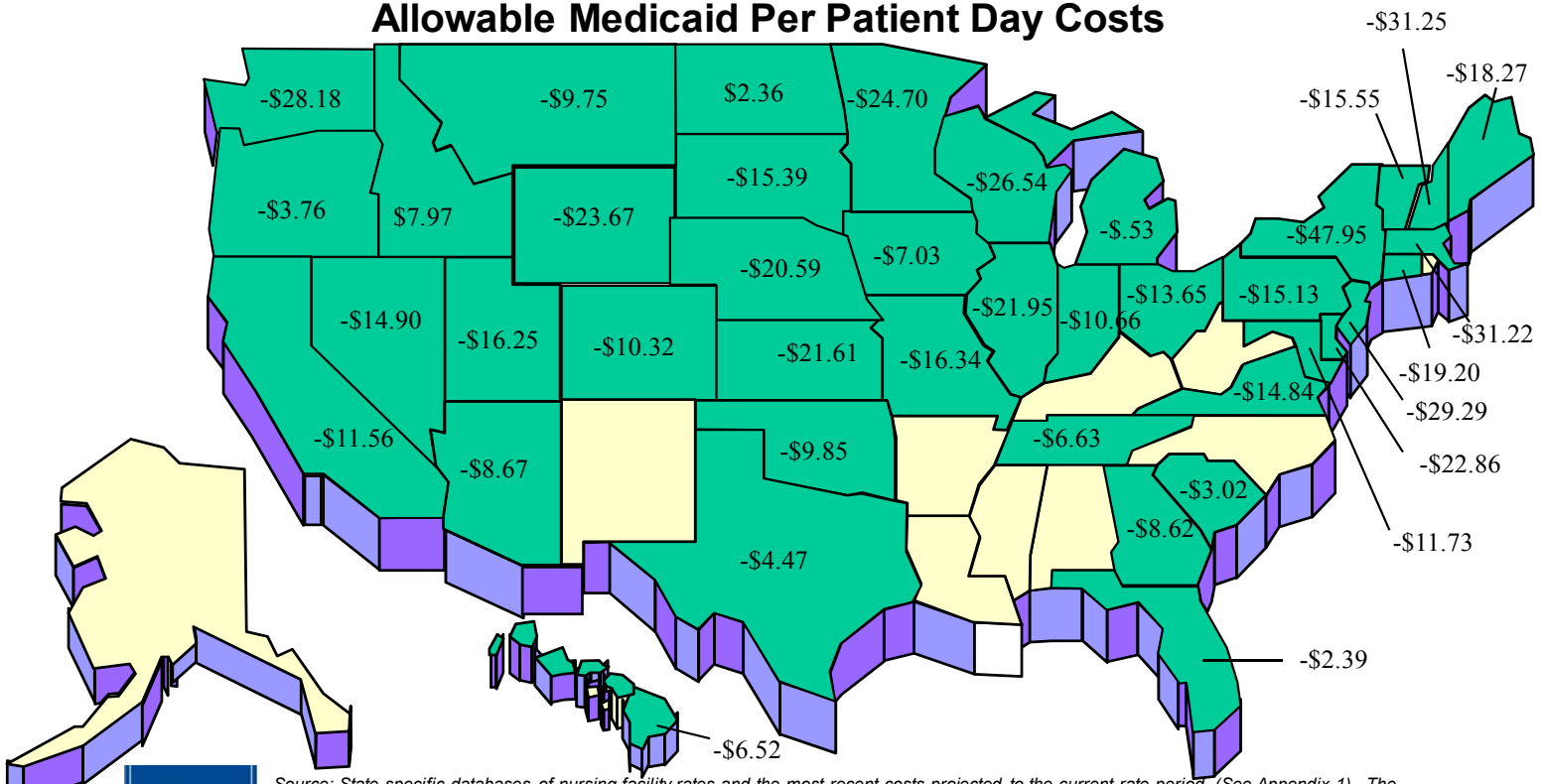


Source: State-specific databases of nursing facility rates and costs compiled by Eljay, LLC. (See Appendix 1). The amounts represent the difference between Medicaid rates and allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case , the shortfalls would be much higher.

CHART 1

The Projected Average 2010 Shortfall in Medicaid Reimbursement Is $17.33 Per Medicaid Patient Day

Average Disparity By State Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs

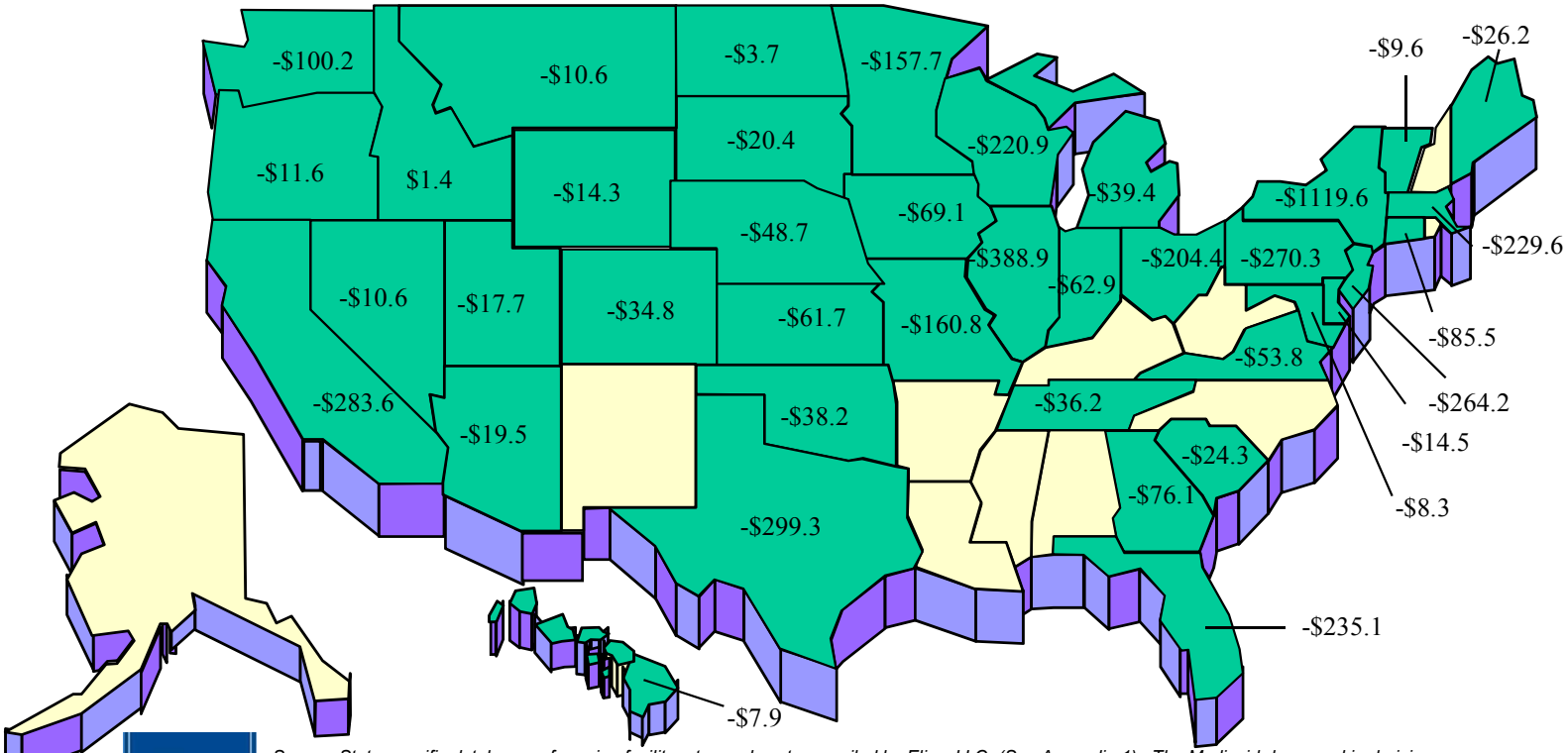


Source: State-specific databases of nursing facility rates and the most recent costs projected to the current rate period. (See Appendix 1). The amounts represent the difference between Medicaid rates and projected allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and projected costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case, the shortfalls would be much higher.

CHART 2

2008 Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs (In Millions)

$5.5 Billion Medicaid Funding Shortfall Nationwide

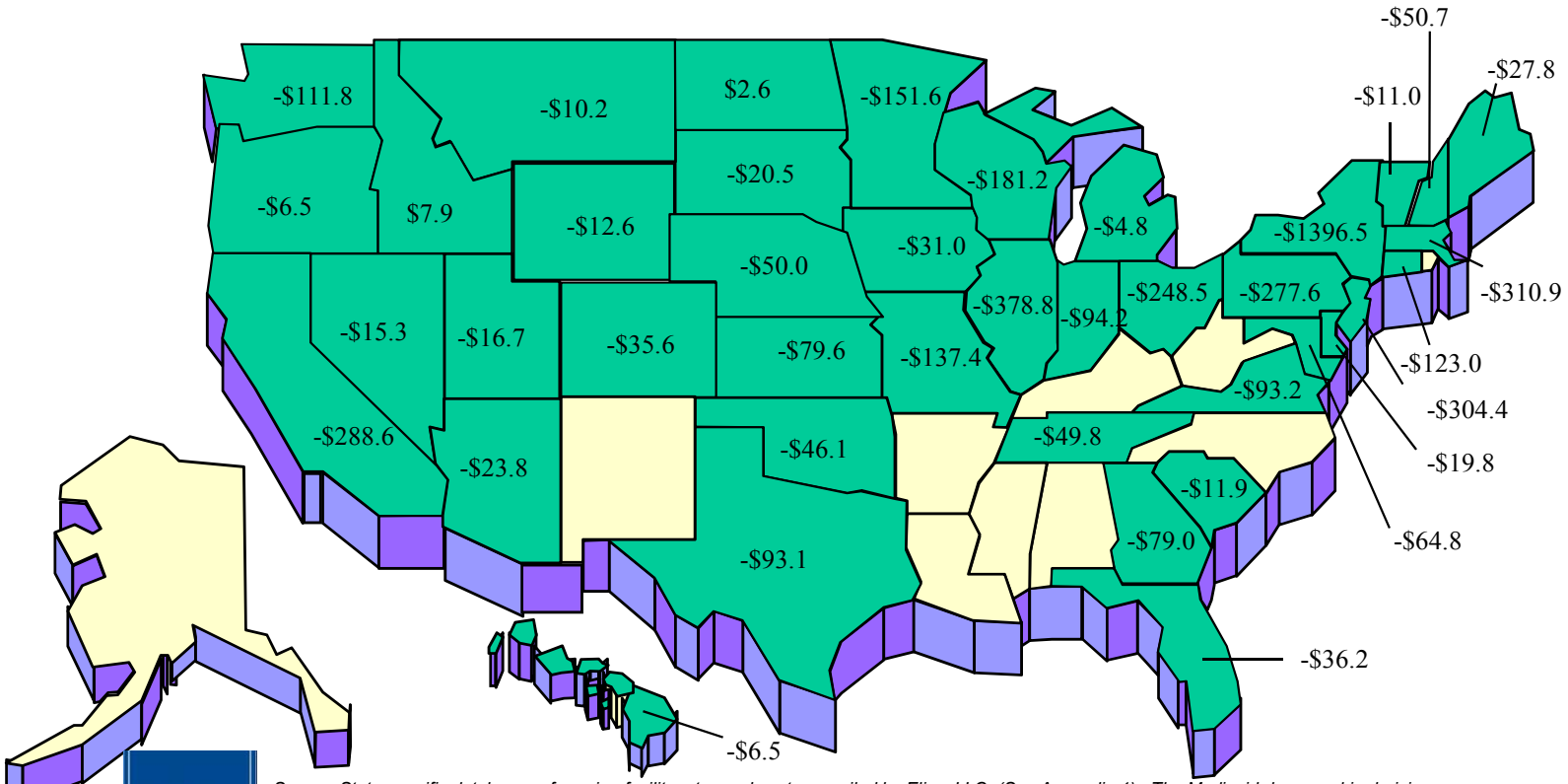


Source: State-specific databases of nursing facility rates and costs compiled by Eljay, LLC. (See Appendix 1). The Medicaid days used in deriving state-specific shortfalls were derived from CMS-OSCAR Form 672: F75-78, current surveys as of December 2008. The weighted average shortfall for the 39 states reporting exceeded $4.7 billion dollars, based upon over 282 million Medicaid days. Extrapolating this shortfall to 327 million Medicaid days nationwide (per CMS-OSCAR Data) results in almost a $5.5 billion national shortfall.

CHART 2

Projected 2010 Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs (In Millions)

$5.6 Billion Medicaid Funding Shortfall Nationwide



Source: State-specific databases of nursing facility rates and costs compiled by Eljay, LLC. (See Appendix 1). The Medicaid days used in deriving state-specific shortfalls were derived from CMS-OSCAR Form 672: F75-78, current surveys as of June 2010. The weighted average shortfall for the 40 states reporting was close to $4.9 billion dollars, based upon 282 million Medicaid days. Extrapolating this shortfall to 325 million Medicaid days nationwide (per CMS-OSCAR Data) results in over a $5.6 billion national shortfall.

Appendix I

Project Approach and Methodology

PROJECT APPROACH AND METHODOLOGY

The American Health Care Association initially surveyed its state affiliates as to the availability of a database of state-specific Medicaid rate and allowable cost information. Those that responded in the affirmative were asked to complete "data collection spreadsheets" reflecting the Medicaid rates and allowable costs for each provider based upon the provider's fiscal or calendar years ending in 2008 (or 2009, if available). In addition, the state affiliates were requested to provide current Medicaid rates by provider to allow comparisons, not only between allowable costs and Medicaid rates in 2008, but between current (FY 2010) rates and 2008 (or 2009, if available) costs trended to the same time period. Sample data collection spreadsheets are included as Appendix IV.

Eljay was engaged to assist in this process by:

1. Developing the data collection spreadsheets;
2. Instructing and guiding state affiliates through the process;
3. Reviewing the results for reasonableness and compliance with document instructions;
4. Contacting other sources such as state agencies, their consultants and independent accounting firms to obtain the data in those states where the data was readily available, but the state affiliate did not have it;
5. Developing the comparisons between current Medicaid rates and the most recent cost reports trended to the same time frame; and
6. Compiling the results into a report.

In almost all cases, the state affiliates indicated that the data were derived from a database of Medicaid rates and allowable costs obtained from their state agencies. Allowable costs include only those costs recognized by the state agency as directly or indirectly related to patient care and typically exclude necessary operating costs including, but not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of facilities, and out-of-state travel. The cost database reflected costs that have been audited or desk-reviewed by the Medicaid state agency in over 70% of the states in 2008. Eljay did not replicate the calculations nor trace individual facility cost or rate data to Medicaid cost reports, rate worksheets, or state agency databases.

Comparisons of Medicaid rates and allowable costs for 2008 were derived for 39 states, representing over 86% of the Medicaid patient days in the country. Current Medicaid rates by provider were obtained from 40 states allowing us to determine an estimated 2010 shortfall for these states that represent almost 87% of Medicaid days nationwide.[12] The remaining states not reflected in the comparisons indicated that the data was not readily available. However, as can be seen by the charts on pages 19 – 22, these states reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide. The comparisons include all of the states representing the largest Medicaid populations, including California, Florida, Illinois, Massachusetts, New York, Ohio, Pennsylvania and Texas. Based upon the high percentage of nationwide Medicaid patient days represented by the states, it is likely that the overall results would not materially change had all states been represented.

[12]In New Jersey, the state agency provided 2010 rate data but no 2008 data in that the 2008 cost reports were not used for rate setting. As such, we projected a 2010 shortfall for New Jersey by projecting the latest available cost report data (2006) to 2010 and comparing these projected costs to 2010 rates. However no 2008 actual shortfall determination could be made.

Appendix II

Calculation of 2008 and Projected 2010 Weighted Average Medicaid Shortfall

State-by-State Comparison

Calculation of 2008 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	$ 162.07	$ 169.03	$ (6.96)	2,796,713	$ 453,263,312	$ 472,728,436	$ (19,465,124)
California	$ 156.56	$ 168.04	$ (11.48)	24,703,382	$ 3,867,561,450	$ 4,151,156,273	$ (283,594,823)
Colorado	$ 186.87	$ 196.80	$ (9.93)	3,503,457	$ 654,690,987	$ 689,480,314	$ (34,789,327)
Connecticut	$ 218.11	$ 231.30	$ (13.19)	6,480,275	$ 1,413,412,774	$ 1,498,887,601	$ (85,474,827)
Delaware	$ 207.24	$ 224.91	$ (17.67)	820,315	$ 170,002,054	$ 184,497,017	$ (14,494,964)
Florida	$ 180.05	$ 195.62	$ (15.57)	15,102,170	$ 2,719,145,694	$ 2,954,286,480	$ (235,140,786)
Georgia	$ 133.48	$ 141.62	$ (8.14)	9,354,825	$ 1,248,682,064	$ 1,324,830,341	$ (76,148,277)
Hawaii	$ 223.68	$ 231.77	$ (8.09)	981,120	$ 219,456,922	$ 227,394,182	$ (7,937,261)
Idaho	$ 175.19	$ 173.77	$ 1.42	973,813	$ 170,602,247	$ 169,219,433	$ 1,382,814
Illinois	$ 112.20	$ 134.69	$ (22.49)	17,290,460	$ 1,939,989,559	$ 2,328,851,994	$ (388,862,435)
Indiana	$ 148.57	$ 155.65	$ (7.08)	8,889,274	$ 1,320,679,474	$ 1,383,615,535	$ (62,936,062)
Iowa	$ 121.18	$ 136.38	$ (15.20)	4,548,779	$ 551,221,030	$ 620,362,469	$ (69,141,440)
Kansas	$ 132.45	$ 149.04	$ (16.59)	3,719,689	$ 492,672,771	$ 554,382,407	$ (61,709,636)
Maine	$ 172.67	$ 189.33	$ (16.66)	1,573,338	$ 271,668,205	$ 297,880,010	$ (26,211,805)
Maryland	$ 213.27	$ 214.76	$ (1.49)	5,601,927	$ 1,194,722,877	$ 1,203,069,748	$ (8,346,871)
Massachusetts	$ 191.30	$ 214.08	$ (22.78)	10,077,025	$ 1,927,734,905	$ 2,157,289,538	$ (229,554,632)
Michigan	$ 187.31	$ 191.56	$ (4.25)	9,278,872	$ 1,738,025,574	$ 1,777,460,782	$ (39,435,207)
Minnesota	$ 154.24	$ 178.99	$ (24.75)	6,370,517	$ 982,588,585	$ 1,140,258,888	$ (157,670,303)
Missouri	$ 122.35	$ 141.73	$ (19.38)	8,296,837	$ 1,015,117,995	$ 1,175,910,694	$ (160,792,699)
Montana	$ 162.67	$ 172.41	$ (9.74)	1,087,503	$ 176,904,097	$ 187,496,375	$ (10,592,278)
Nebraska	$ 140.84	$ 160.88	$ (20.04)	2,429,398	$ 342,156,366	$ 390,841,496	$ (48,685,129)
Nevada	$ 173.49	$ 184.01	$ (10.52)	1,006,968	$ 174,698,851	$ 185,292,152	$ (10,593,302)
New Jersey	$ 204.96	$ 230.09	$ (25.13)	10,514,972	$ 2,155,148,626	$ 2,419,389,868	$ (264,241,242)
New York	$ 214.19	$ 253.39	$ (39.20)	28,561,329	$ 6,117,551,024	$ 7,237,155,115	$ (1,119,604,091)
North Dakota	$ 171.66	$ 174.80	$ (3.14)	1,169,517	$ 200,759,278	$ 204,431,561	$ (3,672,283)
Ohio	$ 166.07	$ 177.06	$ (10.99)	18,597,944	$ 3,088,560,485	$ 3,292,951,885	$ (204,391,400)
Oklahoma	$ 128.07	$ 136.15	$ (8.08)	4,730,382	$ 605,820,084	$ 644,041,575	$ (38,221,490)
Oregon	$ 206.83	$ 213.20	$ (6.37)	1,827,088	$ 377,896,645	$ 389,535,197	$ (11,638,552)
Pennsylvania	$ 197.61	$ 212.38	$ (14.77)	18,300,220	$ 3,616,306,543	$ 3,886,600,798	$ (270,294,255)
South Carolina	$ 148.05	$ 154.13	$ (6.08)	3,996,960	$ 591,749,964	$ 616,051,482	$ (24,301,518)
South Dakota	$ 123.51	$ 138.58	$ (15.07)	1,351,002	$ 166,862,287	$ 187,221,890	$ (20,359,604)
Tennessee	$ 141.56	$ 146.22	$ (4.66)	7,766,394	$ 1,099,410,746	$ 1,135,602,142	$ (36,191,396)
Texas	$ 111.89	$ 126.20	$ (14.31)	20,915,993	$ 2,340,290,440	$ 2,639,598,298	$ (299,307,858)
Utah	$ 156.82	$ 173.47	$ (16.65)	1,061,438	$ 166,454,632	$ 184,127,567	$ (17,672,935)
Vermont	$ 181.96	$ 195.05	$ (13.09)	732,786	$ 133,337,682	$ 142,929,847	$ (9,592,165)
Virginia	$ 143.17	$ 151.90	$ (8.73)	6,162,135	$ 882,232,939	$ 936,028,382	$ (53,795,443)
Washington	$ 159.07	$ 183.59	$ (24.52)	4,087,898	$ 650,261,903	$ 750,497,157	$ (100,235,254)
Wisconsin	$ 140.87	$ 172.02	$ (31.15)	7,090,974	$ 998,905,455	$ 1,219,789,283	$ (220,883,828)
Wyoming	$ 151.76	$ 178.66	$ (26.90)	533,276	$ 80,930,014	$ 95,275,146	$ (14,345,133)
		TOTALS		282,286,963	$ 46,317,476,539	$ 51,056,419,355	$ (4,738,942,817)
		Weighted Averages			$ 164.08	$ 180.87	$ (16.79)
		Shortfall extrapolated to all 50 states					$ (5,493,579,364)
		Total States			39		
		Percentage of Days			86.3%		

Calculation of Projected 2010 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	$ 166.99	$ 175.66	$ (8.67)	2,749,466	$ 459,133,354	$ 482,971,226	$ (23,837,872)
California	$ 164.65	$ 176.21	$ (11.56)	24,965,336	$ 4,110,542,643	$ 4,399,141,932	$ (288,599,289)
Colorado	$ 188.76	$ 199.08	$ (10.32)	3,453,214	$ 651,828,656	$ 687,465,823	$ (35,637,167)
Connecticut	$ 221.38	$ 240.58	$ (19.20)	6,407,591	$ 1,418,512,509	$ 1,541,538,257	$ (123,025,748)
Delaware	$ 206.36	$ 229.22	$ (22.86)	866,646	$ 178,841,023	$ 198,652,546	$ (19,811,523)
Florida	$ 202.66	$ 205.05	$ (2.39)	15,163,047	$ 3,072,943,067	$ 3,109,182,748	$ (36,239,682)
Georgia	$ 139.84	$ 148.46	$ (8.62)	9,160,945	$ 1,281,066,577	$ 1,360,033,924	$ (78,967,348)
Hawaii	$ 231.67	$ 238.19	$ (6.52)	991,866	$ 229,785,673	$ 236,252,641	$ (6,466,968)
Idaho	$ 193.56	$ 185.59	$ 7.97	987,786	$ 191,195,928	$ 183,323,271	$ 7,872,657
Illinois	$ 117.57	$ 139.52	$ (21.95)	17,256,479	$ 2,028,844,208	$ 2,407,623,917	$ (378,779,709)
Indiana	$ 151.78	$ 162.44	$ (10.66)	8,835,560	$ 1,341,061,369	$ 1,435,248,444	$ (94,187,075)
Iowa	$ 139.23	$ 146.26	$ (7.03)	4,406,010	$ 613,448,708	$ 644,422,955	$ (30,974,247)
Kansas	$ 132.41	$ 154.02	$ (21.61)	3,681,745	$ 487,499,826	$ 567,062,331	$ (79,562,505)
Maine	$ 178.11	$ 196.38	$ (18.27)	1,523,662	$ 271,379,410	$ 299,216,712	$ (27,837,302)
Maryland	$ 212.89	$ 224.62	$ (11.73)	5,528,019	$ 1,176,859,923	$ 1,241,703,584	$ (64,843,661)
Massachusetts	$ 196.09	$ 227.31	$ (31.22)	9,957,439	$ 1,952,554,157	$ 2,263,425,393	$ (310,871,237)
Michigan	$ 205.54	$ 206.07	$ (0.53)	9,113,892	$ 1,873,269,427	$ 1,878,099,790	$ (4,830,363)
Minnesota	$ 162.91	$ 187.61	$ (24.70)	6,138,128	$ 999,962,371	$ 1,151,574,123	$ (151,611,752)
Missouri	$ 132.69	$ 149.03	$ (16.34)	8,409,587	$ 1,115,868,080	$ 1,253,280,730	$ (137,412,649)
Montana	$ 167.43	$ 177.18	$ (9.75)	1,043,569	$ 174,724,810	$ 184,899,610	$ (10,174,801)
Nebraska	$ 143.37	$ 163.96	$ (20.59)	2,428,674	$ 348,198,920	$ 398,205,307	$ (50,006,387)
Nevada	$ 183.01	$ 197.91	$ (14.90)	1,023,544	$ 187,318,711	$ 202,569,511	$ (15,250,799)
New Hampshire	$ 195.21	$ 226.46	$ (31.25)	1,623,438	$ 316,911,379	$ 367,643,824	$ (50,732,445)
New Jersey	$ 204.96	$ 234.25	$ (29.29)	10,393,660	$ 2,130,284,642	$ 2,434,714,956	$ (304,430,314)
New York	$ 216.50	$ 264.45	$ (47.95)	29,123,975	$ 6,305,340,562	$ 7,701,835,157	$ (1,396,494,595)
North Dakota	$ 194.36	$ 192.00	$ 2.36	1,114,106	$ 216,537,557	$ 213,908,268	$ 2,629,289
Ohio	$ 177.45	$ 191.10	$ (13.65)	18,206,102	$ 3,230,672,767	$ 3,479,186,057	$ (248,513,290)
Oklahoma	$ 128.89	$ 138.74	$ (9.85)	4,682,361	$ 603,509,542	$ 649,630,801	$ (46,121,258)
Oregon	$ 217.14	$ 220.90	$ (3.76)	1,725,764	$ 374,732,352	$ 381,221,223	$ (6,488,872)
Pennsylvania	$ 205.96	$ 221.09	$ (15.13)	18,348,275	$ 3,779,010,751	$ 4,056,620,154	$ (277,609,403)
South Carolina	$ 154.12	$ 157.14	$ (3.02)	3,941,381	$ 607,445,577	$ 619,348,547	$ (11,902,969)
South Dakota	$ 128.76	$ 144.15	$ (15.39)	1,330,848	$ 171,360,040	$ 191,841,797	$ (20,481,757)
Tennessee	$ 144.63	$ 151.26	$ (6.63)	7,517,315	$ 1,087,229,292	$ 1,137,069,091	$ (49,839,800)
Texas	$ 126.29	$ 130.76	$ (4.47)	20,836,459	$ 2,631,436,451	$ 2,724,575,425	$ (93,138,973)
Utah	$ 161.54	$ 177.79	$ (16.25)	1,028,770	$ 166,187,509	$ 182,905,022	$ (16,717,513)
Vermont	$ 182.56	$ 198.11	$ (15.55)	710,183	$ 129,650,952	$ 140,694,293	$ (11,043,341)
Virginia	$ 143.60	$ 158.44	$ (14.84)	6,277,673	$ 901,473,837	$ 994,634,504	$ (93,160,667)
Washington	$ 161.03	$ 189.21	$ (28.18)	3,968,149	$ 638,990,969	$ 750,813,397	$ (111,822,428)
Wisconsin	$ 154.56	$ 181.10	$ (26.54)	6,828,846	$ 1,055,466,374	$ 1,236,703,936	$ (181,237,562)
Wyoming	$ 164.03	$ 187.70	$ (23.67)	532,709	$ 87,380,334	$ 99,989,568	$ (12,609,233)
	TOTALS			282,282,218	$ 48,598,460,235	$ 53,489,230,792	$ (4,890,770,556)
	Weighted Averages				$ 172.16	$ 189.49	$ (17.33)
	Shortfall extrapolated to all 50 states						$ (5,634,701,111)
	Total States				40		
	Percentage of Days				86.8%		

Appendix III

Impact of High Cost Providers on the Medicaid Average Shortfall

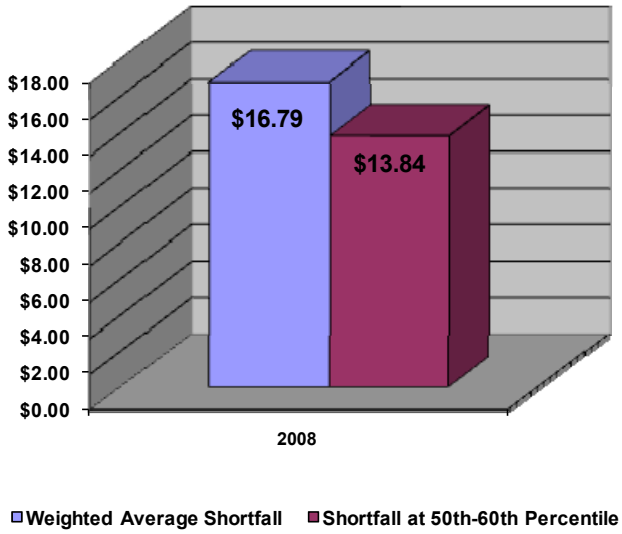
IMPACT OF HIGH COST PROVIDERS ON THE MEDICAID AVERAGE SHORTFALL

Some researchers and analysts reviewing this report have expressed concern that the use of averages, even weighted averages, can skew the Medicaid shortfall results. The issue raised is that the inclusion of all providers, especially outliers with shortfalls significantly above or below the norm, will distort the findings.

It was found that extremely high cost providers, such as hospital-based units, tended to skew the average shortfall upward to a greater degree than the tendency of the lowest cost providers to skew the average downward. As such, we also examined the Medicaid shortfall of those providers whose per diem costs rank at or around the mid-range of all providers in each state. We determined the weighted average Medicaid shortfall of providers with per diem costs that rank between the 50th and 60th percentile of per diem costs of all providers. In each state, we found that providers at these cost levels would be considered efficient and economical under any reasonable cost standard. A graphic comparison between the weighted average shortfall for all providers and the weighted average shortfall for providers with costs between the 50th and 60th percentile is reflected in Figure X for 2008.

FIGURE X

Medicaid Shortfall Comparison – All States Weighted Average Shortfall for All Providers vs. All States Weighted Average Shortfall for Providers With Per Diem Costs at 50th - 60th Percentile



Our findings reflect that even providers whose costs are very reasonable are incurring substantial Medicaid shortfalls. When examining all the states in the study, the average Medicaid shortfall for providers whose per diem costs rank in the 50th to 60th percentile of all providers in each state was $13.84 in 2008. This is only $2.95 per patient day less than the average shortfall for all providers and demonstrates that Medicaid payment is substantially inadequate in reimbursing even reasonable cost providers.

Appendix IV

Data Collection Document
(For 2008 and For Current Rates)

AHCA DATA COLLECTION INSTRUCTIONS FOR 2008 DATA

General Instructions:

Please provide Excel spreadsheets similar to those attached, identifying the difference between Medicaid allowable costs and Medicaid rates for each facility based upon 2008 cost report data. The rates must match the cost report period; not vice versa. We've attached sample spreadsheets that reflect the format and documentation that is required for this project. In essence, we need the average Medicaid rate and Medicaid allowable cost for each facility for its fiscal year that ends in 2008 and the supporting documentation reflecting the computation for each facility.

On the spreadsheets, please indicate whether the data is "as reported" or "audited/desk-reviewed" and the data source (State agency database, etc.). We ask, if at all possible, that the data be "audited/desk-reviewed." If the data is unaudited, we ask you to provide, on a statewide basis (not by individual provider), the average historical audit adjustment percentage representing the percentage difference between "as reported" and "audited/desk reviewed" costs.

If your state utilizes a provider tax program, the tax should be included as an allowable cost, unless the Medicaid rates are net of the reimbursement for provider taxes.

Summary Tab:

This tab summarizes the weighted average Medicaid rate and allowable cost for each facility. The rate for allowable cost for each facility is brought forward from the "Rates" and "Costs" tabs.

Rate Tab:

Use this tab to provide Medicaid rates by provider that correspond to their 2008 cost report period. The Medicaid rate(s) for each facility are weighted by the days or months that they were in effect during the cost report period. The rates must include any supplemental Medicaid payments facilities receive such as add-ons for specialty services or populations if the associated cost of that service is included as an allowable cost.

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Cost Tab:

The cost tab provides an example of supporting documentation that is needed for each facility. Your worksheet will reflect the cost categories utilized in your state in determining Medicaid allowable costs. For each provider, you must indicate their fiscal year end and the number of months represented by the cost report. This information will be utilized by Eljay in trending the costs to the most current rate year.

Medicaid Allowable Nursing Cost

If your state uses an acuity based system such as RUGs, the Medicaid allowable nursing cost should be determined by multiplying the total nursing cost by a ratio; the numerator being the average Medicaid Case Mix Index (CMI) and the denominator being the average overall CMI for the cost report year. For example:

Assumptions:

Total nursing cost for cost report year	$3,000,000
Average Medicaid CMI for cost report year	0.95
Average overall CMI for cost report year	0.98

Calculation of Medicaid allowable nursing cost:

$3,000,000 * (0.95/0.98) = $2,908,163

Current Rates Tab

The current rates tab should reflect the most current weighted average Medicaid rates by provider; if possible, those in effect for state fiscal year 2010. If rates are set by care level, average the rates by weighting them by the percentage of Medicaid days at each care level.

AHCA DATA COLLECTION (SUMMARY)

Is the data "as reported" or "audited/desk reviewed"	☐ As Reported	☐ Audited/Desk Reviewed
Please make every effort to obtain data that is audited or desk reviewed. If the data is neither audited nor desk reviewed, please indicate on average what has been the historical percentge difference between unaudited and audited cost reports in your state.	Historical % Difference	
Data Source (please write in)		
In your calculation of average Medicaid cost, are nursing costs adjusted by the ratio of average Medicaid CMI to average overall CMI? (Yes or No)	☐ Yes	☐ No

FACILITY	PROVIDER NUMBER	OWNERSHIP TYPE[1]	FACILITY YEAR END	# OF MONTHS COVERED BY COST REPORT	AVERAGE MEDICAID RATE	AVERAGE MEDICAID COST	DIFFERENCE	TOTAL MEDICAID DAYS	TOTAL MEDICAID REVENUE	TOTAL MEDICAID COST	TOTAL MEDICAID PROFIT/ SHORTFALL
Facility 1	*123456*	*1*	*12/31/2008*	*12*	*151.00*	*160.49*	*(9.49)*	*32,676*	*4,934,115*	*5,244,188*	*(310,073)*

MEDICAID RATE FOR COST REPORTING PERIOD*

* In most cases, the rate period will not correspond with the cost report period. This will require a computation averaging two or more Medicaid rates for the applicable time frame that each was in effect for the cost report period.

** In determining weighted average Medicaid rates, rates can be weighted by Medicaid days for the applicable time period or calendar days or months, depending upon the information available.

FACILITY	PROVIDER NUMBER	OWNERSHIP TYPE[1]	FACILITY YEAR END	MEDICAID RATE (1)	DAYS APPLICABLE **	SUBTOTAL	MEDICAID RATE (2)	DAYS APPLICABLE **	SUBTOTAL
Facility 1	*123456*	*1*	*12/31/2008*	*150.00*	*10,849*	*1,627,350*	*151.00*	*10,939*	*1,651,789*

MEDICAID RATE (3)	DAYS APPLICABLE **	SUBTOTAL	TOTAL MEDICAID REVENUE	TOTAL MEDICAID DAYS	WEIGHTED AVERAGE MEDICAID RATE PER DAY
152.00	*10,888*	*1,654,976*	*4,934,115*	*32,676*	*151.00*

MEDICAID ALLOWABLE COST FOR COST REPORTING PERIOD

FACILITY	PROVIDER NUMBER	OWNERSHIP TYPE[1]	FACILITY YEAR END	NUMBER OF MONTHS REPRESENTED BY COST REPORT	RN SALARIES	LPN SALARIES	AIDE SALARIES	TOTAL NURSING SALARIES	NURSING OTHER	TOTAL NURSING EXPENSE
Facility 1	*123456*	*1*	*12/31/2008*	*12*	*750,000*	*1,000,000*	*1,500,000*	*3,250,000*	*745,000*	*3,995,000*

MEDICAID CMI	OVERALL CMI	RATIO OF MEDICAID CMI TO OVERALL CMI	CMI ADJUSTED NURSING EXPENSE	SOCIAL SERVICES SALARIES	SOCIAL SERVICES OTHER	RECREATION AND ACTIVITIES SALARIES	RECREATION AND ACTIVITIES OTHER	DIETARY SALARIES	DIETARY OTHER
0.95	*1.00*	*0.95*	*3,795,250*	*75,000*	*12,000*	*73,000*	*30,000*	*250,000*	*300,000*

LAUNDRY SALARIES	LAUNDRY OTHER	HOUSEKEEPING SALARIES	HOUSEKEEPING OTHER	A&G SALARIES	A&G OTHER	MAINTENANCE SALARIES	MAINTENANCE OTHER	UTILITIES	FRINGE BENEFITS	PROPERTY	PROPERTY TAXES
55,000	*22,000*	*140,000*	*50,000*	*250,000*	*350,000*	*45,000*	*65,000*	*85,000*	*850,000*	*500,000*	*45,000*

TOTAL NON-NURSING EXPENSE	TOTAL ADJUSTED EXPENSE	TOTAL DAYS	MEDICAID ALLOWABLE EXPENSE PPD	TOTAL MEDICAID DAYS
3,197,000	*6,992,250*	*43,568*	*160.49*	*32,676*