A Report on Shortfalls in Medicaid Funding for Nursing Home Care

ELJAY, LLC

FOR THE

AMERICAN HEALTH CARE ASSOCIATION

DECEMBER 2011

TABLE OF CONTENTS

REPORT HIGHLIGHTS

- The average shortfall in Medicaid nursing home reimbursement for 2011 is projected to be $19.55 per Medicaid patient day. The actual shortfall in 2011 will likely be somewhat higher, since actual cost increases historically have outpaced projected inflationary increases for nursing homes.

- Un-reimbursed nursing home Medicaid allowable costs are projected to exceed $6.3 billion in 2011, which represents an unprecedented high.

- The 2011 projected shortfall is at an unprecedented high and the outlook for 2012 is even worse.

- For every dollar of allowable cost incurred in providing long term care for a Medicaid patient in 2011, the Medicaid program reimbursed approximately 90 cents on average. Unprecedented state budget deficits and the expiration of federal stimulus funds on July 1, 2011 contributed to the second lowest percentage of cost coverage in the ten years that this annual report has been compiled

- The actual daily reimbursement shortfall for 2009 was estimated at $16.54 per Medicaid patient day; slightly less than the 2008 actual shortfall of $16.79.[1] The shortfall has increased by almost 83% between 1999 and 2009.

- States continue to rely heavily upon provider taxes to fund nursing home reimbursement. New or expanded provider tax programs, for the most part, continue to mitigate rate reductions. In some states, provider taxes have helped to fund inflationary increases that states otherwise would be unable to provide as a result of budget deficits. Very few provider tax dollars are now being used to fund major enhancements to rate systems.

- States continue to budget for, and to redirect more long term care funding to non-institutional services, including new programs and delivery systems that will further promote state rebalancing efforts. 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. At least 60% of states have either reduced rates or provided no rate increases for FY 2012.

- Medicare cross-subsidization of Medicaid continues to serve an important function in sustaining nursing home care. Reimbursements from these two government programs combined have resulted in a break-even margin for 2009; however, we project a very different scenario for nursing care in 2012. With planned Medicare rate reductions in 2012 and a projected negative Medicaid margin topping 14%, the margin percentage for these two government programs combined will only reach a negative 2.7%. The combined shortfall of both Medicare and Medicaid is projected to exceed $2 billion, marking an end to the current reliance on Medicare cross-subsidization of Medicaid shortfalls and the beginning of greater uncertainty.

[1] The decrease in the shortfall between 2008 and 2009 is primarily due to implementation of a nursing facility provider tax program in Florida. The tax, plus federal matching funds, reduced Florida's shortfall from $15.57 in 2008 to $2.39 in 2009. As a result, the 2009 shortfall nationwide was reduced $0.74 per Medicaid patient day. This reduction was short-lived as costs in Florida since that time have outpaced rate increases by over $7 per Medicaid day. The Florida shortfall for 2011 now exceeds $9 per Medicaid patient day.

MEDICAID 2009 & PROJECTED 2011 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 in the previous nine reports, identifies the shortfall for the latest year for which audited or desk-reviewed cost reports were available, which for most states was 2009. In a few states, 2010 year-end cost reports for providers were available and used. A shortfall for the current year of 2011 is projected by trending costs from 2009 (or 2010, if available) to the current year and then comparing those costs to current Medicaid rates.

METHODOLOGY

Overall, data were obtained from 37 states, plus the District of Columbia for 2009 (or 2010, if available), which represents more than 83% of the Medicaid patient days nationwide. Data from almost two-thirds of the states reporting in 2009 were based upon audited or desk-reviewed cost reports, or a blend of both audited and desk-reviewed reports. As-filed Medicaid cost reports or Medicare cost reports were used for the remaining states.[3]

Eljay projected the shortfall in Medicaid reimbursement for the current year by comparing current year rates to allowable costs for 2009 (or 2010, if available) trended to the current year. The trending factor used to project 2009 costs to the current rate year was the Medicare Skilled Nursing Facility Market Basket Index (Market Basket), which is the same inflation index that most states use for rate setting purposes and that the Centers for Medicare & Medicaid Services (CMS) uses to set Medicare rate increases. Trended costs were increased as well 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 2011 cost data become available, the actual shortfall for 2011 will likely be higher than what is projected in this report.

[2] The President of Eljay, LLC is a retired partner of BDO Seidman, LLP (BDO) and BDO's former National Director of Long Term Care Services. Both this year's study and the nine studies 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 such instances, these states may not have audited cost reports if none were used in the state's 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.

For example, we conducted a state-by-state comparison of the actual 2009 shortfalls and the shortfalls we projected in our November 2009 report and found 25 of 36 states had greater actual shortfalls than what we projected. Moreover, the average shortfall for all states in this comparison was $2.37 higher than originally projected.

ESTIMATED MEDICAID SHORTFALL: 2009

The estimated average shortfall in Medicaid reimbursement slightly decreased from $16.79 per Medicaid patient day in 2008 to $16.54 in 2009[4]. For every dollar of allowable cost incurred for a Medicaid patient in 2009, Medicaid programs reimbursed, on average, approximately 91 cents. The 2009 shortfall compilation incorporates data from 37 states, plus the District of Columbia.[5] When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing facilities was estimated at nearly $5.4 billion.

PROJECTED MEDICAID SHORTFALL: 2011[6]

Between 2009 and 2011, overall Medicaid rates increased by 2.9% while Market Basket inflationary projections for the same time period were 4.3%. As a result, the estimated 2011 projected shortfall climbed significantly to $19.55.[7] We estimate that state Medicaid programs, on average, reimbursed only 90% of projected allowable costs incurred on behalf of Medicaid patients in 2011, the second lowest percentage since the inception of this study.

The 2011 shortfall compilation incorporates data from 37 states, plus the District of Columbia.[8] When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing facilities

[4] The decrease in the shortfall between 2008 and 2009 is primarily due to implementation of a nursing facility provider tax program in Florida. The tax, plus federal matching funds, reduced Florida's shortfall from $15.57 in 2008 to $2.39 in 2009. As a result, the 2009 shortfall nationwide was reduced $0.74 per Medicaid patient day. This reduction was short-lived as costs in Florida since that time have outpaced rate increases by over $7 per Medicaid day. The Florida shortfall for 2011 now exceeds $9 per Medicaid patient day.

[5] 2009 cost report data was not made available by the state agencies in Illinois and New Jersey. Therefore, in computing 2009 shortfalls for these states, the latest available cost report data – 2008 reports in Illinois and 2006 reports in New Jersey – were trended to 2009 and compared to 2009 rates.

[6] No determination of the Medicaid shortfall could be made for 2010, since 2010 cost reports were unavailable in all but a few states. The 2011 Medicaid shortfall is a projection based upon trending of the most recently available cost reports to 2011 and comparing these trended costs to current rates.

[7] This shortfall projection, based upon trending 2009 (or 2010 if available) allowable costs to 2011 by the Medicare Skilled Nursing Facility Market Basket for comparison to 2011 rates is conservative. The actual 2011 shortfall will likely be greater once actual allowable cost data for 2011 becomes available, since historically, allowable costs have increased annually by a greater percentage than the Market Basket.

[8] In New Jersey and Illinois, the state agency provided 2009 and 2011 rate data, but no additional cost data for these two states has been provided since 2006 and 2008, respectively. As such, we projected a 2011 shortfall for both of these states by projecting 2006 (New Jersey) and 2008 (Illinois) cost report data to 2011 and comparing these projected costs to 2011 rates.

was projected to exceed $6.3 billion. Taken together based on the years that we have issued this study, the shortfall in Medicaid nursing home funding has increased 116% – from $9.05 per patient day in 1999 to a projected $19.55 in 2011.

The charts on pages 21 – 24 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 the inception of this study.

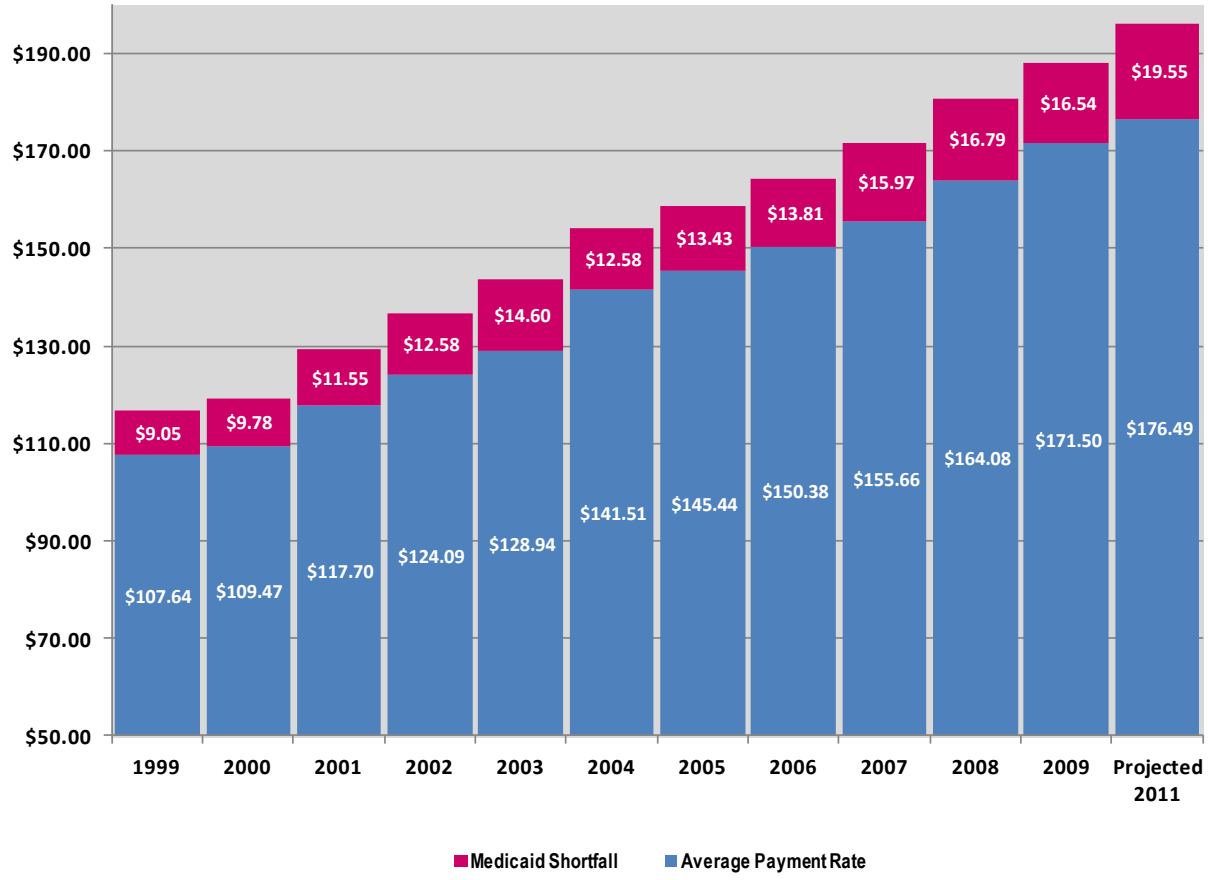
MEDICAID ALLOWABLE COSTS COMPARED TO TOTAL COSTS

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. These costs 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 as well as Eljay's 37 years of experience in preparing and analyzing cost reports, these legitimate business costs typically constitute 2% to 3% of total costs. Based upon total projected 2011 Medicaid allowable costs of $196.04 per day, a 2% disallowance of legitimate business costs is equivalent to additional unreimbursed cost of approximately $3.92 per day, which would increase the projected 2011 Medicaid shortfall to more than $23 per patient day.

FIGURE I

Shortfall Per Medicaid Patient Day

All States in Each Year [1]



[1] No determination of the Medicaid shortfall could be made for 2010 since cost reports for 2010 were unavailable in all but 10 states. The 2011 Medicaid shortfall is a projection based upon trending of the most recently available (2009 or 2010) cost reports to 2011 and comparing these trended costs to current rates.

FIGURE II

Percentage of Costs Covered by the Rates

All States in Each Year

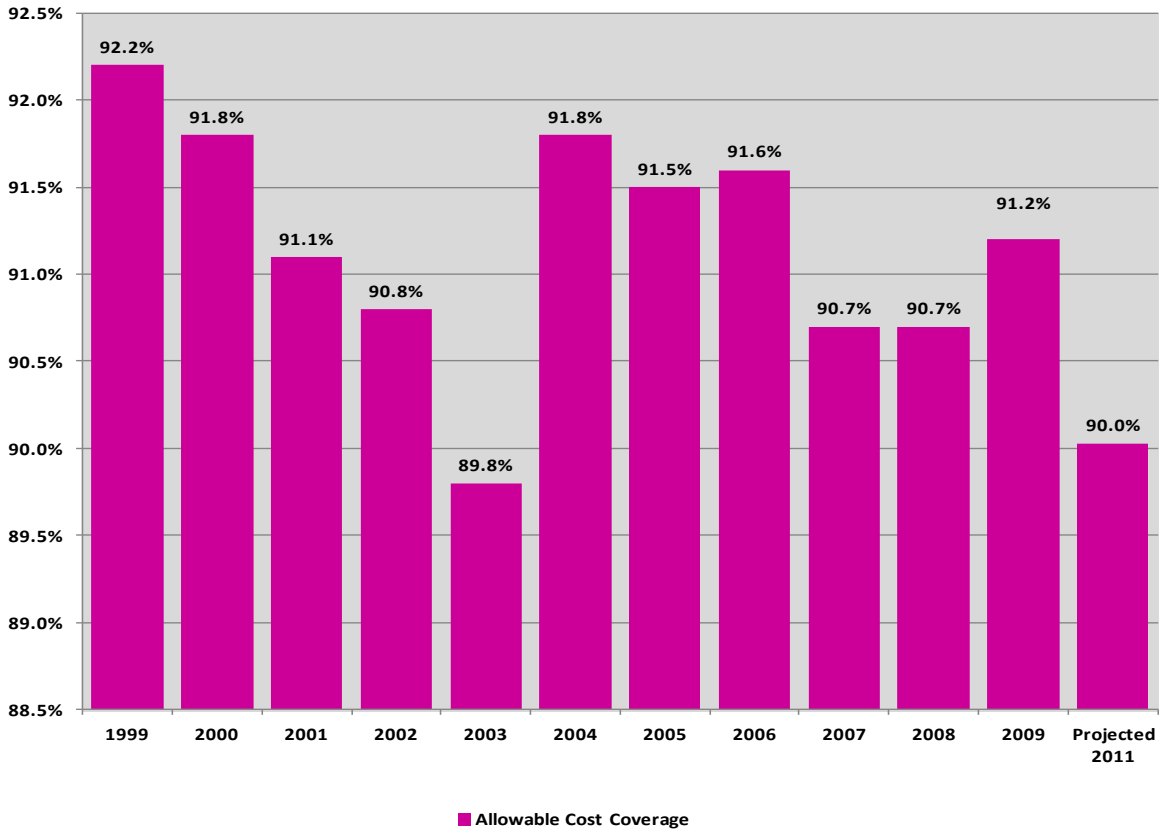


TABLE I

State-by-State Comparison of Rates & Costs

State	Rate 09	Cost 09	Difference 09
Arizona	$ 177.23	$ 183.12	$ (5.89)
California	$ 163.40	$ 174.45	$ (11.05)
Colorado	$ 188.33	$ 201.90	$ (13.57)
Connecticut	$ 220.31	$ 231.47	$ (11.16)
Delaware	$ 208.62	$ 227.80	$ (19.18)
District of Columbia	$ 260.97	$ 279.41	$ (18.44)
Florida	$ 202.66	$ 205.05	$ (2.39)
Georgia	$ 135.22	$ 146.54	$ (11.32)
Hawaii	$ 228.79	$ 233.89	$ (5.10)
Illinois	$ 117.29	$ 138.85	$ (21.56)
Indiana	$ 151.69	$ 158.18	$ (6.49)
Iowa	$ 125.69	$ 141.99	$ (16.30)
Kansas	$ 136.19	$ 150.58	$ (14.39)
Maine	$ 176.81	$ 192.59	$ (15.78)
Maryland	$ 212.29	$ 223.75	$ (11.46)
Massachusetts	$ 192.84	$ 219.10	$ (26.26)
Michigan	$ 195.18	$ 196.51	$ (1.33)
Minnesota	$ 164.34	$ 185.58	$ (21.24)
Missouri	$ 128.70	$ 147.89	$ (19.19)
Montana	$ 170.49	$ 177.96	$ (7.47)
Nebraska	$ 143.59	$ 162.31	$ (18.72)
Nevada	$ 178.83	$ 184.32	$ (5.49)
New Jersey	$ 204.96	$ 234.25	$ (29.29)
New York	$ 219.54	$ 251.16	$ (31.62)
North Dakota	$ 188.01	$ 191.20	$ (3.19)
Ohio	$ 172.16	$ 186.47	$ (14.31)
Oklahoma	$ 129.30	$ 138.70	$ (9.40)
Oregon	$ 220.44	$ 221.10	$ (0.66)
Pennsylvania	$ 199.42	$ 222.68	$ (23.26)
Rhode Island	$ 185.72	$ 200.55	$ (14.83)
South Dakota	$ 127.70	$ 144.95	$ (17.25)
Texas	$ 123.20	$ 131.44	$ (8.24)
Utah	$ 162.11	$ 182.65	$ (20.54)
Vermont	$ 188.14	$ 204.02	$ (15.88)
Virginia	$ 148.73	$ 157.08	$ (8.35)
Washington[1]	$ 159.00	$ 185.35	$ (26.35)
Wisconsin	$ 146.87	$ 182.28	$ (35.41)
Wyoming	$ 160.55	$ 186.45	$ (25.90)

[1] The shortfall for the state of Washington only represents a comparison of operating costs to the 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 11	Projected Cost 11	Projected Difference 11
Arizona	$ 177.23	$ 189.75	$ (12.52)
California	$ 170.64	$ 183.54	$ (12.90)
Colorado	$ 190.83	$ 204.39	$ (13.56)
Connecticut	$ 220.66	$ 239.45	$ (18.79)
Delaware	$ 208.62	$ 232.81	$ (24.19)
District of Columbia	$ 260.69	$ 286.07	$ (25.38)
Florida	$ 206.47	$ 215.92	$ (9.45)
Georgia	$ 143.03	$ 152.93	$ (9.90)
Hawaii	$ 232.84	$ 240.36	$ (7.52)
Illinois	$ 120.30	$ 144.64	$ (24.34)
Indiana	$ 156.39	$ 163.34	$ (6.95)
Iowa	$ 143.81	$ 149.89	$ (6.08)
Kansas	$ 150.06	$ 158.70	$ (8.64)
Maine	$ 177.79	$ 199.00	$ (21.21)
Maryland	$ 223.30	$ 238.46	$ (15.16)
Massachusetts	$ 197.26	$ 229.05	$ (31.79)
Michigan	$ 207.93	$ 205.64	$ 2.29
Minnesota	$ 165.07	$ 193.37	$ (28.30)
Missouri	$ 132.65	$ 154.51	$ (21.86)
Montana	$ 174.24	$ 185.41	$ (11.17)
Nebraska	$ 143.78	$ 165.73	$ (21.95)
Nevada	$ 184.29	$ 198.24	$ (13.95)
New Jersey	$ 208.97	$ 243.01	$ (34.04)
New York	$ 219.71	$ 262.19	$ (42.48)
North Dakota	$ 206.06	$ 205.82	$ 0.24
Ohio	$ 177.42	$ 195.65	$ (18.23)
Oklahoma	$ 126.50	$ 141.63	$ (15.13)
Oregon	$ 221.16	$ 226.24	$ (5.08)
Pennsylvania	$ 211.58	$ 230.82	$ (19.24)
Rhode Island	$ 194.22	$ 208.31	$ (14.09)
South Dakota	$ 129.87	$ 150.12	$ (20.25)
Texas	$ 125.96	$ 135.80	$ (9.84)
Utah	$ 163.32	$ 188.95	$ (25.63)
Vermont	$ 189.06	$ 206.69	$ (17.63)
Virginia	$ 153.28	$ 163.18	$ (9.90)
Washington[1]	$ 168.40	$ 197.06	$ (28.66)
Wisconsin	$ 149.54	$ 190.67	$ (41.13)
Wyoming	$ 163.93	$ 194.24	$ (30.31)

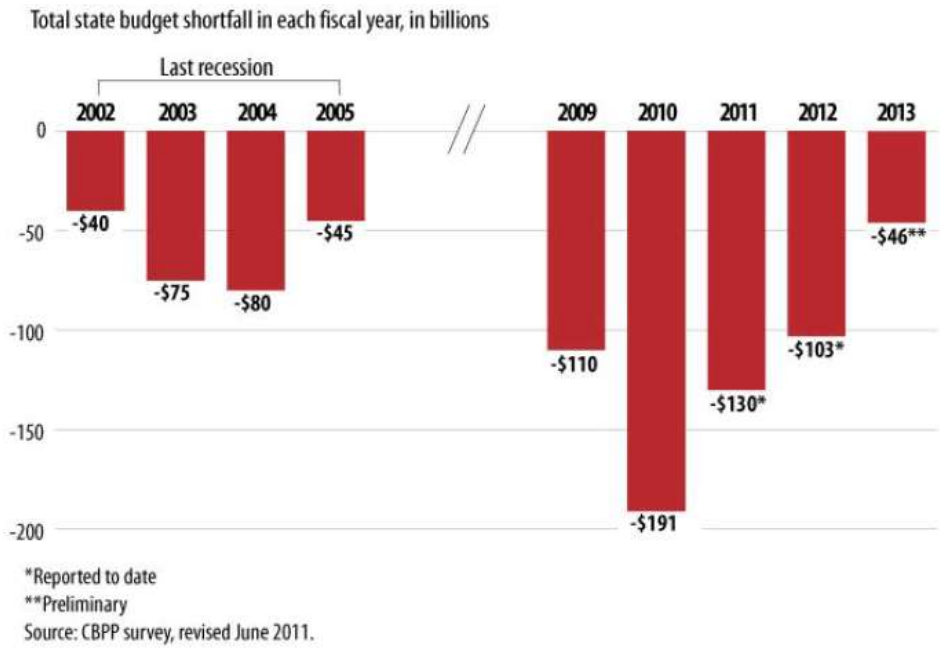
[1] The shortfall for the state of Washington only represents a comparison of operating costs to the operating rate. Accurate allowable property cost data were not available so the comparison excludes property costs and the property component of the rate.

NURSING HOME REIMBURSEMENT TRENDS

Between 2009 and 2011, states experienced the deepest economic downturn since the Great Depression. Figure III below reflects the impact that the recession has had on state budget shortfalls in comparison to the last recession from 2002 to 2005.

FIGURE III

Largest State Budget Shortfalls on Record

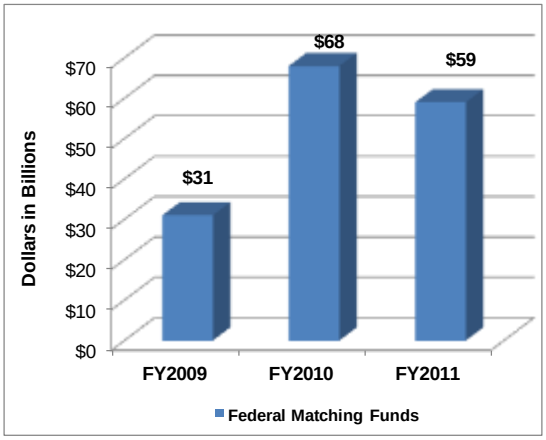


Source: Center on Budget and Policy Priorities Update of June 17, 2011

The impact that these budget deficits would have had on nursing facility rates would have been catastrophic had it not been for enhanced federal matching funds (Federal Medical Assistance Percentage or FMAP) that states received as a result of the *American Recovery & Reinvestment Act of 2009 (ARRA).* Figure IV from the Center on Budget and Policy Priorities reflects the $158 billion in enhanced federal matching funds the states received from FY 2009 to FY 2011.

FIGURE IV

***ARRA* Enhanced Federal Matching Funds to States: FY 2009 – FY 2011**

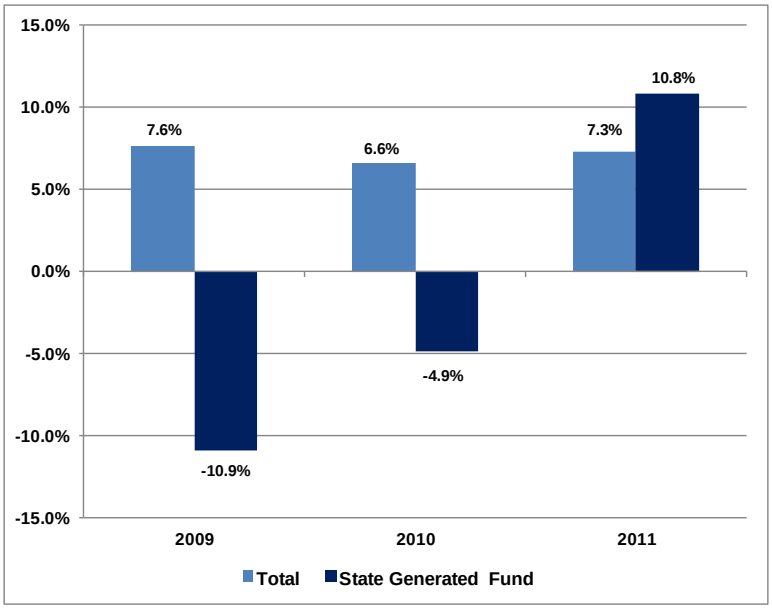


Source: Center on Budget and Policy Priorities Update of June 17, 2011

As a result of these higher federal match rates, states' general fund spending actually decreased by 10.9% and 4.9% in FY 2009 and FY 2010, respectively. Figure V from the Kaiser Commission on Medicaid and the Uninsured reflects total and state Medicaid spending growth from FY 2009 to FY 2011.

FIGURE V

Total & State Funds Medicaid Spending Growth FY 2009 – FY 2011



Source: The Kaiser Commission on Medicaid and the Uninsured 2011 Medicaid Budget Survey

However, even with enhanced *ARRA* funding, more states restricted provider rates than increased them during this recessionary period according to an October 2011 survey report by the Kaiser Commission on Medicaid and the Uninsured on state Medicaid budget trends (Kaiser Survey). The Kaiser Survey indicates that 30 states restricted rates for nursing homes in FY 2011 (24 rate freezes and 6 cuts) and 31 states planned restrictions for FY 2012. These rate restrictions are consistent with our findings, which reflect a significant decline in rate increases during the study period. On average, for the two year period from 2009 to 2011, rates increased only 2.9%. Interestingly, many of the states that did provide rate increases during that period chose to increase nursing facility provider taxes or implement new tax programs rather than use state funds for these rate increases (provider taxes are addressed in the next section of the report). In 2011, allowable cost coverage – or the percentage of allowable costs covered by the rates – was 90%, which represents the lowest coverage since 2003.

PROVIDER TAXES AS A FUNDING SOURCES FOR RATE INCREASES

Provider taxes continue to serve as a major funding source for rate increases in many states. Prior to FY 2004, only 20 states assessed provider taxes on nursing homes. In FY 2012, twice as many – 40 states – and the District of Columbia have implemented nursing home tax programs. Total tax collections exceed $4.5 billion. Overall, provider taxes on nursing homes generate over $6.0 billion in matching federal funds. In states with such programs, these taxes are used to reimburse an average of $21 per patient day in allowable Medicaid nursing home costs.

Since 2009, seven states – including Florida, Idaho, Iowa, Kansas, Nebraska, Washington and Wyoming – have enacted new nursing facility provider tax programs. Many of the 33 other states with provider tax programs also increased these taxes in the past two years. The Kaiser Survey indicates that 11 states increased nursing facility provider taxes in FY 2011, while 21 states have increased nursing facility provider taxes for FY 2012. This data does not take into account the states that have, or will, increase taxes to the new federal maximum of 6% of revenue, which became effective on October 1, 2011. According to the Kaiser Survey, many states anticipate increasing taxes to the new limit.

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, which would reduce the shortfall between rates and allowable Medicaid costs as was often the case with those states first implementing new provider tax programs in 2004. Instead, these programs now help to mitigate rate freezes or rate reductions. In other words, without new provider tax programs or increases to existing provider taxes, providers would receive no rate increase or a rate reduction, which explains why the seven states mentioned above enacted new provider tax programs. In fact, many states are using a greater portion of existing tax revenues and tax increases to reduce the overall state budget deficit rather than to enhance rates for providing nursing home care.

Looking at Medicaid enhanced FMAP expenditures through the end of FY 2011 offers a perfect example of how states have used provider taxes to fund budget deficits. Provider taxes used to cover the state share of Medicaid expenditures are eligible for higher match rates under the *ARRA*. Because higher match rates mean states receive more federal dollars, states had the flexibility to use provider tax dollars to increase rates to providers as initially intended, or lower the tax on providers without also reducing Medicaid rates. Most states with a nursing facility provider tax program did neither. According to the Kaiser Survey, only one state reduced nursing facility provider tax rates; most states used the additional dollars from enhanced FMAP under the *ARRA* to reduce state budget deficits.

In the future, states may not be able to use nursing home provider taxes to offset state Medicaid payments or to fund deficits if federal deficit reduction efforts target provider taxes as a source of savings. The President has proposed reducing the maximum provider tax rate from 6% to 3.5% of revenues, thereby reducing the federal match states with a provider tax receive. Kaiser reports that reducing the maximum provider tax rate would negatively impact 29 of the 40 states with these tax programs. Given the weak finances in these states, there is an increased likelihood that Medicaid rate reductions would follow.

REDIRECTION IN MEDICAID LONG TERM CARE EXPENDITURES

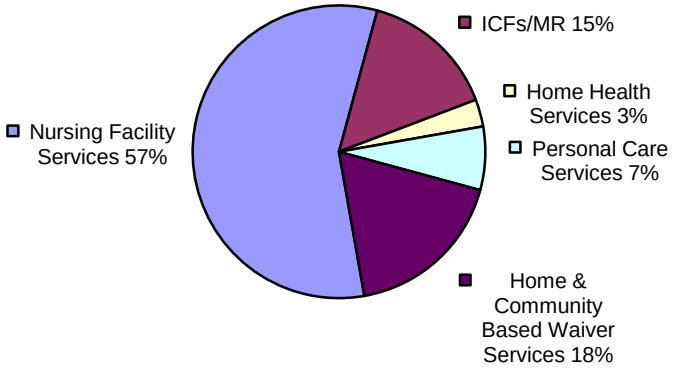
States continue to rebalance their limited resources, redirecting more resources to home and community-based services (HCBS) programs. According to the Kaiser Survey, 32 states in FY 2011 and 33 states in FY 2012 acted to expand non-institutional long term care services; a comparable number of states made such expansions in FY 2009 and FY 2010. However, even more states expanded non-institutional services in FY 2008, demonstrating that even home and community-based services have been impacted by the recession. No states reported any such expansions for institutional services in FY 2011, while 7 states in both FY 2011 and FY 2012 implemented, or planned to implement, cost controls related to institutional placements such as institutional relocation plans or tightening eligibility criteria.

This contraction of Medicaid expenditures is evident when comparing long term care expenditures from 2010 and 2011. Figure VI shows that total expenditures for Medicaid long term care services actually dropped 2% from $120.6 billion in 2010 to $118.2 billion in 2011. While nursing facility expenditures dropped $1 billion, HCBS expenditures increased during the same time frame and by nearly the same amount – just over $1.1 billion. States' increasing commitment to non-institutional services even during recessionary times also is reflected in Figure VI, which illustrates a decline in Medicaid long term care expenditures from 57% spent on nursing facility services to 43%. This 24.5% reduction in Medicaid expenditures for nursing facility services contrasts with the 82% climb in HCBS-related Medicaid expenditures over the last 11 years.

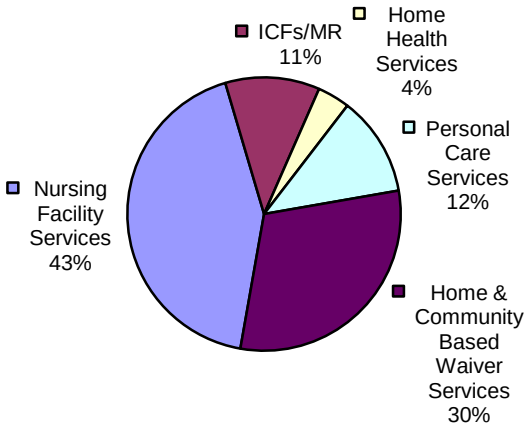
FIGURE VI

Medicaid Long Term Care Expenditure

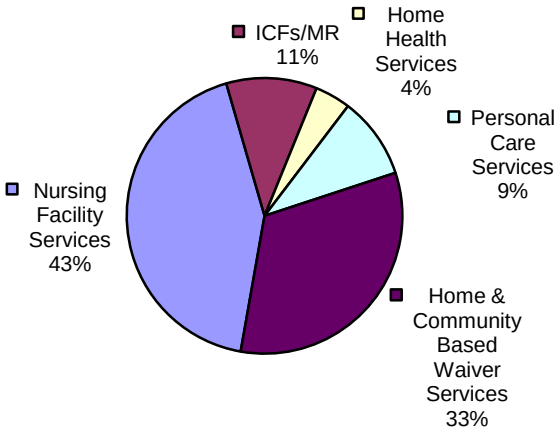
2000 Total LTC Expenditures $69.5 Billion



2010 Total LTC Expenditures $120.6 Billion



2011 Total LTC Expenditures $118.2 Billion



Source: CMS Medicaid Statement of Expenditures (CMS-64) 2000; CMS Medicaid Program Budget Report (CMS-37), August 2010 and 2011, annual estimate, 2011.

Expenditures for nursing facility services increased only $10.9 billion between 2000 and 2011, which equates to a 2.2% compounded annual growth rate. During the same period, expenditures for HCBS have tripled, rising $26.3 billion. Figure VII reflects the percentage change and annual rate of growth in Medicaid expenditures by program between 2000 and 2011. This chart clearly demonstrates that relative to the Medicaid long term care population, nursing homes are facing significant constraints on two fronts: a reduction in the number of Medicaid beneficiaries using nursing home services and a much slower rate of growth, or in many states, a contraction in what the states pay for these services.

FIGURE VII

Long Term Care Medicaid Expenditures Growth

Expenditures (in billions)	2000	2011	% Change	Annual Rate of Growth
NF	$ 39.6	$ 50.5	27.5%	2.20%
ICFs-MR	$ 10.4	$ 12.6	21.2%	1.70%
HCBS	$ 12.5	$ 38.8	210.4%	10.9%
PC and Home Health	$ 7.0	$ 16.3	132.9%	8.00%
Total	$ 69.5	$ 118.2	70.1%	5.70%

The increased emphasis on HCBS is only going to increase. The *Affordable Care Act (ACA)* offers a number of new options for states to increase the federal match rate by expanding home and community-based alternatives. The *ACA* also extends the Money Follows the Person (MFP) grant program, giving states another five years to obtain resources to move individuals out of institutional settings.

Another trend that will increase the redirection of funds to HCBS services is the growth and expansion of Medicaid managed care programs for long term care. Currently, 11 states have capitated, managed long term care programs. Much broader efforts are underway focusing on "dual eligibles" – individuals who are dually eligible for both Medicare and Medicaid. Twenty-one states intend to modify, expand or initiate new programs to better coordinate care for dually eligible beneficiaries and integrate Medicare and Medicaid financing.[9] It is highly likely that the

[9] Kaiser Commission on Medicaid and the Uninsured: A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey

financing and delivery model in most, if not all these states, will employ a capitated managed care approach.

The experience in states with existing statewide managed care models for long term care such as Arizona, Minnesota, and New Mexico reveals much higher utilization of HCBS services and much lower nursing home use rates per thousand elderly than in most other states. As such, expansion of Medicaid managed care for long term care will accelerate the rebalancing trend towards community-based funding.

With states still in recovery mode from the recession, it will be difficult to find the financial resources necessary to meet both the increasing demand for non-institutional services and adequately compensate nursing facility providers for services to the more fragile, higher-acuity population who need skilled nursing care. Again, experience has shown that managed care and diversion programs can succeed in reducing nursing home placements; however, more program beneficiaries also take advantage of the expanded array of community-based services, which results in significant increases in program expenditures (i.e., the "woodwork effect"). Since state economies have not rebounded to meet this increased demand, the likely impact will be more stringent eligibility requirements for services, enrollment limitations, and further constraints in rate increases.

NURSING HOME REIMBURSEMENT OUTLOOK FOR 2012

The outlook for 2012 is extremely bleak. According to the Kaiser Survey, 42 states faced budget deficits, collectively totaling $103 billion at the start of FY 2012. Tax revenues are still below pre-recession levels. With the expiration of *ARRA* enhanced FMAP, state spending had to be increased to replace the enhanced federal match, contributing to an average projected increase in state general fund spending of 28.7% in FY 2012.

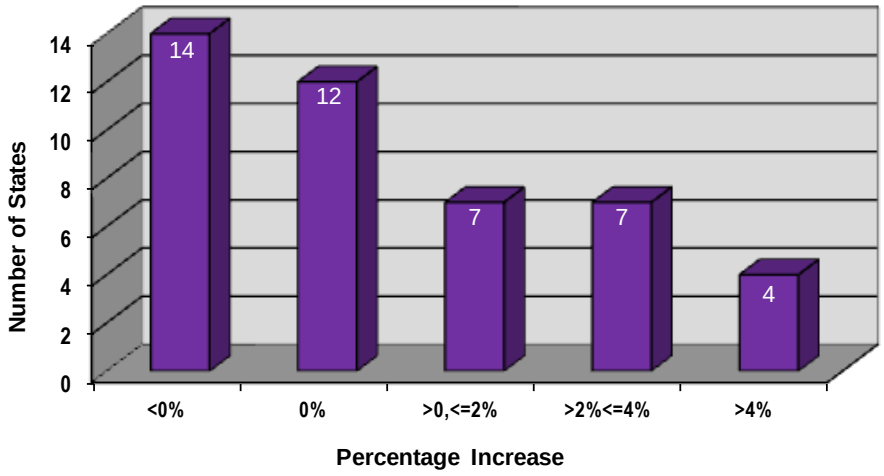
The one positive note is that total growth in Medicaid spending for FY 2012 is projected at just 2.2% across all states, one of the lowest increases in spending on record. Many states achieve lower growth rates by constraining or reducing Medicaid rates. The Kaiser Survey indicates that a total of 30 states restricted rates for nursing homes in FY 2011 (24 rate freezes and 6 cuts). Thirty-one states planned restrictions for nursing home rates in FY 2012. Seventeen states plan to freeze rates and 14 states planned rate cuts.

As part of our data gathering for this report, we requested FY 2012 provider rates from the AHCA state affiliates, or, at a minimum, the average change in Medicaid rates between FY 2011 and FY 2012. Our findings were very consistent with what was reported in the Kaiser Survey. Of the 44 states reporting, 14 reflected rate reductions in FY 2012 and 12 others exhibited rate freezes. Only 11 of the 44 states reported FY 2012 increases exceeding 2%. Almost all of the states that reported increases above 2% funded at least part of the increase through an increase in provider tax rates.

The Medicaid day-weighted average rate change for the 44 states reporting was a reduction of just over one tenth of one percent. Figure VIII reflects our findings with almost 60% of the states reporting no rate increase or a rate decrease for FY 2012.

FIGURE VIII

Projected 2012 Percentage Increase in Medicaid Rates



Even if nursing home costs conservatively increase at the same pace as the forecasted annual Market Basket (approximately 2.6% per year), the shortfall will likely increase to $24.65 per Medicaid patient day in FY 2012, ballooning 78% since 2006. The percentage of cost covered by the Medicaid rates would drop to 87.8%, far lower than any other year in which we have conducted this study.

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 2009 was 18.1%,[10] while our analysis indicates a 9.6% shortfall on Medicaid payment for that year (i.e., weighted average 2009 shortfall of $16.54 divided by weighted average Medicaid rate of $171.50). The weighted average 2010 margin from the two government-funded programs combined is essentially a break even (see Figure IX).

Figure IX

Combined Medicare/Medicaid Shortfall for 2009

Payer	2009 Average Rate	Days in Millions	Revenue in Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	$ 441.44	67.4	$ 29.7	18.1%	$ 5.39
Medicaid	$ 171.50	325.5	$ 55.8	(9.6%)	$ (5.36)
					$ 0.03

Net Medicare/Medicaid Margin as a Percentage of Revenue	0.03%

Sources: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using 2009 SNF claims data. Medicare margin percentage derived from March 2011 MedPAC *Report to the Congress: Medicare Payment Policy*. Medicaid rates, days and margins derived from this report.

We also estimated a combined shortfall for 2012 taking into account the October 1, 2011 reduction in Medicare Part A payments to skilled nursing facilities (SNFs) of approximately $3.87 billion or 11.1%, which would prospectively correct for unexpected overpayments to SNFs as a result of the transition from a RUG III to a RUG IV payment system. For purposes of this analysis, we conservatively assume that SNF margins (18.1%) will not decrease even with the 2012 Medicare rate decreases. The Medicaid shortfall percentage for 2012 was projected at a negative 14% (i.e., projected shortfall of $24.65 divided by a weighted average Medicaid rate for 2012 that will likely not increase from 2011).

[10] March 2011 Medicare Payment Advisory Commission *Report to the Congress.*

Figure X reflects the impact of this Medicare rate reduction, which increases the shortfall from the two government-funded programs combined to a negative 2.7%. It now appears that Medicaid shortfalls are accelerating to such a degree that Medicare margins will no longer be adequate to cover the Medicaid deficit.

Figure X
Combined Medicare/Medicaid Shortfall for 2012

Payer	2012 Average Rate	Days in Millions	Revenue in Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	$ 457.59	67.4	$ 30.84	18.1%	$ 5.58
Medicaid	$ 176.49	322.9	$ 56.99	(14.0%)	$ (7.96)
					$ (2.38)

Net Medicare/Medicaid Shortfall as a Percentage of Revenue	(2.7%)

Sources: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model based upon FY 12 Medicare rates and using 2009 SNF claims data. Medicare margin percentage is assumed to be the same as 2009, which was derived from the March 2011 MedPAC *Report to the Congress Medicare Payment Policy*. Medicaid rates, days and margins derived from this report.

SUMMARY

Between 2009 and 2011, Medicaid rates increased only 2.9% – the lowest two-year increase in the 10-year history of this report. As such, the projected Medicaid shortfall is at an unprecedented high and the percentage of Medicaid allowable costs covered by the Medicaid rates is at its lowest point since 2003.

Medicaid rate increases rebounded nicely after the 2002 – 2005 recession. Unfortunately, there will not be a repeat performance for nursing home rate increases in 2012 and beyond. State budget deficits in this latest recession were more than double compared to the last recession from 2002 to 2005. Only 20 states had nursing facility provider tax programs in 2003, most of

which imposed taxes far below the federal maximum; so, provider taxes offered a significant avenue for rate relief. Today, 40 states have nursing facility tax programs, many of which impose taxes at, or close to, the maximum tax allowed under federal law. In addition, provider taxes are a target for federal deficit reduction in future years and state finances are too weak to replace those funds. Finally, recovery from the current recession remains slow with major deficits continuing as states grapple with replacing the lost enhanced FMAP funds.

It certainly appears that 2012 will look much worse than 2011 with most states either freezing or reducing rates. With negligible rate increases across the country, and conservatively assuming costs increase at the same pace as the forecasted annual Market Basket, the 2012 projected Medicaid shortfall will climb to almost $25 per Medicaid day. Under this scenario, nursing homes will experience negative Medicaid margins averaging almost 14%.

MedPAC has acknowledged the fact that Medicare margins have helped to subsidize Medicaid shortfalls over the years. With 2012 Medicare revenue reductions averaging $58 per Medicare day, it does not appear that future Medicare margins will be enough to subsidize the accelerating Medicaid shortfalls. We estimate a negative Medicaid margin approaching 14% for 2012; assuming Medicare margins continue to average 18%, the 2012 shortfall from the two programs combined would exceed $2 billion dollars.

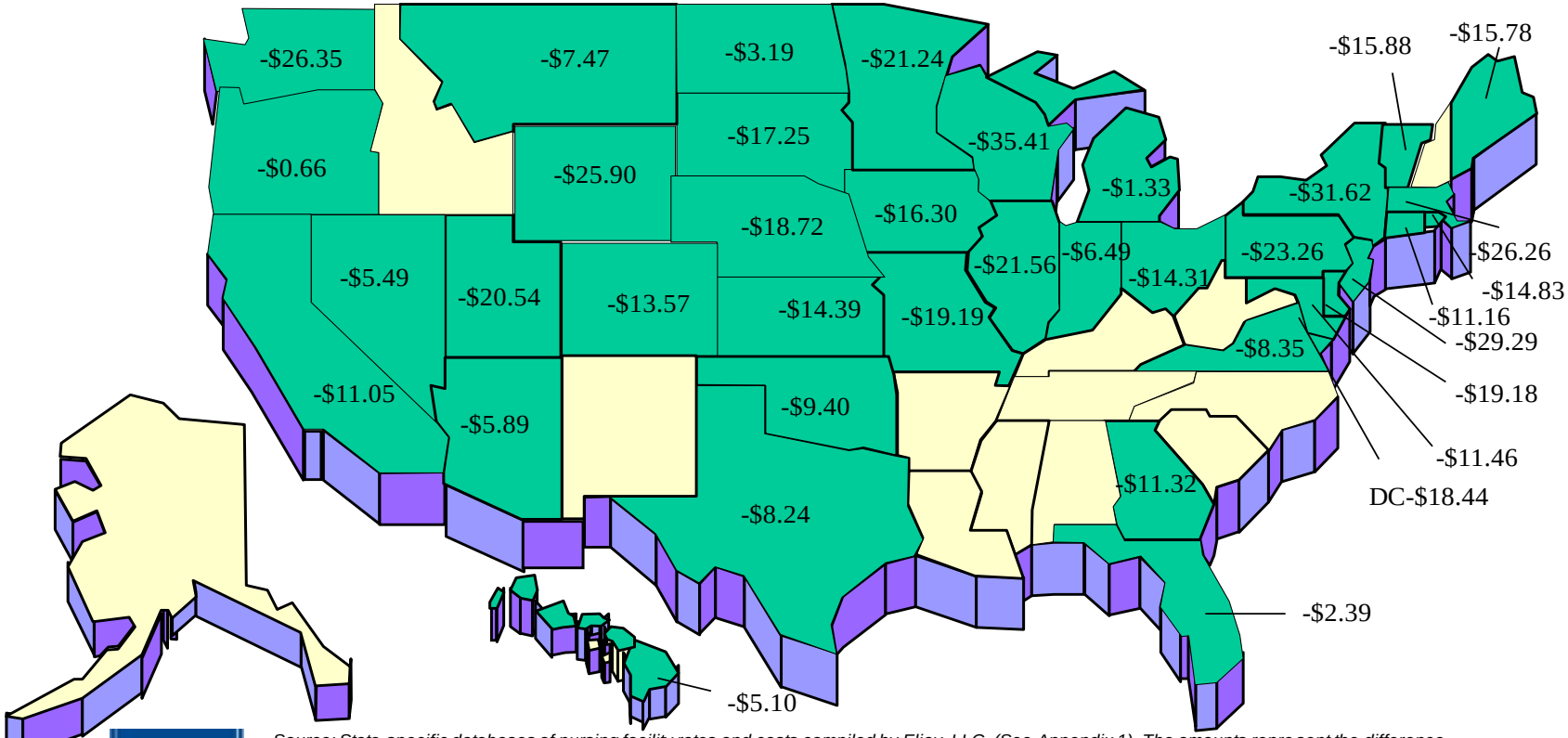
Historically, there has always been a major disconnect between what Medicaid pays for nursing home services and the cost of providing those services. That gap is rapidly expanding, leaving nursing homes with significant Medicaid volume little choice but to further constrain costs to survive. The challenge is not whether costs can be cut, but whether doing so will allow skilled nursing care providers to deliver the quality care and quality of life consumers expect and regulators demand.

CHARTS

CHART 1

In 2009, on Average, the Shortfall in Medicaid Reimbursement Was $16.54 Per Medicaid Patient Day

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

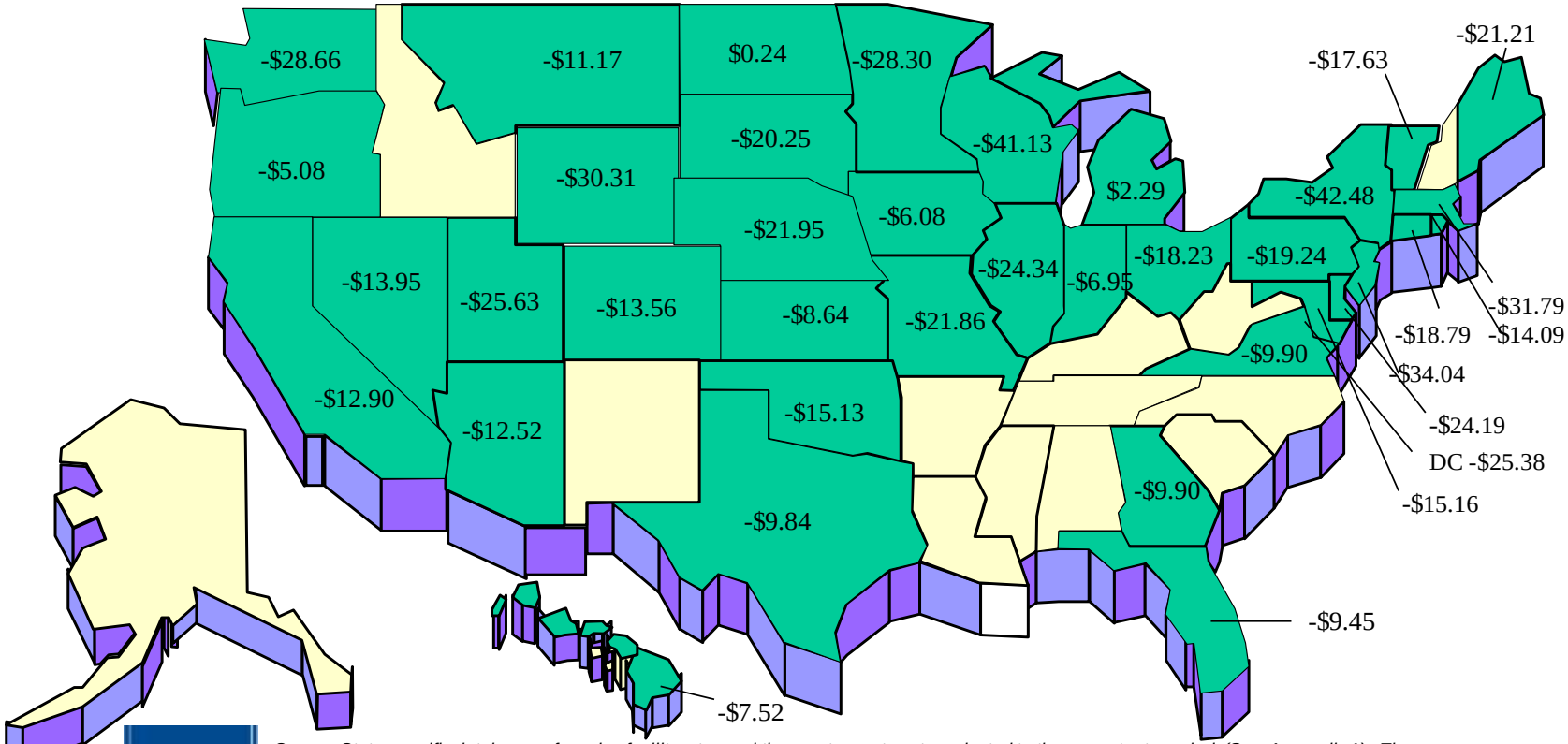


Source: State-specific databases of nursing facility rates and costs compiled by Eljay, LLC. (See Appendix 1). The amounts represent the difference between Medicaid rates and allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between 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 2011 Shortfall in Medicaid Reimbursement Is $19.55 Per Medicaid Patient Day

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

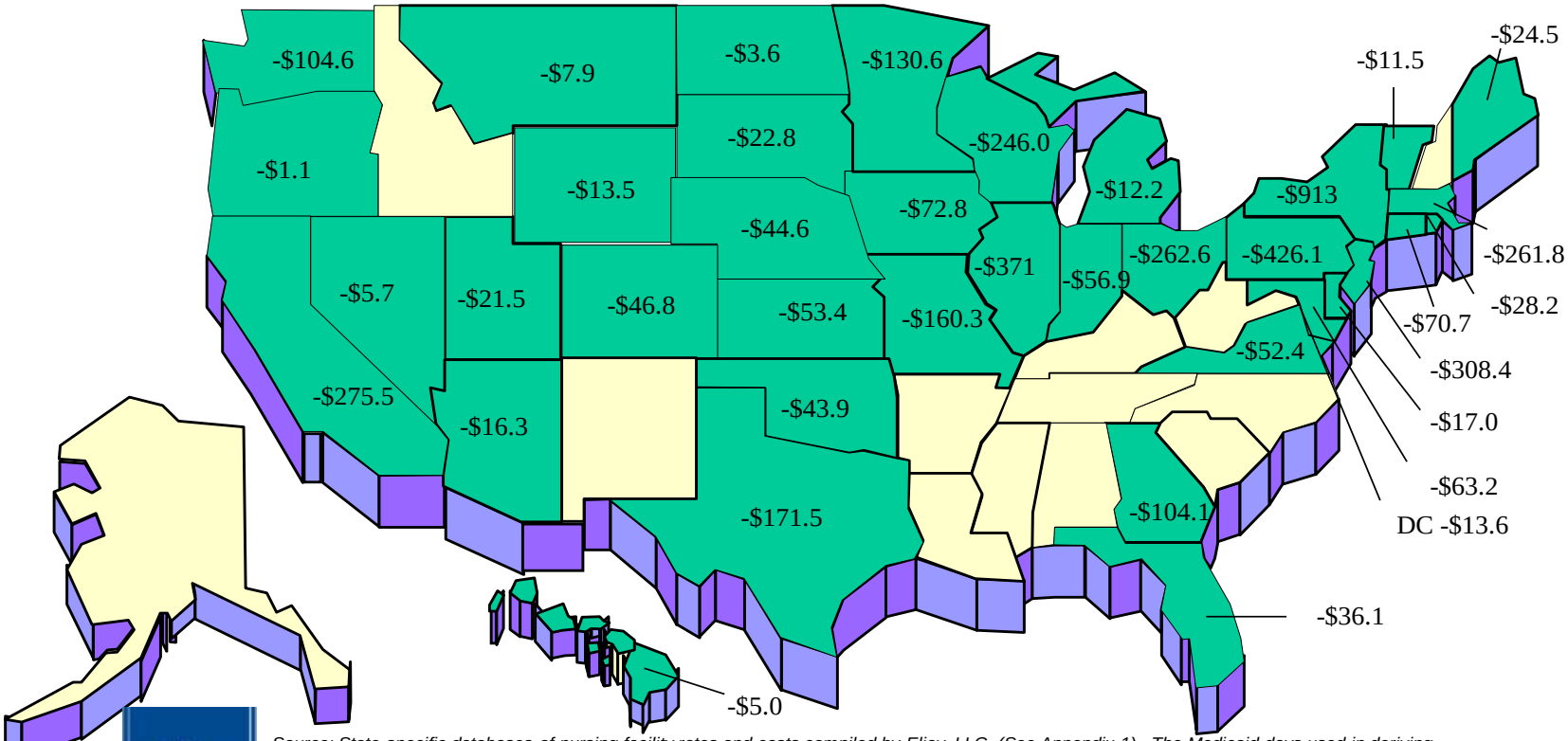


Source: State-specific databases of nursing facility rates and the most recent costs projected to the current rate period. (See Appendix 1). The amounts represent the difference between Medicaid rates and projected allowable Medicaid costs for each facility weighted by the facility's annual Medicaid 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

2009 Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs (In Millions)

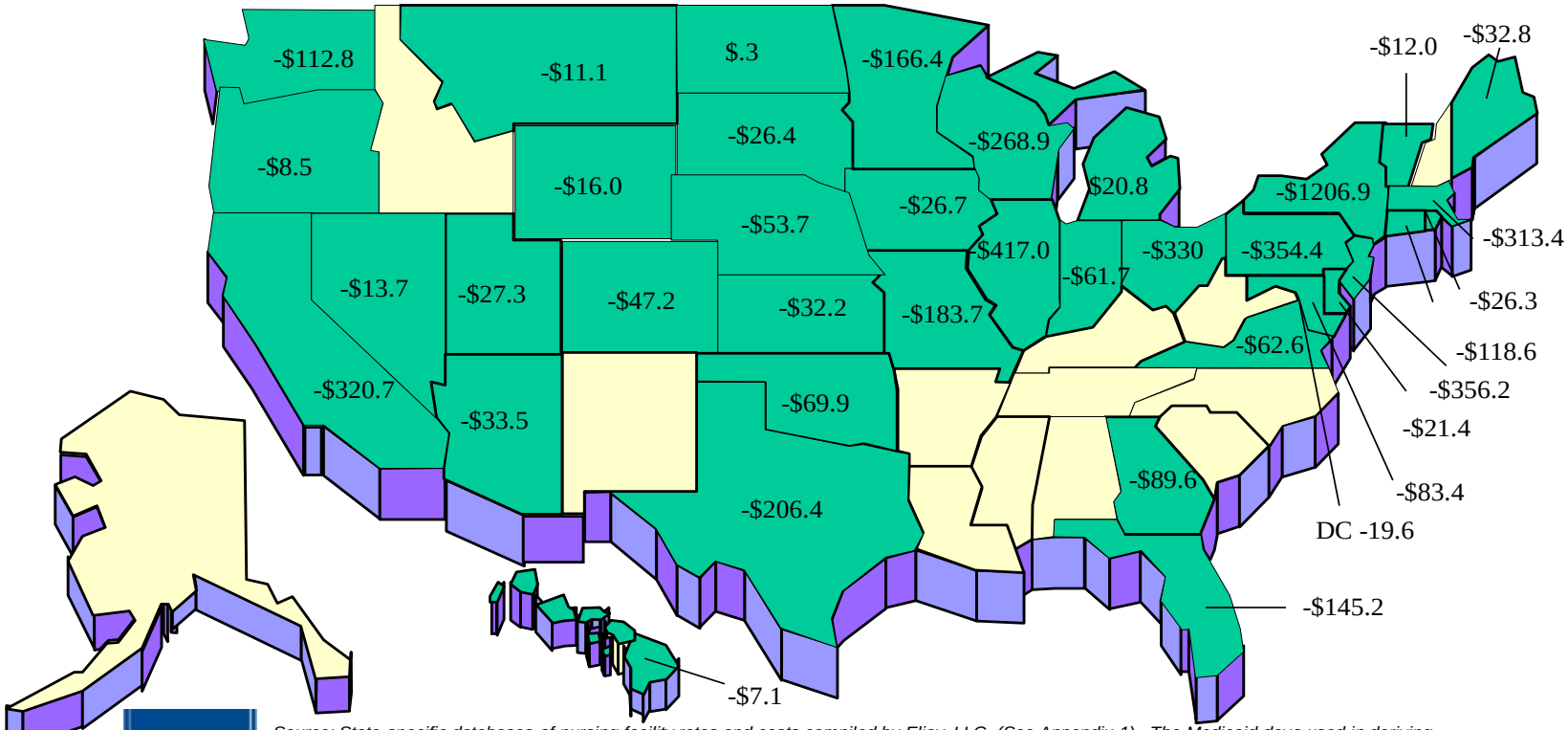
$5.4 Billion Medicaid Funding Shortfall Nationwide



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 2009. The weighted average shortfall for the 37 states plus the District of Columbia reporting was close to $4.5 billion dollars, based upon 271 million Medicaid days. Extrapolating this shortfall to 325 million Medicaid days nationwide (per CMS-OSCAR Data) results in almost a $5.4 billion national shortfall.

Projected 2011 Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs (In Millions)

$6.3 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 2011. The weighted average shortfall for the 37 states plus the District of Columbia reporting was close to $5.3 billion dollars, based upon over 269 million Medicaid days. Extrapolating this shortfall to 323 million Medicaid days nationwide (per CMS-OSCAR Data) results in over a $6.3 billion national shortfall.

APPENDIX I

PROJECT APPROACH & METHODOLOGY

PROJECT APPROACH & 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 2009 (or 2010, 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 2009, but between current (FY 2011) rates and 2009 (or 2010, 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 65% of the states in 2009. 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 2009 were derived for 37 states, plus the District of Columbia, representing over 83% of the Medicaid patient days in the country. Current Medicaid rates by provider were obtained from 37 states, plus the District of Columbia, allowing us to determine an estimated 2011 shortfall for these states that represent over 83% of Medicaid days nationwide.[11] 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 21 – 24, 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.

[11] In New Jersey and Illinois, the state agency provided 2009 and 2011 rate data but no cost data has been provided since 2006 and 2008, in these two states respectively. As such, we projected a 2011 shortfall for both of these states by projecting 2006 (New Jersey) and 2008 (Illinois) cost report data to 2011 and comparing these projected costs to 2011 rates.

APPENDIX II

CALCULATION OF 2009 & PROJECTED 2011 WEIGHTED AVERAGE MEDICAID SHORTFALL

STATE-BY-STATE COMPARISON

Calculation of 2009 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	$ 177.23	$ 183.12	$ (5.89)	2,768,670	$ 490,691,303	$ 506,998,766	$ (16,307,464)
California	$ 163.40	$ 174.45	$ (11.05)	24,927,858	$ 4,073,211,916	$ 4,348,664,741	$ (275,452,825)
Colorado	$ 188.33	$ 201.90	$ (13.57)	3,448,170	$ 649,393,781	$ 696,185,442	$ (46,791,661)
Connecticut	$ 220.31	$ 231.47	$ (11.16)	6,333,930	$ 1,395,428,128	$ 1,466,114,788	$ (70,686,659)
Delaware	$ 208.62	$ 227.80	$ (19.18)	883,907	$ 184,400,753	$ 201,354,097	$ (16,953,343)
District of Columbia	$ 260.97	$ 279.41	$ (18.44)	739,976	$ 193,111,488	$ 206,756,642	$ (13,645,154)
Florida	$ 202.66	$ 205.05	$ (2.39)	15,117,477	$ 3,063,707,948	$ 3,099,838,718	$ (36,130,771)
Georgia	$ 135.22	$ 146.54	$ (11.32)	9,194,662	$ 1,243,302,255	$ 1,347,385,834	$ (104,083,579)
Hawaii	$ 228.79	$ 233.89	$ (5.10)	985,581	$ 225,491,167	$ 230,517,632	$ (5,026,465)
Illinois	$ 117.29	$ 138.85	$ (21.56)	17,206,357	$ 2,018,133,608	$ 2,389,102,664	$ (370,969,056)
Indiana	$ 151.69	$ 158.18	$ (6.49)	8,768,567	$ 1,330,103,860	$ 1,387,011,857	$ (56,907,997)
Iowa	$ 125.69	$ 141.99	$ (16.30)	4,466,080	$ 561,341,613	$ 634,138,719	$ (72,797,106)
Kansas	$ 136.19	$ 150.58	$ (14.39)	3,708,942	$ 505,120,864	$ 558,492,545	$ (53,371,681)
Maine	$ 176.81	$ 192.59	$ (15.78)	1,555,135	$ 274,963,494	$ 299,503,532	$ (24,540,037)
Maryland	$ 212.29	$ 223.75	$ (11.46)	5,513,925	$ 1,170,551,151	$ 1,233,740,732	$ (63,189,581)
Massachusetts	$ 192.84	$ 219.10	$ (26.26)	9,968,836	$ 1,922,390,373	$ 2,184,172,011	$ (261,781,639)
Michigan	$ 195.18	$ 196.51	$ (1.33)	9,182,556	$ 1,792,251,304	$ 1,804,464,103	$ (12,212,800)
Minnesota	$ 164.34	$ 185.58	$ (21.24)	6,146,921	$ 1,010,185,030	$ 1,140,745,636	$ (130,560,606)
Missouri	$ 128.70	$ 147.89	$ (19.19)	8,355,249	$ 1,075,320,492	$ 1,235,657,712	$ (160,337,220)
Montana	$ 170.49	$ 177.96	$ (7.47)	1,059,976	$ 180,715,318	$ 188,633,340	$ (7,918,021)
Nebraska	$ 143.59	$ 162.31	$ (18.72)	2,382,778	$ 342,143,098	$ 386,748,703	$ (44,605,605)
Nevada	$ 178.83	$ 184.32	$ (5.49)	1,039,372	$ 185,870,861	$ 191,577,012	$ (5,706,151)
New Jersey	$ 204.96	$ 234.25	$ (29.29)	10,528,951	$ 2,158,013,715	$ 2,466,406,678	$ (308,392,963)
New York	$ 219.54	$ 251.16	$ (31.62)	28,873,048	$ 6,338,788,870	$ 7,251,754,635	$ (912,965,765)
North Dakota	$ 188.01	$ 191.20	$ (3.19)	1,132,321	$ 212,887,650	$ 216,499,753	$ (3,612,104)
Ohio	$ 172.16	$ 186.47	$ (14.31)	18,350,738	$ 3,159,263,084	$ 3,421,862,147	$ (262,599,063)
Oklahoma	$ 129.30	$ 138.70	$ (9.40)	4,669,516	$ 603,768,394	$ 647,661,843	$ (43,893,449)
Oregon	$ 220.44	$ 221.10	$ (0.66)	1,713,373	$ 377,695,896	$ 378,826,722	$ (1,130,826)
Pennsylvania	$ 199.42	$ 222.68	$ (23.26)	18,319,396	$ 3,653,253,948	$ 4,079,363,099	$ (426,109,151)
Rhode Island	$ 185.72	$ 200.55	$ (14.83)	1,904,555	$ 353,714,029	$ 381,958,585	$ (28,244,557)
South Dakota	$ 127.70	$ 144.95	$ (17.25)	1,321,331	$ 168,733,925	$ 191,526,879	$ (22,792,954)
Texas	$ 123.20	$ 131.44	$ (8.24)	20,818,293	$ 2,564,813,735	$ 2,736,356,471	$ (171,542,737)
Utah	$ 162.11	$ 182.65	$ (20.54)	1,046,283	$ 169,613,010	$ 191,103,672	$ (21,490,662)
Vermont	$ 188.14	$ 204.02	$ (15.88)	722,233	$ 135,880,879	$ 147,349,936	$ (11,469,057)
Virginia	$ 148.73	$ 157.08	$ (8.35)	6,269,663	$ 932,487,037	$ 984,838,727	$ (52,351,689)
Washington	$ 159.00	$ 185.35	$ (26.35)	3,969,895	$ 631,213,267	$ 735,819,994	$ (104,606,727)
Wisconsin	$ 146.87	$ 182.28	$ (35.41)	6,947,643	$ 1,020,400,308	$ 1,266,416,342	$ (246,016,034)
Wyoming	$ 160.55	$ 186.45	$ (25.90)	519,483	$ 83,402,931	$ 96,857,531	$ (13,454,599)
		TOTALS		270,861,647	$ 46,451,760,484	$ 50,932,408,242	$ (4,480,647,758)
		Weighted Averages			$ 171.50	$ 188.04	$ (16.54)
		Shortfall extrapolated to all 50 states					$ (5,384,402,568)
		Total States			38		
		Percentage of Days			83.2%		

Calculation of Projected 2011 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	$ 177.23	$ 189.75	$ (12.52)	2,676,894	$ 474,425,913	$ 507,940,625	$ (33,514,712)
California	$ 170.64	$ 183.54	$ (12.90)	24,858,694	$ 4,241,887,609	$ 4,562,564,767	$ (320,677,158)
Colorado	$ 190.83	$ 204.39	$ (13.56)	3,480,993	$ 664,277,886	$ 711,480,150	$ (47,202,264)
Connecticut	$ 220.66	$ 239.45	$ (18.79)	6,312,744	$ 1,392,970,007	$ 1,511,586,460	$ (118,616,453)
Delaware	$ 208.62	$ 232.81	$ (24.19)	884,614	$ 184,548,173	$ 205,946,985	$ (21,398,813)
District of Columbia	$ 260.69	$ 286.07	$ (25.38)	770,355	$ 200,823,974	$ 220,375,596	$ (19,551,622)
Florida	$ 206.47	$ 215.92	$ (9.45)	15,369,902	$ 3,173,423,625	$ 3,318,669,197	$ (145,245,572)
Georgia	$ 143.03	$ 152.93	$ (9.90)	9,046,132	$ 1,293,868,297	$ 1,383,425,007	$ (89,556,709)
Hawaii	$ 232.84	$ 240.36	$ (7.52)	941,594	$ 219,240,782	$ 226,321,570	$ (7,080,788)
Illinois	$ 120.30	$ 144.64	$ (24.34)	17,131,505	$ 2,060,920,045	$ 2,477,900,876	$ (416,980,830)
Indiana	$ 156.39	$ 163.34	$ (6.95)	8,874,376	$ 1,387,863,611	$ 1,449,540,522	$ (61,676,911)
Iowa	$ 143.81	$ 149.89	$ (6.08)	4,391,167	$ 631,493,699	$ 658,191,993	$ (26,698,294)
Kansas	$ 150.06	$ 158.70	$ (8.64)	3,725,767	$ 559,088,661	$ 591,279,291	$ (32,190,631)
Maine	$ 177.79	$ 199.00	$ (21.21)	1,544,651	$ 274,623,466	$ 307,385,509	$ (32,762,043)
Maryland	$ 223.30	$ 238.46	$ (15.16)	5,503,456	$ 1,228,921,672	$ 1,312,354,062	$ (83,432,389)
Massachusetts	$ 197.26	$ 229.05	$ (31.79)	9,858,173	$ 1,944,623,195	$ 2,258,014,513	$ (313,391,318)
Michigan	$ 207.93	$ 205.64	$ 2.29	9,081,930	$ 1,888,405,705	$ 1,867,608,085	$ 20,797,620
Minnesota	$ 165.07	$ 193.37	$ (28.30)	5,879,942	$ 970,602,018	$ 1,137,004,375	$ (166,402,357)
Missouri	$ 132.65	$ 154.51	$ (21.86)	8,402,335	$ 1,114,569,743	$ 1,298,244,787	$ (183,675,044)
Montana	$ 174.24	$ 185.41	$ (11.17)	993,997	$ 173,194,072	$ 184,297,021	$ (11,102,949)
Nebraska	$ 143.78	$ 165.73	$ (21.95)	2,446,966	$ 351,824,748	$ 405,535,649	$ (53,710,900)
Nevada	$ 184.29	$ 198.24	$ (13.95)	983,941	$ 181,330,435	$ 195,056,408	$ (13,725,973)
New Jersey	$ 208.97	$ 243.01	$ (34.04)	10,463,471	$ 2,186,551,547	$ 2,542,728,102	$ (356,176,555)
New York	$ 219.71	$ 262.19	$ (42.48)	28,411,565	$ 6,242,305,018	$ 7,449,228,313	$ (1,206,923,295)
North Dakota	$ 206.06	$ 205.82	$ 0.24	1,098,985	$ 226,456,788	$ 226,193,032	$ 263,756
Ohio	$ 177.42	$ 195.65	$ (18.23)	18,101,744	$ 3,211,611,409	$ 3,541,606,201	$ (329,994,792)
Oklahoma	$ 126.50	$ 141.63	$ (15.13)	4,621,282	$ 584,592,193	$ 654,512,192	$ (69,919,999)
Oregon	$ 221.16	$ 226.24	$ (5.08)	1,681,586	$ 371,899,565	$ 380,442,022	$ (8,542,457)
Pennsylvania	$ 211.58	$ 230.82	$ (19.24)	18,419,497	$ 3,897,197,149	$ 4,251,588,269	$ (354,391,120)
Rhode Island	$ 194.22	$ 208.31	$ (14.09)	1,866,060	$ 362,426,163	$ 388,718,947	$ (26,292,785)
South Dakota	$ 129.87	$ 150.12	$ (20.25)	1,301,765	$ 169,060,247	$ 195,420,992	$ (26,360,745)
Texas	$ 125.96	$ 135.80	$ (9.84)	20,979,248	$ 2,642,546,042	$ 2,848,981,840	$ (206,435,798)
Utah	$ 163.32	$ 188.95	$ (25.63)	1,066,508	$ 174,182,163	$ 201,516,774	$ (27,334,612)
Vermont	$ 189.06	$ 206.69	$ (17.63)	680,850	$ 128,721,538	$ 140,724,927	$ (12,003,389)
Virginia	$ 153.28	$ 163.18	$ (9.90)	6,318,896	$ 968,560,332	$ 1,031,117,400	$ (62,557,067)
Washington	$ 168.40	$ 197.06	$ (28.66)	3,934,773	$ 662,615,773	$ 775,386,367	$ (112,770,594)
Wisconsin	$ 149.54	$ 190.67	$ (41.13)	6,536,636	$ 977,488,559	$ 1,246,340,401	$ (268,851,842)
Wyoming	$ 163.93	$ 194.24	$ (30.31)	529,305	$ 86,768,928	$ 102,812,155	$ (16,043,227)
		TOTALS		269,172,299	$ 47,505,910,749	$ 52,768,041,381	$ (5,262,130,632)
		Weighted Averages			$ 176.49	$ 196.04	$ (19.55)
		Shortfall extrapolated to all 50 states					$ (6,313,411,443)
		Total States			38		
		Percentage of Days			83.3%		

APPENDIX III

IMPACT OF HIGH COST PROVIDERS ON THE MEDICAID AVERAGE SHORTFALL

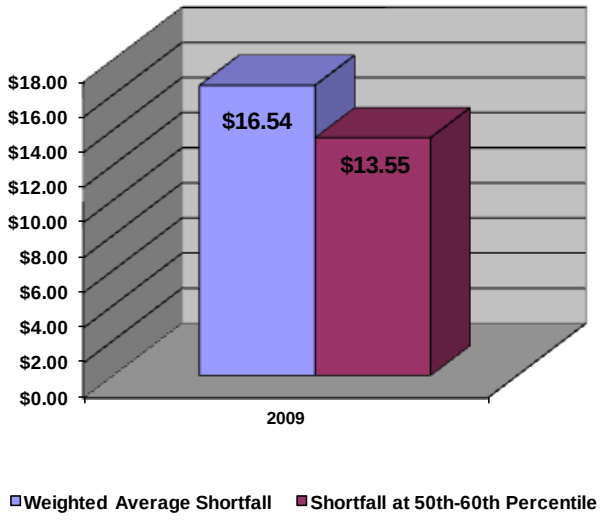
IMPACT OF HIGH COST PROVIDERS ON THE MEDICAID AVERAGE SHORTFALL

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 50^{th} and 60^{th} 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 50^{th} and 60^{th} percentile is reflected in Figure XI for 2009.

FIGURE XI

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 $13.55 in 2009. This is only $2.99 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

(2009 & CURRENT RATES)

AHCA DATA COLLECTION INSTRUCTIONS FOR 2009 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 2009 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 2009 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 2009 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.

AHCA DATA COLLECTION INSTRUCTIONS FOR 2009 DATA

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 2011. 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 percentage 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*	*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*	*12/31/2009*	*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*	*12/31/2009*	*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*