A Report on Shortfalls in Medicaid Funding for Nursing Center Care

ELJAY, LLC

FOR THE
AMERICAN HEALTH CARE ASSOCIATION

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Report Highlights

The majority of nursing center providers deliver Medicaid-covered services to residents at rates that are inadequate to cover their costs.

- Nursing centers rely heavily on two public programs, Medicare and Medicaid, to pay for the services they provide to most of their patients. The rates paid by states for Medicaid do not adequately reimburse the actual costs incurred by providers, resulting in a major disconnect between payment levels and the needs of the patients.

- The adequacy of Medicaid funding for nursing centers continues to decline even as state budgets show marginal improvement. Even greater uncertainty looms ahead as the 113th Congress likely will consider sweeping changes to Medicaid and Medicare.

The Medicaid shortfall has reached historic levels.

- Unreimbursed allowable Medicaid costs for 2012 are projected to exceed $7 billion. Expressed as a shortfall in reimbursement per Medicaid patient day, the estimated average Medicaid shortfall for 2012 is projected to be $22.34,[1] which is 14.3 percent higher than the preceding year's projected shortfall of $19.55.

- Based upon the average annual Medicaid shortfall amount per patient day listed above ($22.34), a typical center with an average daily census of 100 patients, of which 63 are funded by the Medicaid program, would lose $1,407 dollars each day for providing needed care to Medicaid beneficiaries. Over the course of the year, the shortfall between the center's Medicaid rate and its Medicaid cost would exceed $500,000.

- Medicaid rate increases historically have not kept up with allowable cost increases, and this was no exception in 2012. Between 2010 and 2012, we project costs will increase an average of 4.2 percent, while rates only increased an average of 2.5 percent.

Medicare no longer mends the Medicaid funding gap.

- Medicare cross-subsidization of Medicaid has historically played an important role in sustaining nursing center care. However, with recent Medicare rate reductions, this program can no longer fully subsidize increasing Medicaid shortfalls.

[1] No determination of the actual Medicaid shortfall could be made for 2011 since cost reports for 2011 were unavailable in all but 13 states. The 2012 Medicaid shortfall is a projection based upon trending of the most recently available (2010 or 2011) cost reports to 2012 and comparing these trended costs to current rates.

- Using Medicare margin data and 2012 projected Medicaid shortfall data, we project a combined Medicare/Medicaid shortfall that exceeds $2.51 billion for the current year or, expressed as a margin percentage across these two programs, a negative 2.8 percent of revenue.[2]

Providers have been forced to heavily leverage provider taxes in order to mitigate significant Medicaid underpayments.

- Existing, new, and expanded provider taxes have been used to mitigate rate reductions and, in some instances, fund other areas of state Medicaid programs or other areas of the state budgets.

- Between 2010 and 2012, eight states have implemented new provider taxes for nursing centers and in 2012, 23 states[3] have increased the provider tax rate for nursing centers. Twenty of the 43 states with a nursing center provider tax are at the maximum taxable amount of six percent of revenue.

Trends in the delivery of long term services and supports (LTSS) continue to drive down nursing center utilization while new questions about future demand emerge.

- Managed LTSS will likely result in a decline in occupancy. The managed care environment hinges upon care management and coordination across all settings, with an emphasis on non-institutional services. In fact, most states build incentives into managed care plan contracts emphasizing home and community-based services (HCBS) over center-based services.

- Medicare-Medicaid integration efforts will impact Medicaid long-stay occupancy and has implications for Medicare-financed post-acute care average lengths of stay.

- Expanding HCBS programs also will continue to drive down occupancy rates.

- However, demographic trends among older adults indicate that many may need higher intensity LTSS and emphasizes the importance of ensuring individuals have access to HCBS or center-based services depending upon their needs and preferences.

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[2] Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using CMS data on the national distribution of Medicare Part A days by RUG category covering the first three quarters of 2012. Medicare margin percentage derived from March 2012 MedPAC Report to the Congress: Medicare Payment Policy. Medicaid rates, days and margins derived from this report.

[3] KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012

Medicaid Shortfalls in 2010 and Projected Shortfalls for 2012 – Nursing Center 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 difference between Medicaid reimbursement and allowable Medicaid costs in as many states as feasible.[4] The report identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available, which in most states was 2010. In some states, cost reports for providers with year ends in 2011 were available and used. Similar to last year's study, a shortfall for the current year (2012) is projected by trending the 2010 costs (or 2011, if available) to the current year and comparing them to current Medicaid rates.

1. Methodology

Using the most recently available cost reports (2010 for most states), 38 states were able to provide data to Eljay, representing 83 percent of the Medicaid patient days in the country. Data from 70 percent of the states reporting 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.[5]

In terms of arriving at a national figure, the analysis includes the eleven states that represent over half of all days covered under the Medicaid program: California, Florida, Georgia, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas. Based upon the high percentage of nationwide Medicaid patient days represented by the states overall, it is likely that the results would not materially change had all states been represented.

Eljay projected the shortfall in Medicaid reimbursement for the current year (2012) by comparing current year rates to 2010 allowable costs (or 2011, if available) trended to the current year. The trending factor used in projecting 2010 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 estimated cost of any new or expanded provider tax programs if that cost was not already included in the base year's cost reports.

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[4] The President of Eljay, LLC is a retired partner of BDO, LLP (BDO) and formerly their National Director of Long Term Care Services. Both this year's study and the ten 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.

[5] 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.

Historically, allowable Medicaid costs have increased annually by a greater percentage than the Market Basket, meaning that once actual 2012 cost data become available, the actual shortfall for 2012 will likely be higher than what is projected in this report. To illustrate, we conducted a state-by-state comparison of the actual 2010 shortfalls and the shortfalls we projected for that year in our December 2010 report. The comparison revealed that 21 of the 36 states had greater actual shortfalls than projected. The actual average per diem shortfall for 2010 was $18.54, 7.0 percent higher than the originally projected shortfall of $17.33.

2. Estimated Medicaid Shortfall: 2010

The estimated average shortfall in Medicaid reimbursement increased from $16.54 per Medicaid patient day in 2009 to $18.54 per Medicaid patient day in 2010; a 12.1 percent increase. During this time period, Medicaid programs reimbursed nursing center providers for approximately 90.4 percent of their allowable costs per Medicaid patient, on average. The 2010 shortfall compilation incorporates data from 37 states.[6] When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing centers was estimated to be over $6.0 billion.

3. Projected Medicaid Shortfall: 2012[7]

Between 2010 and 2012, overall Medicaid rates increased by 2.5 percent, much lower than the Market Basket inflationary projections for the same time period, which are 4.5 percent. The estimated 2012 projected shortfall climbed to $22.34 from $18.54 in 2010, a 20.5 percent increase in the shortfall amount.[8] We estimate that in 2012, state Medicaid programs, on average, reimbursed nursing center providers only 88.9 percent of their projected allowable costs incurred on behalf of Medicaid patients. This means that for every dollar of allowable cost incurred for a Medicaid patient in 2012, Medicaid programs reimbursed, on average, approximately 89 cents. This represents the lowest percentage since the inception of this study in 1999. Figure 1 below depicts the year-over-year shortfall escalation. Figure 2 shows the year-over-year percentage of allowable costs covered by Medicaid rates.

[6] Cost report data for 2010 was not made available by the state agency in Illinois. Therefore, in computing the 2010 shortfall for this state, the latest available cost reports data—2009 reports—were trended to 2010 and compared to the 2010 rates.

[7] No determinations of the Medicaid shortfall could be made for 2011, since 2011 cost reports were unavailable in most states. The 2012 Medicaid shortfall is a projection based upon trending of the most recently available cost reports to 2012 and comparing these trended costs to current rates.

[8] This shortfall projection, based upon trending 2010 (or 2011, if available) allowable costs to 2012 by the SNF Market Basket for comparison to 2012 rates is conservative. The actual 2012 shortfall will likely be greater once actual 2012 allowable cost data becomes available. Historically, allowable costs have increased annually by a greater percentage than the Market Basket.

Figure 1. Average Annual Medicaid Rate and Shortfall Amount

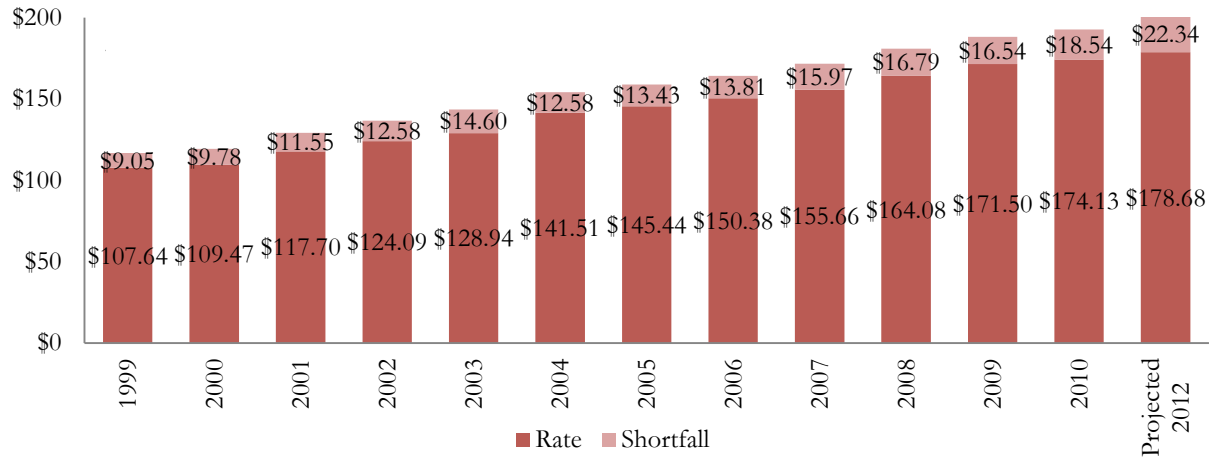
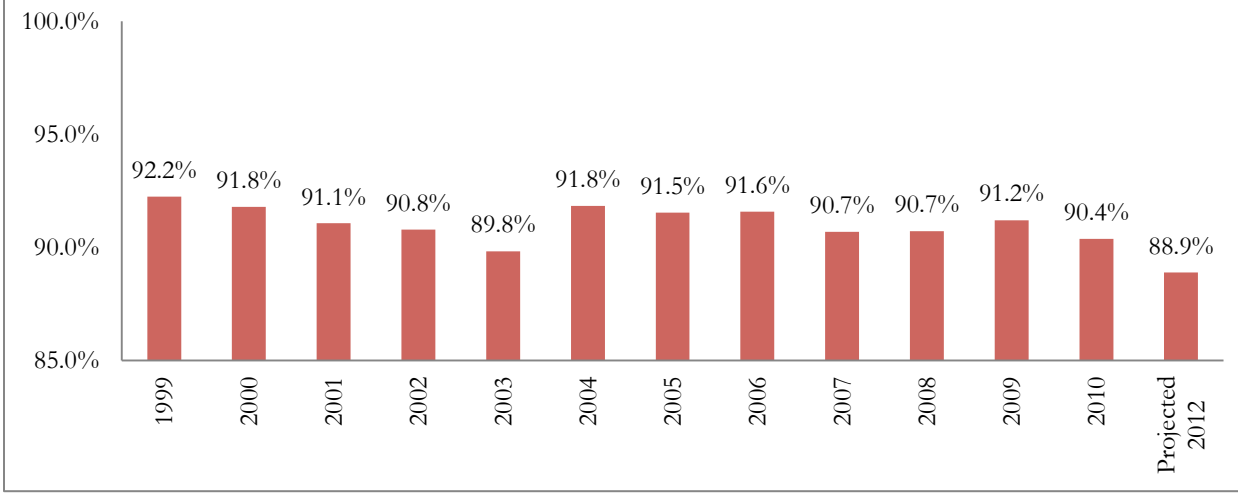


Figure 2. Percent of Allowable Costs Covered by Medicaid Rates



4. 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 state Medicaid agency as directly or indirectly related to patient care and typically exclude necessary operating costs. Non-allowable costs include, but are 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 centers, 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 38 years of preparing and analyzing cost reports, these legitimate

business costs typically constitute two to three percent of total costs. A two percent disallowance of legitimate business costs is equivalent to additional unreimbursed cost of approximately $4.02 per day based upon total projected 2012 Medicaid allowable costs of $201.03 per day. This would increase the projected 2012 Medicaid shortfall to $26.36 per Medicaid patient day.

5. State-by-State Data Tables

Tables 1 and 2, on the following pages, provide an overview of state-by-state comparisons of 2010 rates to 2010 costs and 2012 rates compared to projected 2012 costs, as well as the difference in these amounts for these two years.

Table 1. State-by-State Comparison of 2010 Rates to 2010 Costs			
State	**2010 Rate**	**2010 Cost**	**2010 Difference**
Arizona	$ 171.13	$ 188.44	$ (17.31)
California	$ 168.05	$ 182.42	$ (14.37)
Colorado	$ 193.57	$ 206.57	$ (13.00)
Connecticut	$ 220.82	$ 230.84	$ (10.02)
Delaware	$ 207.63	$ 235.79	$ (28.16)
Florida	$ 206.47	$ 215.92	$ (9.45)
Georgia	$ 141.78	$ 148.56	$ (6.78)
Hawaii	$ 228.59	$ 244.43	$ (15.84)
Illinois	$ 117.88	$ 141.44	$ (23.56)
Indiana	$ 153.79	$ 161.35	$ (7.56)
Iowa	$ 147.87	$ 160.18	$ (12.31)
Kansas	$ 141.48	$ 153.42	$ (11.94)
Maine	$ 178.79	$ 193.44	$ (14.65)
Maryland	$ 222.47	$ 239.73	$ (17.26)
Massachusetts	$ 196.84	$ 223.36	$ (26.52)
Michigan	$ 207.40	$ 203.48	$ 3.92
Minnesota	$ 164.34	$ 188.22	$ (23.88)
Missouri	$ 132.75	$ 151.62	$ (18.87)
Montana	$ 175.97	$ 185.24	$ (9.27)
Nebraska	$ 143.94	$ 165.81	$ (21.88)
Nevada	$ 187.86	$ 192.16	$ (4.30)
New Jersey	$ 207.76	$ 232.76	$ (24.99)
New York	$ 211.14	$ 255.46	$ (44.32)
North Dakota	$ 202.99	$ 205.02	$ (2.03)
Ohio	$ 177.77	$ 189.32	$ (11.55)
Oklahoma	$ 126.59	$ 142.77	$ (16.18)
Oregon	$ 222.12	$ 226.67	$ (4.55)
Pennsylvania	$ 203.54	$ 225.78	$ (22.24)
Rhode Island	$ 195.86	$ 211.56	$ (15.70)
South Dakota	$ 132.76	$ 150.00	$ (17.24)
Texas	$ 128.09	$ 138.27	$ (10.18)
Utah	$ 172.62	$ 191.32	$ (18.70)
Vermont	$ 192.67	$ 217.66	$ (24.99)
Virginia	$ 152.43	$ 159.40	$ (6.98)
Washington	$ 160.98	$ 188.73	$ (27.75)
Wisconsin	$ 153.71	$ 189.23	$ (35.53)
Wyoming	$ 162.23	$ 188.02	$ (25.79)

Table 2. State-by-State Comparison of 2012 Rates to Projected 2012 Costs			
State	**2012 Rate**	**Projected 2012 Cost**	**Projected Difference**
Arizona	$ 167.99	$ 191.51	$ (23.52)
California	$ 178.11	$ 191.27	$ (13.16)
Colorado	$ 198.01	$ 209.26	$ (11.25)
Connecticut	$ 229.49	$ 244.22	$ (14.73)
Delaware	$ 207.63	$ 242.44	$ (34.81)
Florida	$ 205.61	$ 220.03	$ (14.42)
Georgia	$ 146.38	$ 158.86	$ (12.48)
Hawaii	$ 233.17	$ 252.61	$ (19.43)
Illinois	$ 132.49	$ 155.55	$ (23.06)
Indiana	$ 154.63	$ 173.07	$ (18.44)
Iowa[9]	$ 154.31	$ 162.77	$ (8.46)
Kansas	$ 150.41	$ 160.23	$ (9.82)
Maine	$ 181.42	$ 200.52	$ (19.11)
Maryland	$ 230.84	$ 246.76	$ (15.92)
Massachusetts	$ 199.35	$ 230.37	$ (31.02)
Michigan	$ 215.39	$ 213.91	$ 1.49
Minnesota	$ 168.97	$ 196.68	$ (27.70)
Missouri	$ 141.31	$ 160.07	$ (18.77)
Montana	$ 177.77	$ 191.99	$ (14.22)
Nebraska	$ 154.32	$ 172.95	$ (18.63)
Nevada	$ 187.07	$ 198.06	$ (10.99)
New Hampshire	$ 179.66	$ 237.05	$ (57.38)
New Jersey	$ 198.51	$ 240.34	$ (41.83)
New York	$ 221.25	$ 267.64	$ (46.39)
North Dakota	$ 214.03	$ 211.17	$ 2.86
Ohio	$ 168.43	$ 192.78	$ (24.35)
Oklahoma	$ 127.30	$ 145.98	$ (18.68)
Oregon	$ 222.12	$ 232.58	$ (10.46)
Pennsylvania	$ 208.14	$ 234.40	$ (26.26)
Rhode Island	$ 199.41	$ 214.99	$ (15.58)
South Dakota	$ 126.09	$ 156.14	$ (30.05)
Texas	$ 128.33	$ 143.15	$ (14.82)
Utah	$ 178.47	$ 195.85	$ (17.37)
Vermont	$ 198.64	$ 222.32	$ (23.68)
Virginia	$ 156.17	$ 166.32	$ (10.15)
Washington	$ 180.86	$ 207.16	$ (26.30)
Wisconsin	$ 156.23	$ 196.34	$ (40.11)
Wyoming	$ 214.86	$ 215.02	$ (0.16)

[9] Iowa's provider tax system requires that providers spend a minimum of 60 percent of the enhanced payments funded by the tax on wages and other costs of employment. As a result, their actual shortfall is likely greater than what is reported here. For example, their FY 12 minimum spending requirement would result in an annual cost increase of approximately 3.25 percent rather than the estimated annual market basket increase of 2.2% used in the Study. This would result in an increase in the shortfall to $11.50 per Medicaid patient day.

Financing Factors Impacting Nursing Center Capacity

Because so many patients in nursing centers are covered by Medicaid or Medicare, federal and state government decision making and economic health have profound implications for the stability of nursing centers. In contrast, the majority of other health care providers, with the exception of home and community-based services (HCBS) providers, are more reliant upon private insurance and private pay. For example, the projected percentage of hospital revenue derived from private health insurance is projected to be 33.6 percent in 2012.[10]

Yet with such a reliance on Medicaid funding, there continues to be a major disconnect between what Medicaid pays for nursing center services and the cost of providing those services. That gap is rapidly expanding, yet consumers expect, and regulators demand, that nursing center providers continue to deliver high quality patient care. Besides struggling to provide quality care and manage operating costs within reimbursement constraints, nursing centers are also under pressure to improve the physical environment for their patients. The average age of a nursing center is 29 years[11] and state Medicaid programs in recent years have not had the resources to fund programs which adequately compensate providers who replace or substantially renovate their centers.

Additionally, in June 2012, the U.S. Supreme Court upheld the Affordable Care Act of 2010's (ACA's) employer health care coverage requirements. As a result, nursing centers, like all employers, must meet the ACA's employer coverage requirements. Benefits offered must meet certain federal requirements for coverage, benefits provided, and affordability. For some nursing centers, the employer coverage requirements may be a new expense or an increase in operating expenses, thus presenting a notable, new budget challenge that will not be covered by already insufficient Medicaid revenue.

1. Provider Taxes as a Funding Source for Rates

Provider taxes continue to serve as a major funding source for Medicaid payment rates in many states. In particular, during the Great Recession (fiscal years (FYs) 2007-2009) and continuing into the fragile state recovery, states heavily relied upon provider taxes to both mitigate or eliminate nursing center Medicaid rate freezes or reductions, as well as to reduce state budget deficits.

Prior to FY 2004, only 20 states assessed provider taxes on nursing centers. In FY 2012, more than twice as many – 43 states, including the District of Columbia – have implemented nursing center provider tax programs. In addition, 23 states increased the rate at which they tax nursing centers.[12]

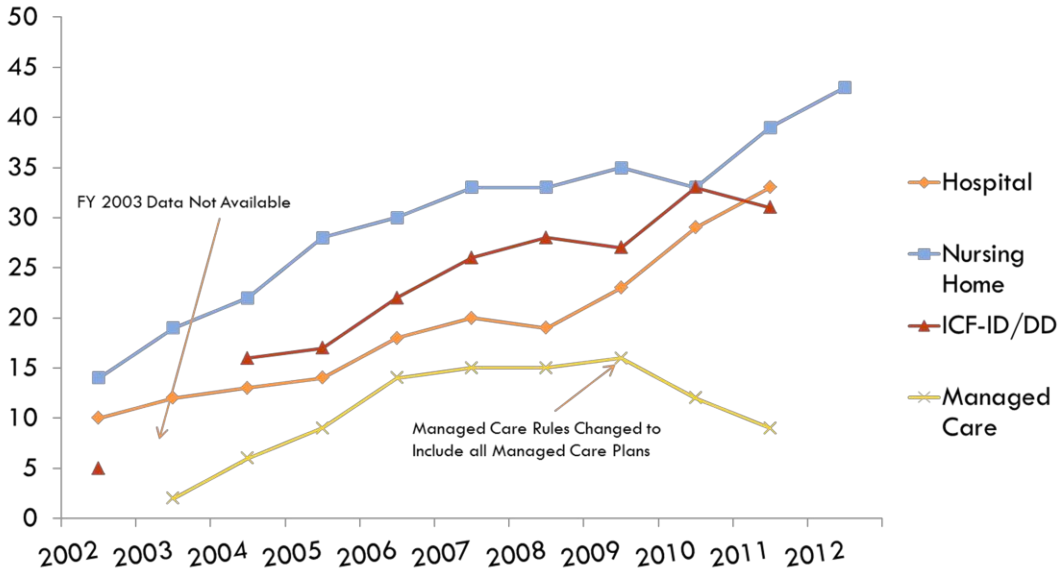
[10] CMS Form 672: F75 - F78

[11] Margaret P. Calkins, PhD, Private Bedrooms in Nursing Homes: Benefits, Disadvantages, and Costs, AIA, Blueprints for Senior Living, Summer 2009; Formation Capital Press Release. 1 September 2006; Medicare Payment Advisory Commission. Report to Congress: Sources of Financial Data on Medicare Providers. June 2004

[12] KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012

In 2012, three states – Arizona,[13] Delaware, and Hawaii – enacted new nursing center provider tax programs. See Figure 3, below, for information about the number of states using provider taxes for different classes of providers over time.

Figure 3. State Use of Provider Taxes by Number of States



Source: Medicaid and CHIP Payment and Access Commission. March 2012 Report to Congress. 2012 nursing home data point based on AHCA research.

Total tax collections among nursing centers exceed $5.0 billion annually.[14] In states with such programs, these taxes help to reimburse an average of approximately $23 per patient day in allowable Medicaid nursing center costs, in addition to funding other Medicaid services and being used outside the Medicaid program.

The use of provider tax funds has changed dramatically as a result of massive state budget deficits in recent years. 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, thus preventing providers from keeping pace in increasing costs of provided care to Medicaid beneficiaries. In fact, many states are using a greater portion of existing provider tax revenues and provider tax increases to reduce the overall state budget deficit rather than to enhance rates for providing care in nursing centers.

[13] At the time of this report being issued, the Arizona legislature has approved the tax, but the state Medicaid agency is waiting for CMS approval of the capitation methodology.
[14] AHCA survey of state affiliates.

As the 113th Congress approaches, the stability of the provider tax program is unclear. An array of proposals are aimed at reducing the provider tax safe harbor assessment amount, which is currently set at 6.0 percent of revenue. Such a reduction would have significant implications for state Medicaid budgets and Medicaid agencies' capacity to fund critical services. In its March 2012 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) notes that great caution should be taken before making any changes to the provider tax authority until its role in Medicaid financing is better understood.[15]

2. 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 centers in 2012 is projected to be 14.6 percent,[16, 17] while our analysis indicates a 12.5 percent shortfall on Medicaid payment for that year (i.e., the weighted average 2012 shortfall of $22.34 divided by the weighted average Medicaid rate of $178.68). The weighted average 2012 figure from these two government-funded programs is negative, meaning that providers cannot rely on Medicare to fully subsidize the costs of providing care to low income individuals covered by Medicaid (Table 3).[18]

Table 3. 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[19]	$467.09	68.6	$32.06	14.6%	$4.68
Medicaid	$178.68	321.7	$57.49	-12.5%	($7.19)
Net Medicare/Medicaid Shortfall					($2.51)
Net Medicare/Medicaid Margin as a Percentage of Revenue					-2.8%

Source: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using CMS data on the national distribution of Medicare Part A days by RUG category covering the first three quarters of 2012. Medicare margin percentage derived from March 2012 MedPAC Report to the Congress: Medicare Payment Policy. Medicaid rates, days and margins derived from this report.

[15] MACPAC. March 2012 Report to Congress.
[16] MedPAC. March 2012 Report to Congress.
[17] At the December 2012 MedPAC meeting, MedPAC reported that they project the 2013 margin to be between 11 and 14 percent, which is very similar to their 2012 projection.
[18] This estimate takes 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 percent that was published in the Federal Register, Volume 76, Number 152, August 8, 2011.
[19] These data are for Medicare Part A and do not reflect nursing center services provided under Part B or Medicare Advantage.

3. State Budget and Medicaid Programmatic Trends

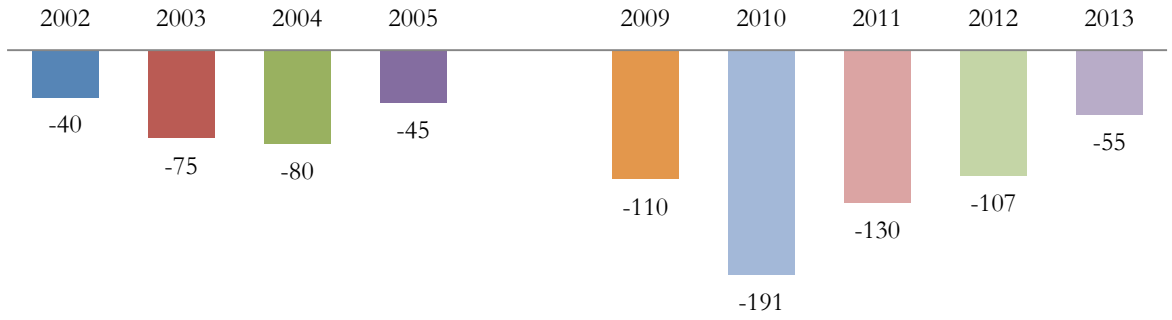
Following the most serious economic conditions since the Great Depression, state fiscal conditions improved in 2012 and are projected to continue to improve in 2013. However, such improvements should be considered in the context of the lingering recovery from the Great Recession. Recent research indicates that state fiscal year 2013 general fund revenues are projected to increase by $27.8 billion, while additional spending is projected to increase by only $14.6 billion, or 2.2 percent.[20]

Such a spending pattern indicates that states remain extremely cautious about their fiscal health for several reasons, including:

- Concern about the federal budget and potential reductions in federal funding to the state due to potential Congressional action to address the looming "fiscal cliff;"
- Expenditure of virtually all state "rainy day" reserves, leaving little buffer for future emergencies;
- Cessation of American Recovery and Reinvestment Act of 2009 (ARRA) funds; and
- A reduction of key federal funding sources and mechanisms, such as Medicaid provider tax.[21]

Despite the improvement in economic outlook, state budgetary recovery remains uncertain and mixed. Twenty-three states still are projecting fiscal year 2013 general fund revenues below fiscal 2008 levels and, while improved over 2012, the projected 2013 state budget gap is $55 billion.[22] Additionally, the impact of the Great Recession and resulting budget gaps are unprecedented in modern history. See Figure 4 below for trends in budget gaps.

Figure 4. State Budget Gaps, SFY 2002-2005 and 2009-2013



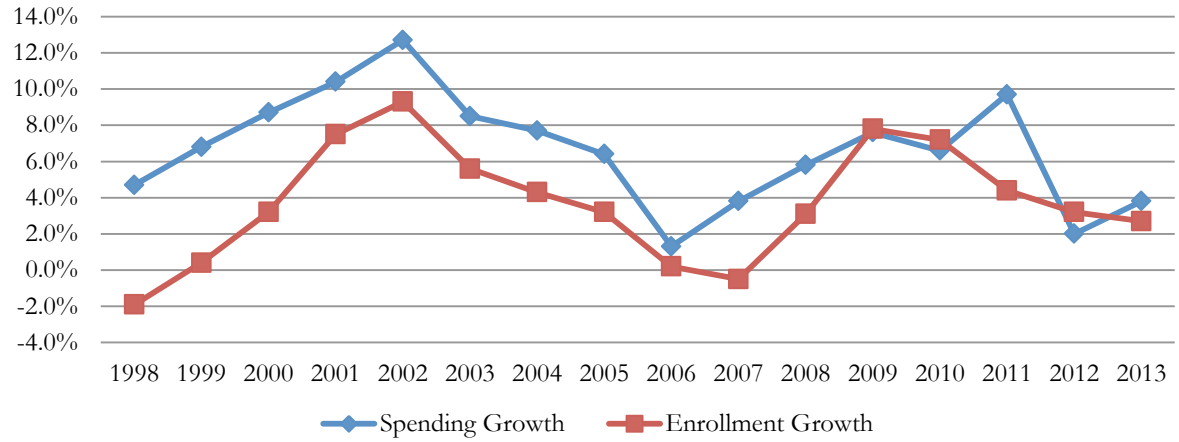
Source: KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012.

Relative to Medicaid, 2011 and 2012 growth rates are below historical trends with spending growth of 3.9 percent projected for 2013.[23] This slower growth rate is attributed to a lower rate of

[20] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2012.
[21] Ibid.
[22] Ibid.
[23] Ibid.

enrollment and continued state efforts to contain Medicaid cost growth. Figure 5 provides an overview of trends in Medicaid spending and enrollment.

Figure 5. Percent Change in Total Medicaid Spending and Enrollment, FY1998-FY2013

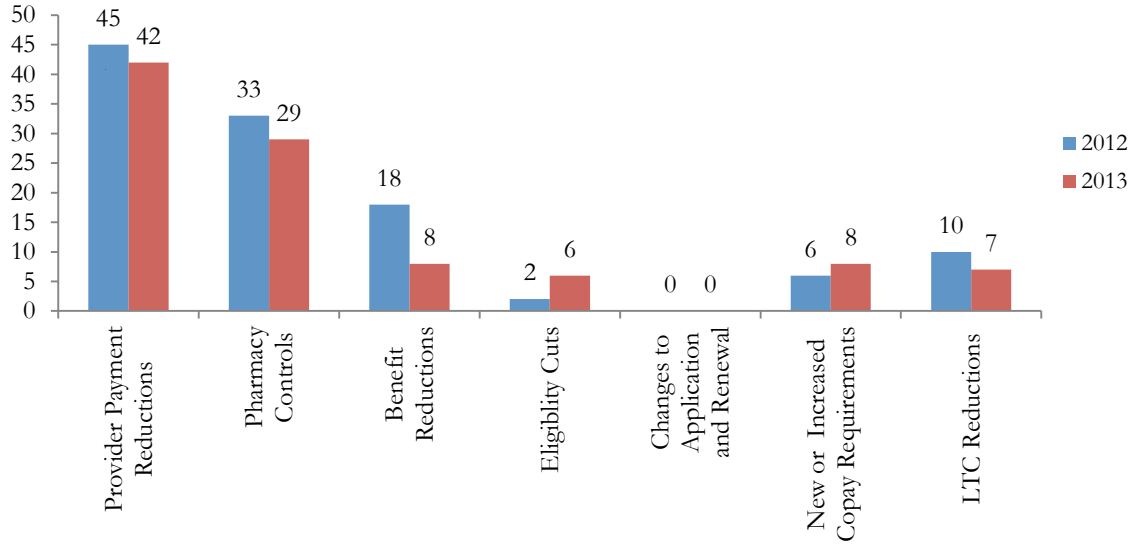


Source: KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012.

Mixed improvement in state budgets is accompanied by mixed state Medicaid activity. Some states have expanded eligibility, benefits, and raised rates, while others continue containment efforts to fund new initiatives and/or to address ongoing budgetary challenges. For example, in 2012, 19 states expanded benefits, while in 2013, an additional 15 benefit expansions are planned. Eligibility also is being expanded; in 2012, 15 states expanded eligibility for at least one group or program while an additional 13 expansions are planned for 2013. States also are expanding long term care, primarily for home and community-based services (HCBS); in 2012, 29 HCBS expansions took place while in 2013, 34 expansions are planned.[24] No expansion is expected for institutional long term care. Figure 6 provides an overview of state cost containment activities during this same time period.

[24] KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012.

Figure 6. 2012 and 2013 State Cost Containment Actions



Source: KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012.

4. Outlook for Medicaid Financing

In an effort to control growth of the federal deficit, Congress enacted the Budget Control Act of 2012 (BCA). The BCA sets caps on security and nonsecurity budget authority.[25] Because Congress did not act upon legislation aimed at reining in spending, the BCA spending caps were reset to apply to the 2013 through 2021 budgets. Additionally, automatic procedures will go into effect to reduce both discretionary and mandatory spending during that period (e.g., sequestration). Medicare is included in the automatic process for achieving federal savings and could receive cuts; Medicaid is excluded. Despite Medicaid being carved out of the sequestration process, many state officials and Medicaid advocates fear that federal lawmakers will be forced to make reductions in non-sequestration programs to reduce the impact upon programs included the sequestration process, such as Medicare. Such reductions could have a devastating impact on an industry already struggling to deliver care and supports while receiving Medicaid payment rates that do not adequately cover the costs of such care.

[25] Congressional Budget Office. Sequestration Update Report: August 2012.

Trends in Long Term Services and Supports Impacting Nursing Centers

In response to rapidly increasing demand for long term services and supports (LTSS) and overall Medicare and Medicaid budgetary pressure, a number of trends, some long-standing and others new, will impact nursing centers.

1. Home and Community-Based Services Expansion

States continue to heavily emphasize home and community-based services (HCBS) and are allocating more Medicaid funds toward HCBS programs and away from nursing centers. In terms of Medicaid financing for LTSS, as with overall Medicaid spending, the Great Recession significantly impacted state spending on such services. Between Federal Fiscal Year (FFY) 2009 and FFY 2010, total LTSS spending contracted by one percent after growth rates of nine percent between FFY 2007 to FFY 2008 and approximately six percent between FFY 2008 and FFY 2009. HCBS spending continued to increase during this period but at a much lower rate than in previous years; all non-institutional spending grew at about two percent between FFY 2009 and FFY 2010, compared to double-digit rates of growth in preceding years. At the same time, however, nursing center expenditures contracted at twice that rate, approximately four percent.[26]

However, in 2012 and planned for 2013, states again are heavily investing in HCBS expansion efforts. In FFY 2012, 24 states expanded HCBS while 26 states plan expansions in 2013.[27] In part, the availability of ACA opportunities aimed at expanding the use of HCBS has spurred state activity. Of particular interest to states is that many of these programs offer enhanced federal Medicaid matching rates for HCBS above the states' traditional matching rate. The combination of enhanced Federal Medical Assistance Percentages (EFMAP), the recent U.S. Supreme Court ruling that upheld the vast majority of the ACA, and anemic state budgetary recovery likely will entice more states to explore or act upon these options. No such EFMAP opportunities exist for center-based LTSS.

2. Medicaid Managed Long Term Services and Supports

Medicaid managed long term services and supports (MLTSS) is a rapidly growing payment and systems transformation effort. State use of this effort currently is not widespread; MLTSS accounted for only 5 percent of Medicaid's total LTSS expenditures in FFY 2009. Sixteen states currently offer MLTSS programs: Arizona, California, Delaware, Florida, Hawaii, Massachusetts, Michigan, Minnesota, New Mexico, New York, North Carolina, Pennsylvania, Tennessee, Texas, Washington and Wisconsin. Among states with MLTSS programs, 7 of 16 have programs that operate statewide, but some of these statewide programs only serve specific populations. However, by 2014, 26 states

[26] Burwell, et. al. Medicaid Long Term Services and Supports Spending 2011. Thomson Reuters.
[27] KCMU. Medicaid Today; Preparing for Tomorrow – A Look at State Medicaid Program Spending Enrollment and Policy Trends. October 2012.

will have some form of MLTSS.[28] The managed care environment hinges upon care management and coordination across all settings, with an emphasis on non-institutional services. In fact, most states build incentives into managed care plan contracts emphasizing HCBS over center-based services. In states that allow plans to negotiate rates with providers, the experience is that providers have limited negotiating leverage unless they have a high concentration of centers in a given market or will accept patients that the plans have difficulty placing, such as residents with complex medical needs or severe behavioral issues. Historically, the end result has been lower occupancy rates, slower payment for services and limited opportunity to negotiate adequate rates for services.

3. *Medicare-Medicaid Integration Efforts*

The ACA also established two new divisions with the U.S. Department of Health and Human Services aimed at Medicare and Medicaid payment and systems delivery innovation, including Medicare-Medicaid integration. These offices are the Center for Medicare and Medicaid Innovation (CMMI) and the Medicare-Medicaid Coordination Office (MMCO). Twenty-five states have submitted proposals to CMS for Medicare-Medicaid integration efforts. Of the submitting states, 17 focus on using managed care as the vehicle for integration, five will focus on managed fee-for-service only, and three will test both. To date, the Centers for Medicare and Medicaid Services (CMS), which houses CMMI and MMCO, has taken the initial steps in approving proposals from the Commonwealth of Massachusetts and Ohio State, which both use the managed care model, and Washington State, which focuses on the managed fee-for-service model.

While the goal of better integrating care and services for Medicare-Medicaid eligibles is laudable, the current approaches pose an array of challenges and unknowns for nursing centers. Many of the challenges associated with MLTSS hold true for plan-based integration. Providers are likely to have lower long-stay occupancy rates and experience shorter average lengths of stay for Medicare-financed post-acute care. In addition, there is significant uncertainty and apprehension as to whether payment rates for both Medicare and Medicaid services under this integrated model will at least be comparable to the rates paid using the existing rate methodologies for these two programs.

4. *Increasing Numbers of Older Adults with Intense Support Needs*

Rising levels of older adults with multiple chronic conditions and disabilities may lead to increasing demand for post-acute care following a hospital stay to ensure successful transition to home and the community. Between 2010 and 2050, the U.S. population over age 65 is projected to double from 40.2 to 88.5 million.[29] Additionally, over the past ten years, the percentage of adults age 45 to 64 and

[28] Saucier, Paul, Jessica Kasten, Brian Burwell, and Lisa Gold. 2012. "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Truven Health Analytics. Prepared under CMS Contract No. HHSM-500-2005-00025I.

[29] Vincent, G. and Velkoff, V. The Next Four Decades – The Older Population in the United States: 2010 to 2050. U.S. Census Bureau.

65 and older with two or more of nine chronic conditions likely to result in disability increased notably.[30] Markedly, the percentage of adults age 45 to 64 with two more chronic conditions increased by 20 percent over a ten year period.

Research has long been documented that the incidence of disability and support needs increases with age, particularly among those over age 85. The proportion of people over age 85 also will significantly increase in coming years.[31] Finally, more recent analysis of the prevalence of disability among persons age 65 and older suggests that disability rates have been increasing rather than continuing to decrease.[32, 33] These factors raise serious questions about the capacity of our nation's LTSS system to provide future demand for services.

[30] Fried, V. et. al. Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past Ten Years. U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Health Statistics.
[31] Ibid.
[32] Fuller-Thomson, E, et. al. Basic ADL Disability and Functional Limitation Rates Among Older Americans From 2000-2005: The End of the Decline? J Gerontol A Biol Sci Med Sci. 2009 Vol. 64. No 12, 1333-1336.
[33] National Institutes of Health. Fact Sheet – Disability in Older Adults. October 2010.

Nursing Center Outlook for 2013

Historically, nursing centers have struggled with Medicaid rates insufficient to cover the costs of delivering care to an increasingly frail and medically complex population. The future appears to hold additional instability. Among the states, key trends impacting nursing center capacity include increasingly tight Medicaid LTSS budgets as states expand HCBS to meet growing demand and expanding use of Medicaid managed LTSS.

At the federal level, the sequestration and/or a plan to avert sequestration likely will include some mix of reductions in Medicare reimbursement and may include provisions to reduce or eliminate the Medicaid provider tax authority. Such reductions could have a devastating impact on an already fragile industry delivering care and supports to some of the nation's most vulnerable citizens.

The federal government and states also are experimenting with payment and service delivery system innovations including Medicare and Medicaid Accountable Care Organizations (ACOs), Medicare-Medicaid integration efforts, and Medicare and Medicaid bundled payment methodologies. It is unclear how these approaches will impact the nursing center sector overall, but preliminary experiences raise concerns about its stability.

In conclusion, current financial challenges and future uncertainty paints a difficult picture for the nursing center sector. As the number of oldest adults increases and the profession continues to see rising levels of multiple chronic conditions, the ability to meet the needs and expectations of the growing elderly and disabled populations without major overhauls in how the services are funded is major cause for concern.

Appendices

Appendix 1

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 2010 (or 2011, 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 2010, but between current (FY 2012) rates and 2010 (or 2011, if available) costs trended to the same time period.

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 centers, and out-of-state travel. The cost database reflected costs that have been audited or desk-reviewed by the Medicaid state agency in 70 percent of the states in 2010. Eljay did not replicate the calculations nor trace individual center cost or rate data to Medicaid cost reports, rate worksheets, or state agency databases.

Comparisons of Medicaid rates and allowable costs for 2010 were derived for 37 states, representing 83 percent of the Medicaid patient days in the country. Current Medicaid rates by provider were obtained from 38 states, allowing us to determine an estimated 2012 shortfall for these states, again representing 83 percent of Medicaid days nationwide.[34] The remaining states not reflected in the comparisons indicated that the data were not readily available. States included in this report reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide. It also includes the eleven states that represent over half of all days covered under the Medicaid program: California, Florida, Georgia, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio,

[34] In Illinois, the state agency provided 2009 and 2012 rate data. Cost data were for 2009. As such, we projected a 2012 shortfall for this state by projecting 2009 cost report data to 2012 and comparing these projected costs to 2012 rates.

Pennsylvania, and Texas. Based upon the high percentage of nationwide Medicaid patient days represented by the states overall, it is likely that the results would not materially change had all states been represented.

Appendix 2

Calculation of 2010 and Projected 2012 Weighted Average Medicaid Shortfall State-by-State Comparison

Table A2-1. Calculation of 2010 Weighted Average Medicaid Shortfall							
State	**2010 Rate**	**2010 Cost**	**2010 Difference**	**Annual Medicaid Days**	**Gross Revenue**	**Gross Cost**	**Total Difference**
Arizona	$171.13	$188.44	($17.31)	2,731,346	$467,411,865	$514,704,215	($47,292,349)
California	$168.05	$182.42	($14.37)	24,968,745	$4,196,041,861	$4,554,764,439	($358,722,579)
Colorado	$193.57	$206.57	($13.00)	3,503,396	$678,169,765	$723,709,873	($45,540,108)
Connecticut	$220.82	$230.84	($10.02)	6,348,518	$1,401,877,664	$1,465,462,317	($63,584,653)
Delaware	$207.63	$235.79	($28.16)	875,736	$181,829,201	$206,485,589	($24,656,388)
Florida	$206.47	$215.92	($9.45)	15,301,876	$3,159,342,214	$3,303,904,891	($144,562,677)
Georgia	$141.78	$148.56	($6.78)	9,111,743	$1,291,872,346	$1,353,652,357	($61,780,011)
Hawaii	$228.59	$244.43	($15.84)	992,756	$226,932,808	$242,659,837	($15,727,030)
Illinois	$117.88	$141.44	($23.56)	17,411,751	$2,052,487,595	$2,462,686,459	($410,198,864)
Indiana	$153.79	$161.35	($7.56)	8,838,960	$1,359,382,695	$1,426,167,390	($66,784,694)
Iowa	$147.87	$160.18	($12.31)	4,396,750	$650,131,916	$704,271,905	($54,139,989)
Kansas	$141.48	$153.42	($11.94)	3,701,848	$523,724,161	$567,919,483	($44,195,322)
Maine	$178.79	$193.44	($14.65)	1,515,407	$270,937,338	$293,140,538	($22,203,200)
Maryland	$222.47	$239.73	($17.26)	5,488,609	$1,221,038,836	$1,315,790,661	($94,751,826)
Massachusetts	$196.84	$223.36	($26.52)	9,870,149	$1,942,886,877	$2,204,616,368	($261,729,491)
Michigan	$207.40	$203.48	$3.92	9,104,641	$1,888,333,604	$1,852,613,904	$35,719,701
Minnesota	$164.34	$188.22	($23.88)	5,988,755	$984,175,728	$1,127,216,447	($143,040,719)
Missouri	$132.75	$151.62	($18.87)	8,390,573	$1,113,888,275	$1,272,187,895	($158,299,619)
Montana	$175.97	$185.24	($9.27)	1,022,774	$179,973,856	$189,459,197	($9,485,341)
Nebraska	$143.94	$165.81	($21.88)	2,435,574	$350,573,109	$403,852,290	($53,279,181)
Nevada	$187.86	$192.16	($4.30)	990,035	$185,985,915	$190,246,189	($4,260,274)
New Jersey	$207.76	$232.76	($24.99)	10,404,830	$2,161,736,732	$2,421,804,320	($260,067,588)
New York	$211.14	$255.46	($44.32)	28,794,111	$6,079,548,158	$7,355,629,080	($1,276,080,923)
North Dakota	$202.99	$205.02	($2.03)	1,095,758	$222,429,176	$224,655,392	($2,226,216)
Ohio	$177.77	$189.32	($11.55)	18,216,409	$3,238,253,119	$3,448,644,805	($210,391,686)
Oklahoma	$126.59	$142.77	($16.18)	4,615,347	$584,237,708	$658,933,075	($74,695,368)
Oregon	$222.12	$226.67	($4.55)	1,680,252	$373,217,644	$380,862,792	($7,645,148)

Table A2-1. Calculation of 2010 Weighted Average Medicaid Shortfall							
State	**2010 Rate**	**2010 Cost**	**2010 Difference**	**Annual Medicaid Days**	**Gross Revenue**	**Gross Cost**	**Total Difference**
Pennsylvania	$203.54	$225.78	($22.24)	18,386,479	$3,742,383,856	$4,151,299,141	($408,915,284)
Rhode Island	$195.86	$211.56	($15.70)	1,885,774	$369,351,888	$398,961,735	($29,609,847)
South Dakota	$132.76	$150.00	($17.24)	1,325,003	$175,901,983	$198,748,835	($22,846,852)
Texas	$128.09	$138.27	($10.18)	20,917,439	$2,679,219,432	$2,892,157,365	($212,937,933)
Utah	$172.62	$191.32	($18.70)	1,039,042	$179,355,722	$198,787,258	($19,431,535)
Vermont	$192.67	$217.66	($24.99)	684,682	$131,914,559	$149,026,338	($17,111,779)
Virginia	$152.43	$159.40	($6.98)	6,304,112	$960,915,209	$1,004,899,368	($43,984,160)
Washington	$160.98	$188.73	($27.75)	3,981,949	$641,014,073	$751,513,144	($110,499,071)
Wisconsin	$153.71	$189.23	($35.53)	6,679,660	$1,026,701,934	$1,264,021,830	($237,319,896)
Wyoming	$162.23	$188.02	($25.79)	539,266	$87,486,754	$101,392,162	($13,905,407)

Totals	269,540,055	$46,980,665,574	$51,976,848,882	($4,996,183,308)
Weighted Average		$174.30	$192.84	($18.54)
Shortfall Extrapolated to all 50 states and DC				($6,008,161,315)
Total States				37
Percentage of days				83.2%

Table A2-2. Calculation of Projected 2012 Weighted Average Medicaid Shortfall							
State	**2012 Rate**	**2012 Cost**	**2012 Difference**	**Annual Medicaid Days**	**Gross Revenue**	**Gross Cost**	**Total Difference**
Arizona	$167.99	$191.51	($23.52)	2,552,927	$428,869,793	$488,912,734	($60,042,941)
California	$178.11	$191.27	($13.16)	25,032,999	$4,458,722,965	$4,788,151,089	($329,428,124)
Colorado	$198.01	$209.26	($11.25)	3,523,495	$697,677,804	$737,328,002	($39,650,198)
Connecticut	$229.49	$244.22	($14.73)	6,270,301	$1,438,962,543	$1,531,338,408	($92,375,865)
Delaware	$207.63	$242.44	($34.81)	919,797	$190,977,432	$222,998,474	($32,021,043)
Florida	$205.61	$220.03	($14.42)	15,506,706	$3,188,294,634	$3,411,949,092	($223,654,457)
Georgia	$146.38	$158.86	($12.48)	8,983,664	$1,315,025,927	$1,427,128,682	($112,102,755)
Hawaii	$233.17	$252.61	($19.43)	887,587	$206,962,159	$224,211,480	($17,249,321)
Illinois	$132.49	$155.55	($23.06)	17,002,376	$2,252,608,453	$2,644,754,863	($392,146,411)
Indiana	$154.63	$173.07	($18.44)	8,958,605	$1,385,256,472	$1,550,464,892	($165,208,421)
Iowa[35]	$154.31	$162.77	($8.46)	4,369,022	$674,188,313	$711,165,569	($36,977,256)
Kansas	$150.41	$160.23	($9.82)	3,724,390	$560,202,193	$596,765,408	($36,563,214)
Maine	$181.42	$200.52	($19.11)	1,545,678	$280,411,713	$309,946,673	($29,534,960)
Maryland	$230.84	$246.76	($15.92)	5,512,406	$1,272,476,393	$1,360,219,610	($87,743,217)
Massachusetts	$199.35	$230.37	($31.02)	9,844,596	$1,962,491,919	$2,267,899,457	($305,407,538)
Michigan	$215.39	$213.91	$1.49	9,025,538	$1,944,053,347	$1,930,644,391	$13,408,956
Minnesota	$168.97	$196.68	($27.70)	5,678,109	$959,443,561	$1,116,749,545	($157,305,983)
Missouri	$141.31	$160.07	($18.77)	8,565,874	$1,210,408,057	$1,371,170,117	($160,762,060)
Montana	$177.77	$191.99	($14.22)	945,130	$168,015,103	$181,457,082	($13,441,979)
Nebraska	$154.32	$172.95	($18.63)	2,321,303	$358,228,220	$401,471,860	($43,243,640)
Nevada	$187.07	$198.06	($10.99)	950,732	$177,856,166	$188,305,196	($10,449,030)
New Hampshire	$179.66	$237.05	($57.38)	1,624,559	$291,872,590	$385,097,383	($93,224,793)
New Jersey	$198.51	$240.34	($41.83)	10,361,793	$2,056,908,988	$2,490,384,463	($433,475,475)
New York	$221.25	$267.64	($46.39)	27,732,082	$6,135,723,114	$7,422,191,043	($1,286,467,930)

[35] Iowa's provider tax system requires that providers spend a minimum of 60 percent of the enhanced payments funded by the tax on wages and other costs of employment. As a result, their actual shortfall is likely greater than what is reported here. For example, their FY 12 minimum spending requirement would result in an annual cost increase of approximately 3.25 percent rather than the estimated annual market basket increase of 2.2% used in the Study. This would result in an increase in the shortfall to $11.50 per Medicaid patient day.

Table A2-2. Calculation of Projected 2012 Weighted Average Medicaid Shortfall							
State	**2012 Rate**	**2012 Cost**	**2012 Difference**	**Annual Medicaid Days**	**Gross Revenue**	**Gross Cost**	**Total Difference**
North Dakota	$214.03	$211.17	$2.86	1,070,148	$229,047,675	$225,986,929	$3,060,747
Ohio	$168.43	$192.78	($24.35)	18,086,176	$3,046,253,932	$3,486,588,055	($440,334,123)
Oklahoma	$127.30	$145.98	($18.68)	4,656,656	$592,804,174	$679,787,777	($86,983,603)
Oregon	$222.12	$232.58	($10.46)	1,618,063	$359,406,015	$376,324,115	($16,918,100)
Pennsylvania	$208.14	$234.40	($26.26)	18,259,581	$3,800,549,241	$4,280,045,845	($479,496,604)
Rhode Island	$199.41	$214.99	($15.58)	1,948,399	$388,532,904	$418,879,627	($30,346,723)
South Dakota	$126.09	$156.14	($30.05)	1,294,230	$163,192,925	$202,083,508	($38,890,583)
Texas	$128.33	$143.15	($14.82)	21,308,373	$2,734,473,741	$3,050,311,581	($315,837,840)
Utah	$178.47	$195.85	($17.37)	1,058,908	$188,987,053	$207,385,491	($18,398,438)
Vermont	$198.64	$222.32	($23.68)	643,176	$127,760,916	$142,993,812	($15,232,896)
Virginia	$156.17	$166.32	($10.15)	6,259,235	$977,520,497	$1,041,058,970	($63,538,473)
Washington	$180.86	$207.16	($26.30)	3,838,632	$694,238,272	$795,199,753	($100,961,481)
Wisconsin	$156.23	$196.34	($40.11)	6,376,305	$996,148,057	$1,251,921,825	($255,773,767)
Wyoming	$214.86	$215.02	($0.16)	514,706	$110,590,537	$110,674,684	($84,147)

Totals	268,772,255	$48,025,143,799	$54,029,947,486	(6,004,803,687)
Weighted Average		$178.68	$201.03	($22.34)
Shortfall Extrapolated to all 50 states and DC				($7,187,830,016)
Total States				38
Percentage of days				83.5%

Appendix 3

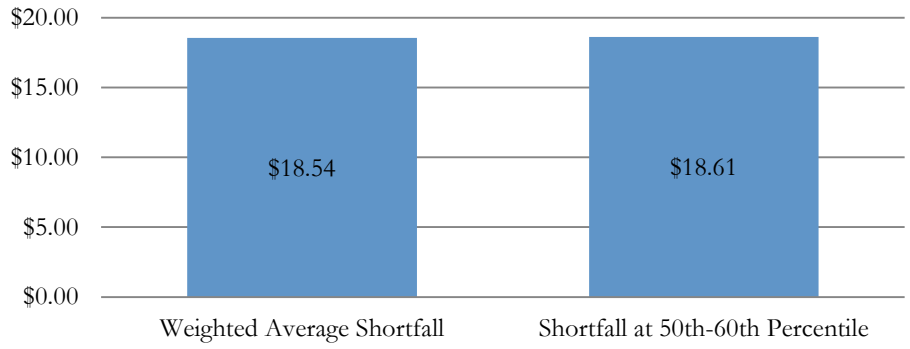
Impact of High Cost Providers on the Medicaid Average Shortfall

IMPACT OF HIGH COST PROVIDERS ON THE MEDICAID AVERAGE SHORTFALL

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

To address this concern, 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—those 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 2010 costs between the 50th and 60th percentile is reflected in Figure A3-1, below.

Figure A3-1. 2010 Medicaid Shortfall Comparison – Weighted Average Shortfall for All Providers vs. Weighted Average Shortfall for Providers with Per Diem Costs at the 50th to 60th Percentile



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 comparable to the average shortfall nationwide. This analysis demonstrates that Medicaid payment is substantially inadequate in reimbursing even reasonable cost providers.