Eljay LLC

A Report on Shortfalls in Medicaid Funding for Nursing Home Care

ELJAY, LLC

FOR THE
AMERICAN HEALTH CARE ASSOCIATION

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REPORT HIGHLIGHTS

- The average shortfall in Medicaid nursing home reimbursement was projected to be $14.17 per Medicaid patient day in 2009. The actual shortfall in 2009 will likely be somewhat higher due to greater then projected inflationary pressures on nursing home costs.

- Un-reimbursed nursing home Medicaid allowable costs were estimated at over $4.6 billion in 2009.

- The Medicaid reimbursement outlook for 2010 and 2011 is bleak. It is worse than any other year in the last seven in which this annual Report has been compiled due to unprecedented state budget deficits and expiration of federal stimulus funds at the end of 2010.

- The actual daily reimbursement shortfall for 2007 was estimated at $14.00 per Medicaid patient day. The 2007 shortfall is greater than the 2006 actual shortfall of $13.81 (per last year's report) and has increased by 55% between 1999 and 2007.

- In 2009, for every dollar of allowable cost incurred for a Medicaid patient, the Medicaid program reimbursed, on average, approximately 92 cents.

- States continue to rely heavily upon provider taxes to fund nursing home reimbursement. However most states with provider taxes chose not to increase nursing home reimbursement nor lower the provider tax rate as a result of a temporary higher federal match rate on these tax funds under the American Recovery and Reinvestment Act of 2009 (ARRA). Instead, the savings from a higher federal match rate on provider tax funds appears, in most states, to have gone to subsidize state budget deficits.

- States continue to redirect more of their long term care budgets to non-institutional services. This heightened competition among long term care programs for limited state resources combined with sagging state economies has dampened 2010 Medicaid rate increases. This negative trend will likely continue in 2011 as the economic outlook for states remains bleak and because of the expiration of the higher temporary ARRA federal match rates (FMAP) as of January 1, 2011.

- Medicare cross-subsidization of Medicaid continues to play an important role in sustaining nursing home care. Even with positive Medicaid rate trends through FY 2009, on average, the combined margin from the two payer sources is still negative. This negative combined margin will grow even more due to Medicare payment reductions of approximately $16 per Medicare patient day in FY 2010 and a substantial decline in FY 2010 Medicaid rate increases.

MEDICAID 2007 AND PROJECTED 2009 NURSING HOME SHORTFALL STUDY SUMMARY

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 feasibly possible.[1] This year's compilation, like the previous seven, identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available, which in most states was 2007. In a few states, cost reports for providers with fiscal year ends of June 30, 2008 were available and used. In addition, similar to last year's study, a shortfall for the current year (2009) is projected by trending the 2007 costs (or 2008 if available) to the current year and comparing them to current Medicaid rates.

Methodology

Overall, data were obtained from 39 states and the District of Columbia for 2007[2] and represented over 84% of the Medicaid patient days in the country. The data from just under two thirds of the states reporting in 2007 were based upon audited or desk-reviewed cost reports, or some blend of both. As-filed Medicaid cost reports or Medicare cost reports were used for the remaining states.[3]

As previously indicated, in addition to determining the shortfall in Medicaid funding in 2007, Eljay projected the shortfall in Medicaid reimbursement for the current year by comparing current year rates to 2007 allowable costs (or 2008 if available) trended to the current year. The trending factor used in projecting 2007 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 also used by the Medicare program in setting Medicare rate increases. The trended costs were also increased by the cost of any new or expanded provider tax programs if that cost was not already included in the base year's cost

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

[2] In New Mexico, the state Medicaid contractor provided shortfall data only for 2007. Fiscal year 2009 rate data was not available in that the rates are now established on a negotiated basis between the provider and the Medicaid managed care contractor. The state agency does not track these rates and therefore a 2009 projected shortfall could not be determined.

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

reports.[4] Historically, allowable Medicaid costs have increased annually by a greater percentage than the Market Basket, meaning once actual 2009 cost data become available, the actual shortfall for 2009 will likely be higher than what is projected in this report. For example, the September 2007 Shortfall Report projected a per diem shortfall of $13.15 for 2007. Now, based upon actual allowable cost data for that year, the actual per diem shortfall was $14.00, over 6% higher than originally projected.

Estimated Medicaid Shortfall: 2007

The estimated average shortfall in Medicaid reimbursement increased per Medicaid patient day from $13.81 in 2006 to $14.00 in 2007; a 1.4% increase. For every dollar of allowable cost incurred for a Medicaid patient in 2007, Medicaid programs reimbursed, on average, approximately 92 cents; which was slightly higher than the percentage of allowable cost covered by the Medicaid rates in 2006. The 2007 shortfall compilation incorporates data from 39 states and the District of Columbia. When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing facilities was estimated to be almost $4.7 billion.

Projected Medicaid Shortfall: 2009[5]

Between 2007 and 2009, overall Medicaid rate increases have approximated market basket projected cost increases, resulting in an estimated 2009 projected shortfall of $14.17.[6] We estimate that, on average, state Medicaid programs are currently reimbursing approximately 92.2% of projected allowable costs incurred on behalf of Medicaid patients, the highest percentage achieved since 1999.

The 2009 shortfall compilation incorporates data from 39 states and the District of Columbia.[7] When extrapolated to all 50 states and the District of Columbia, the shortfall in Medicaid reimbursement to nursing facilities was projected at over $4.6 billion. Taken together, in the

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[4] In Tennessee, 2007 costs were projected to the current year by the skilled market basket plus an estimate of the impact of the federal minimum wage increase effective July 1, 2007. The cost estimate was commensurate with the add-on provided in their 2008 rates for this additional cost.

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

[6] This shortfall projection, based upon trending 2007 (or 2008 if available) allowable costs to 2009 by the SNF Market Basket for comparison to 2009 rates is conservative. The actual 2009 shortfall will likely be greater once actual 2009 allowable cost data becomes available in that historically, allowable costs have increased annually by a greater percentage than the Market Basket.

[7] In New Mexico, the state Medicaid contractor provided shortfall data for 2007 but did not provide 2009 rate information. Thus, a 2007 shortfall was determined for this state but a 2009 shortfall could not be determined due to missing 2009 rate data. In New Jersey, the state agency provided 2009 rate data but no 2007 cost data in that the 2007 cost reports were not used for rate setting. As such, we projected a 2009 shortfall for New Jersey by projecting 2006 cost report data to 2009 and comparing these projected costs to 2009 rates. However, no 2007 shortfall determination could be made.

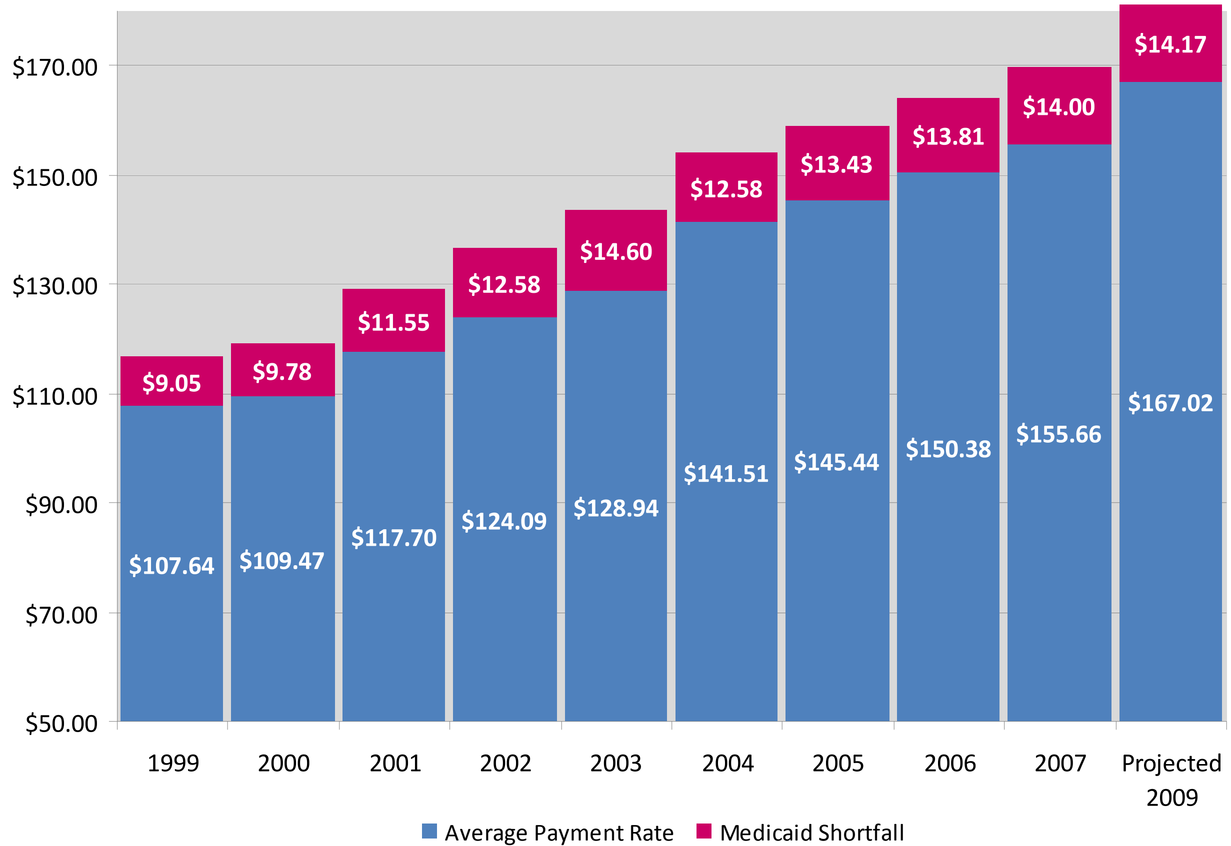
years that we have compiled this study, the shortfall in Medicaid nursing home funding has increased 56.5%, from $9.05 per patient day in 1999 to a projected $14.17 in 2009.

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 inception of the study.

Medicaid Allowable Costs in Comparison to Total Costs

If all costs of operations were considered—not just Medicaid allowable costs—the shortfall would be significantly greater. Allowable costs include only those costs recognized by the Medicaid state agency as directly or indirectly related to patient care and typically exclude necessary operating costs including, but not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of facilities, and out-of-state travel. Based upon historical analysis of cost disallowances in states where such detail was available and Eljay's experience over the past 35 years of preparing and analyzing cost reports, these legitimate business costs typically constitute 2% to 3% of total costs. A 2% disallowance of legitimate business costs is equivalent to additional unreimbursed cost of approximately $3.62 per day based upon total projected 2009 Medicaid allowable costs of $181.19 per day. This would increase the projected 2009 Medicaid shortfall to almost $18 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 2008 since 2008 cost reports were unavailable in all but 8 states. The 2009 Medicaid shortfall is a projection based upon trending the most recently available (2007) cost reports to 2009 and comparing these trended costs to current rates.

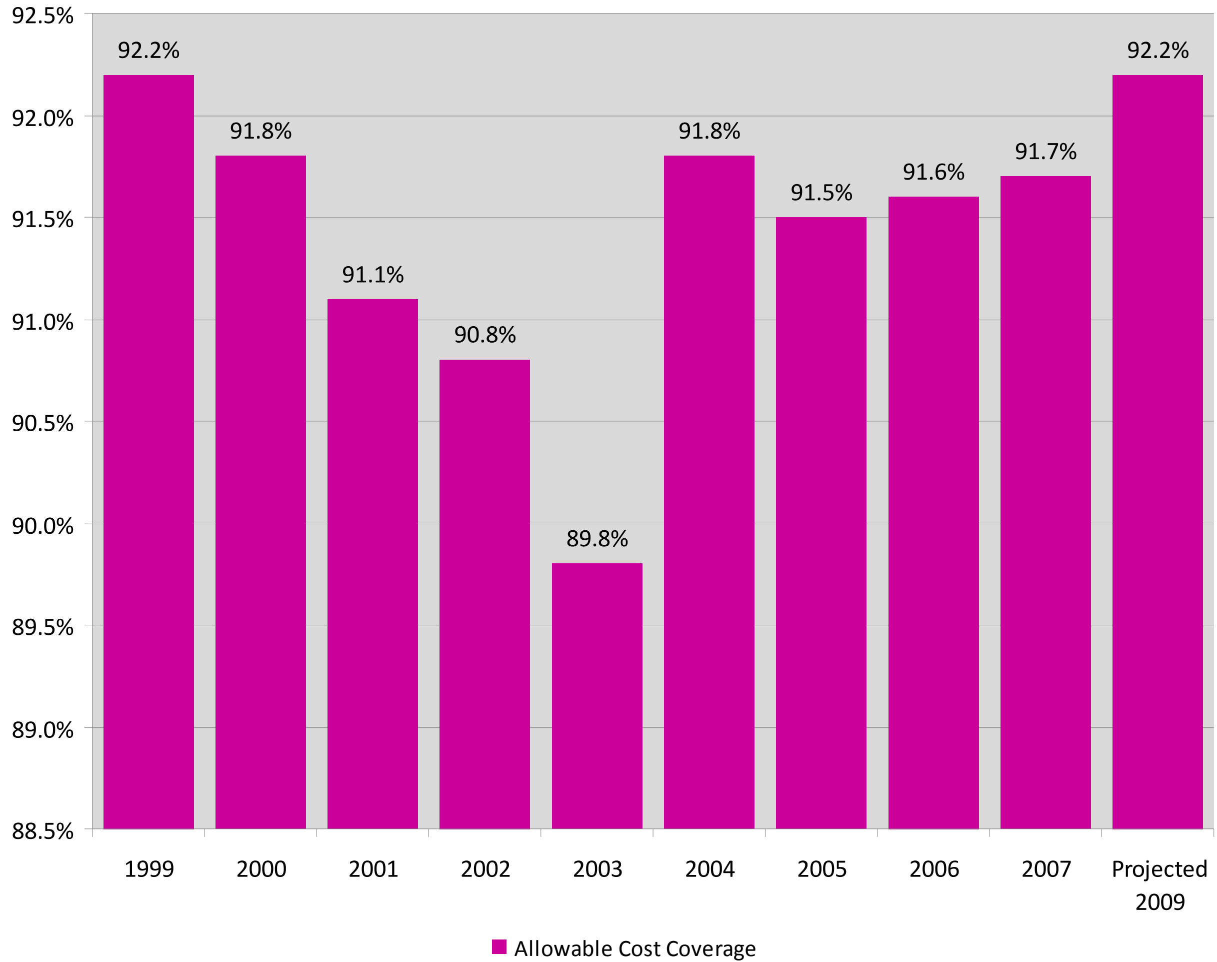


FIGURE II
Percentage of Costs Covered by the Rates
All States in each Year
92.5%
92.0%
91.5%
91.0%
90.5%
90.0%
89.5%
89.0%
88.5%
92.2%
91.8%
91.1%
90.8%
89.8%
91.8%
91.5%
91.6%
91.7%
92.2%
1999
2000
2001
2002
2003
2004
2005
2006
2007
Projected 2009
Allowable Cost Coverage

TABLE I
State-By-State Comparison Of Rates And Costs

State	Rate 07	Cost 07	Difference 07
Arizona	$ 151.96	$ 164.75	$ (12.79)
California	$ 150.69	$ 162.27	$ (11.58)
Colorado	$ 166.24	$ 176.03	$ (9.79)
Connecticut	$ 212.47	$ 225.97	$ (13.50)
District of Columbia	$ 222.96	$ 236.72	$ (13.76)
Florida	$ 175.00	$ 184.37	$ (9.37)
Georgia	$ 127.43	$ 134.32	$ (6.89)
Hawaii	$ 212.98	$ 221.67	$ (8.69)
Idaho	$ 163.99	$ 166.68	$ (2.69)
Illinois	$ 103.89	$ 130.20	$ (26.31)
Iowa	$ 116.52	$ 127.58	$ (11.06)
Kansas	$ 125.07	$ 140.91	$ (15.84)
Maine	$ 168.58	$ 182.76	$ (14.18)
Maryland	$ 194.10	$ 202.91	$ (8.81)
Massachusetts	$ 191.30	$ 214.08	$ (22.78)
Michigan	$ 180.92	$ 184.37	$ (3.45)
Minnesota	$ 147.68	$ 172.04	$ (24.36)
Missouri	$ 116.20	$ 134.03	$ (17.83)
Montana	$ 153.40	$ 155.31	$ (1.91)
Nebraska	$ 134.76	$ 152.27	$ (17.51)
Nevada	$ 168.53	$ 180.48	$ (11.95)
New Mexico	$ 140.74	$ 167.81	$ (27.07)
New York	$ 203.21	$ 224.66	$ (21.45)
North Carolina	$ 136.54	$ 147.07	$ (10.53)
North Dakota	$ 162.12	$ 165.40	$ (3.28)
Ohio	$ 163.96	$ 174.58	$ (10.62)
Oklahoma	$ 124.55	$ 131.21	$ (6.66)
Oregon	$ 195.62	$ 194.98	$ 0.64
Pennsylvania	$ 190.83	$ 204.06	$ (13.23)
Rhode Island	$ 181.75	$ 196.98	$ (15.23)
South Carolina	$ 143.40	$ 149.12	$ (5.72)
South Dakota	$ 118.73	$ 132.39	$ (13.66)
Tennessee	$ 136.12	$ 140.27	$ (4.15)
Texas	$ 106.48	$ 119.02	$ (12.54)
Utah	$ 154.92	$ 166.14	$ (11.22)
Vermont	$ 182.98	$ 197.20	$ (14.22)
Virginia	$ 137.72	$ 144.11	$ (6.39)
Washington[1]	$ 145.47	$ 159.37	$ (13.90)
Wisconsin	$ 136.13	$ 164.79	$ (28.66)
Wyoming	$ 148.84	$ 175.96	$ (27.12)

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

TABLE I
State-By-State Comparison Of Rates And Costs
(Continued)

State	Rate 09	Projected Cost 09	Projected Difference 09
Arizona	$ 159.56	$ 168.98	$ (9.42)
California	$ 162.45	$ 171.34	$ (8.89)
Colorado	$ 188.15	$ 189.90	$ (1.75)
Connecticut	$ 220.42	$ 238.65	$ (18.23)
District of Columbia	$ 250.36	$ 247.20	$ 3.16
Florida	$ 180.05	$ 195.62	$ (15.57)
Georgia	$ 135.59	$ 144.15	$ (8.56)
Hawaii	$ 229.22	$ 231.01	$ (1.79)
Idaho	$ 180.85	$ 181.64	$ (0.79)
Illinois	$ 117.09	$ 137.89	$ (20.80)
Iowa	$ 121.34	$ 134.43	$ (13.09)
Kansas	$ 135.82	$ 148.03	$ (12.21)
Maine	$ 176.94	$ 193.14	$ (16.20)
Maryland[1]	$ 218.25	$ 220.17	$ (1.92)
Massachusetts	$ 192.01	$ 216.96	$ (24.95)
Michigan	$ 195.03	$ 191.34	$ 3.69
Minnesota	$ 162.58	$ 182.89	$ (20.31)
Missouri	$ 122.20	$ 141.35	$ (19.15)
Montana	$ 158.81	$ 164.01	$ (5.20)
Nebraska	$ 138.05	$ 157.14	$ (19.09)
Nevada	$ 179.75	$ 192.02	$ (12.27)
New Jersey	$ 204.96	$ 230.09	$ (25.13)
New York	$ 217.59	$ 241.69	$ (24.10)
North Carolina	$ 155.69	$ 157.16	$ (1.47)
North Dakota	$ 177.82	$ 177.96	$ (0.14)
Ohio	$ 166.72	$ 183.18	$ (16.46)
Oklahoma	$ 128.47	$ 135.50	$ (7.03)
Oregon	$ 206.17	$ 203.43	$ 2.74
Pennsylvania	$ 202.09	$ 215.97	$ (13.88)
Rhode Island	$ 182.25	$ 201.05	$ (18.80)
South Carolina	$ 148.11	$ 153.02	$ (4.91)
South Dakota	$ 127.60	$ 139.87	$ (12.27)
Tennessee	$ 144.30	$ 148.03	$ (3.73)
Texas	$ 112.87	$ 125.83	$ (12.96)
Utah	$ 157.18	$ 171.23	$ (14.05)
Vermont	$ 184.26	$ 200.55	$ (16.29)
Virginia	$ 146.22	$ 152.88	$ (6.66)
Washington[2]	$ 151.06	$ 167.43	$ (16.37)
Wisconsin	$ 144.73	$ 173.14	$ (28.41)
Wyoming	$ 160.37	$ 183.43	$ (23.06)

[1] The FY 09 rates do not reflect a rate reduction of approximately $5 per patient day effective August 01, 2009. If incorporated, the shortfall in Maryland would increase to approximately $7 per patient day.

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

NURSING HOME REIMBURSEMENT TRENDS

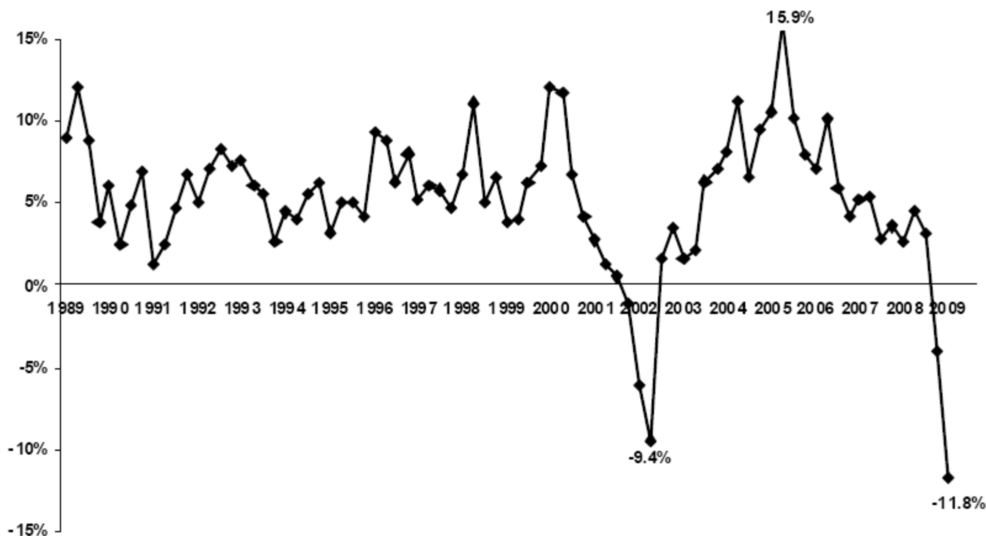
The improved budget stability among states from 2004 to 2009, along with enhanced federal matching programs (see next section) resulted in steady increases in Medicaid rates. From 2003 to 2009, Medicaid rates increased 29.5%. Allowable cost coverage (the percentage of allowable costs covered by the rates) has remained above 90%. However, a good part of the rate increases and improvement in cost coverage can be attributable to enactment of provider taxes which are addressed in the next section of this Report. For example, in 2004, when 12 states imposed provider taxes for the first time, bringing the total number of states with nursing home provider tax programs to over 30, average Medicaid rates in that year climbed 9.7% and cost coverage improved from below 90% to almost 92%.

However, as reflected in Figure III, state tax revenues peaked in 2005 and have since shown a steady decline. In 2009, state tax revenues have decreased dramatically over the same quarterly time period in 2008 and recent Census Bureau figures (09/30/09 Wall Street Journal) indicate that the trend is getting worse as state tax revenues in the second quarter of 2009 plunged 17% from a year earlier. At the same time Medicaid enrollment and spending have experienced significant growth since 2006, peaking at a 7.9% increase in 2009 (Figure IV).

A September 2009 Report by the Kaiser Commission on Medicaid and the Uninsured (Kaiser) on “State Fiscal Conditions and Medicaid” indicates that a 1% increase in the national unemployment rate is expected to result in 1 million more Medicaid and Children’s Health Insurance Program (CHIP) enrollees. In addition, a 1% increase in unemployment results in an additional 1.1 million uninsured and a decline in state tax revenues of 3-4% (Figure V). Kaiser predicts that increases in the national unemployment rate since the start of the recession are expected to result in about 4.8 million more Medicaid and CHIP enrollees and over 5 million more uninsured.

FIGURE III

State Tax Revenue, 1999-2009



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

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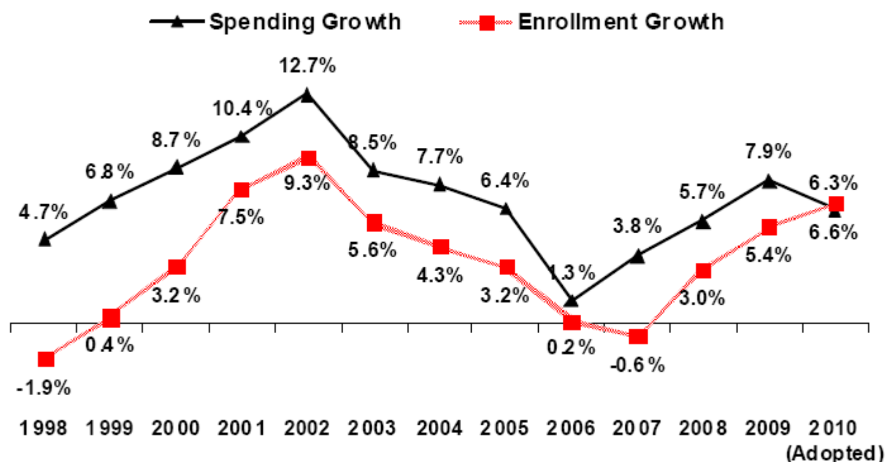
Medicaid and the Uninsured

FIGURE IV

Percent Change in Medicaid Spending and Enrollment, FY 1998- FY 2010



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentage changes in state fiscal year.

SOURCE: Enrollment Data for 1998-2006: *Medicaid Enrollment in 50 States,* KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2009 and FY 2010 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

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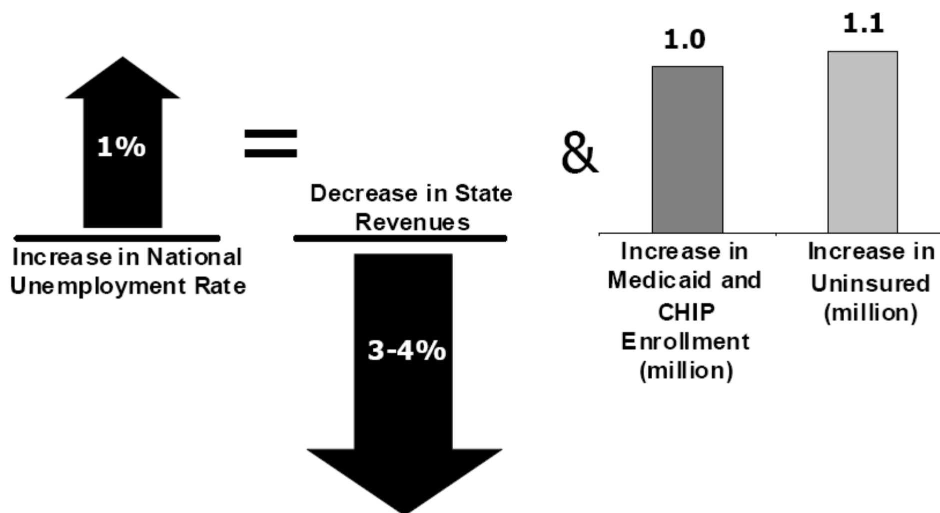
FIGURE V

Effect of a 1% Point Increase in Unemployment



Source: *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses*, Kaiser Commission on Medicaid and the Uninsured, April 2008

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Medicaid and the Uninsured

This toxic combination of lower state tax revenues, increasing Medicaid enrollment and spending, and higher unemployment has resulted in huge state budget deficits (expected in both 2010 and 2011) and is now negatively impacting nursing home Medicaid rate increases. The impact that this has had on FY 2010 Medicaid rate increases and the likely impact it will have on FY 2011 rates is addressed later in this Report.

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

Provider taxes continue to be a major funding source for rate increases in many states. Between FY 2004 and FY 2009, many states implemented or expanded provider tax programs and used these proceeds and corresponding federal matching funds to increase Medicaid rates to nursing homes. Prior to FY 2004, 20 states assessed provider taxes on nursing homes. In FY 2009, 34 states and the District of Columbia have implemented nursing home tax programs. Overall, provider taxes on nursing homes generate over $4.5 billion in matching federal funds, and in the states affected, are used to reimburse an average of $16 per patient day in allowable Medicaid nursing home costs.

Two states (Colorado and Florida) enacted new provider tax programs in FY 2009 while two others did so in FY 2010 (Idaho and Iowa). Six states increased provider tax rates in FY 2009 or FY 2010. However, how provider tax funds are used has changed dramatically as a result of massive state budget deficits. Most new or expanded tax programs are now being used, not to enhance rate increases provided by the state and thereby reduce the shortfall between rates and allowable Medicaid costs (as was commonly done in the 12 states implementing tax programs in 2004), but rather to mitigate rate freezes or rate reductions. In other words, without the new tax or tax increases, providers would have received no rate increase or a rate reduction. Such was the case with tax programs in Florida, Idaho and Iowa. Even with existing tax programs, many states are using a greater portion of these funds to reduce their budget deficits rather than to enhance rates.

A perfect example of states using provider taxes to fund budget deficits is through the enhanced federal match program on Medicaid expenditures through the end of 2010 under the American Recovery and Reinvestment Act of 2009 (ARRA). Provider taxes that are used as the state share of Medicaid expenditures are eligible for the higher match rates. As a result of the higher federal match rates, states could have used existing provider tax dollars to provide higher rates to providers. Alternatively, states could have lowered the provider tax rates without having to reduce Medicaid rates because of a higher federal match on the taxes. However, most states with existing nursing facility provider tax programs did neither. Instead they used the savings, representing the difference between existing provider tax revenues, and the tax revenues needed to sustain existing rates based upon the higher match rates, to reduce deficits.

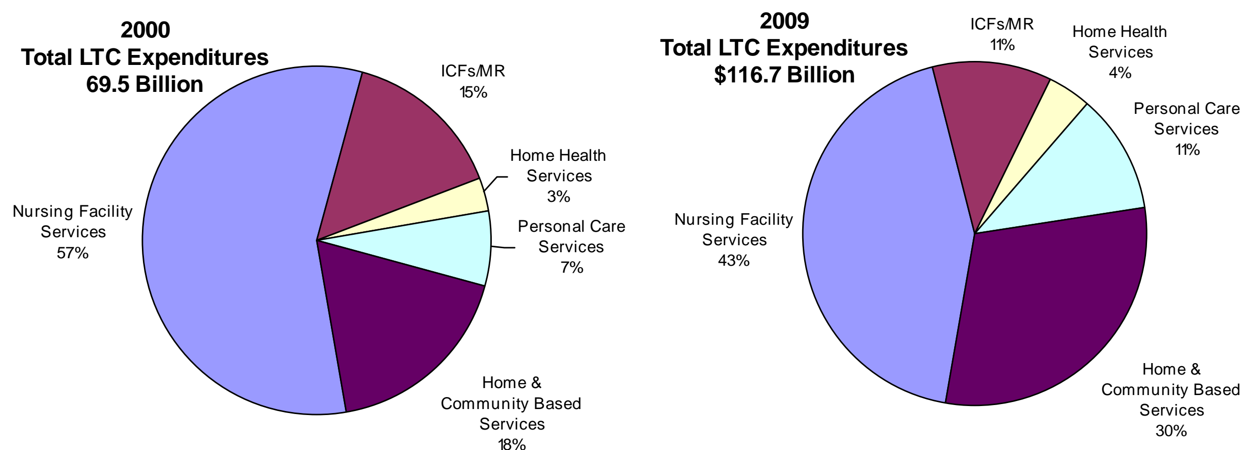
Nursing home provider taxes cannot be counted on as a major catalyst for insuring rate increases during this recession as they were in the last recession for two reasons. First, unlike in 2003 when only 20 states assessed taxes on nursing homes, 34 states and the District of Columbia now do so. Today, every state with high nursing home Medicaid volumes but one (Texas) imposes nursing home provider taxes. Second, states are limited in the amount of revenue that can be raised through provider taxes without jeopardizing federal matching funds. The current limitation is 5.5% of nursing facility revenues, down from 6% prior to January 1, 2008. We estimate that in FY 2009, 20 of the 34 states and the District of Columbia are at, or close to, the 5.5% limit.

Besides provider taxes, a number of states also use Intergovernmental Transfers and Certified Public Expenditures to generate additional federal funds to support state services, including long term care services. In May 2007, CMS issued a proposed rule, which in effect, required the federal dollars generated from these programs to remain with the public facilities that are incurring Medicaid shortfalls. The federal dollars could no longer be used to help subsidize state budgets or to increase rates to non-public providers. New limits also reduced the federal dollars that could be generated from these programs. In 2008 and again in 2009, Congress placed a moratorium on this rule, which will delay implementation until July 2010. If, and when implemented, the rule will certainly increase the pressure on state budgets as more Medicaid expenditures would be financed with state funds, which in turn could impact nursing home reimbursement rates and increase the shortfall between reimbursement and allowable Medicaid costs.

REDIRECTION IN MEDICAID LONG TERM CARE EXPENDITURES

Regardless of economic conditions, states continue to rebalance their limited resources, redirecting more of them to home and community-based services (HCBS) programs. The charts in Figure VI reflect this rebalancing trend with the percentage of Medicaid long term care expenditures spent on nursing facility services declining from 57% to 43% in the last nine years, a reduction of 24.5%. At the same time, the percentage spent on HCBS has climbed 67%.

FIGURE VI
Medicaid LTC Expenditures



Source: CMS Medicaid Statement of Expenditures (CMS-64) 2000, 2006; CMS Medicaid Program Budget Report (CMS-37), August 2009, annual estimate, 2009.

In terms of dollars, expenditures for nursing facility services have only increased $10.6 billion between 2000 and 2009—a compounded annual growth rate of only 2.7%. During the same period, expenditures for HCBS have climbed $22.5 billion, an increase of 180%. Figure VII reflects the percentage change and annual rate of growth in Medicaid expenditures by program between 2000 and 2009. It clearly demonstrates that even with Medicaid rate increases being comparable to nursing home cost increases over this time frame; nursing home expenditure growth has been extremely modest due to declining nursing home occupancy.

FIGURE VII
LTC Medicaid Expenditures Growth

Expenditures (in billions)	2000	2009	% Change	Annual rate of growth
NF	$ 39.6	$ 50.2	26.7%	2.70%
ICFs-MR	$ 10.4	$ 12.8	23.1%	2.30%
HCBS	$ 12.5	$ 35.0	179.9%	12.10%
PC and Home Health	$ 7.0	$ 18.7	168.7%	11.60%
Total	$ 69.5	$ 116.7	67.9%	5.90%

The September 2009 Kaiser Commission Report referenced earlier indicates that states are continuing to expand community-based long term care, but fewer states are adopting these policies compared to FY 2008. Major budget deficits heighten competition among long term care programs for limited state resources and that certainly is reflected in the drastic reduction in rate increases to nursing home providers in 2010 (as addressed on pages 15-19 of this Report). This downward pressure on future nursing home rate increases comes at a time when the functional, medical and psycho-social needs of new admissions are higher as increasing percentages of less disabled recipients are cared for in non-institutional settings.

THE ROLE OF MEDICARE IN SUBSIDIZING MEDICAID SHORTFALLS

Medicare continues to play an important role in the cross-subsidization of Medicaid deficits. According to the Medicare Payment Advisory Commission or MedPAC, the average margin on Medicare payment to nursing homes in 2007 was 14.5%,[8] while our analysis indicates a 9.0%

[8] March 2009 Medicare Payment Advisory Commission Report to Congress.

shortfall on Medicaid payment for that year (weighted average 2007 shortfall of $14.00 divided by weighted average Medicaid rate of $155.66). The weighted average 2007 margin from the two government funded programs combined is a negative 1.2% (see Figure VIII).[9]

Figure VIII
Combined Medicare/Medicaid Shortfall for 2007

Payer	2007 Average Rate	Days in Millions	Revenue in Billions	Revenue in Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	$ 386.43	66.6	$ 25,736	$ 25.74	14.5%	$ 3.73
Medicaid	$ 155.66	335.2	$ 52,178	$ 52.20	(9.0%)	$ (4.70)
			$ 77,914			$ (0.97)
				Net Medicare/Medicaid Shortfall as a Percentage of Revenue		(1.2%)

Sources: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using 2007 SNF claims data. Medicare margin percentage derived from March 2009 Medicare Payment Advisory Commission Report to Congress. Medicaid rates, days and margins derived from this Shortfall Report.

This analysis does not consider the October 1, 2009 reduction in Medicare Part A payments to SNFs of approximately $1.05 billion annually to prospectively correct for unexpected overpayments to SNFs as a result of changes in the nursing weights that occurred as part of the FY 2006 SNF PPS refinement to the RUG system. Figure IX reflects the impact of this Medicare rate reduction which increases the shortfall from the two government funded programs combined to a negative 2.6% (See Figure IX). The combination of declining Medicare margins and greater Medicaid shortfalls (as addressed in the next section of this Report) could have serious adverse financial and quality implications.

[9] Together Medicare and Medicaid represent approximately 80 percent of nursing facility residents. If other payer sources were included (e.g., private pay, private insurance, managed care, etc.), overall margins in 2007 would likely have been close to zero or slightly positive.

FIGURE IX
Combined Medicare/Medicaid Shortfall for 2007

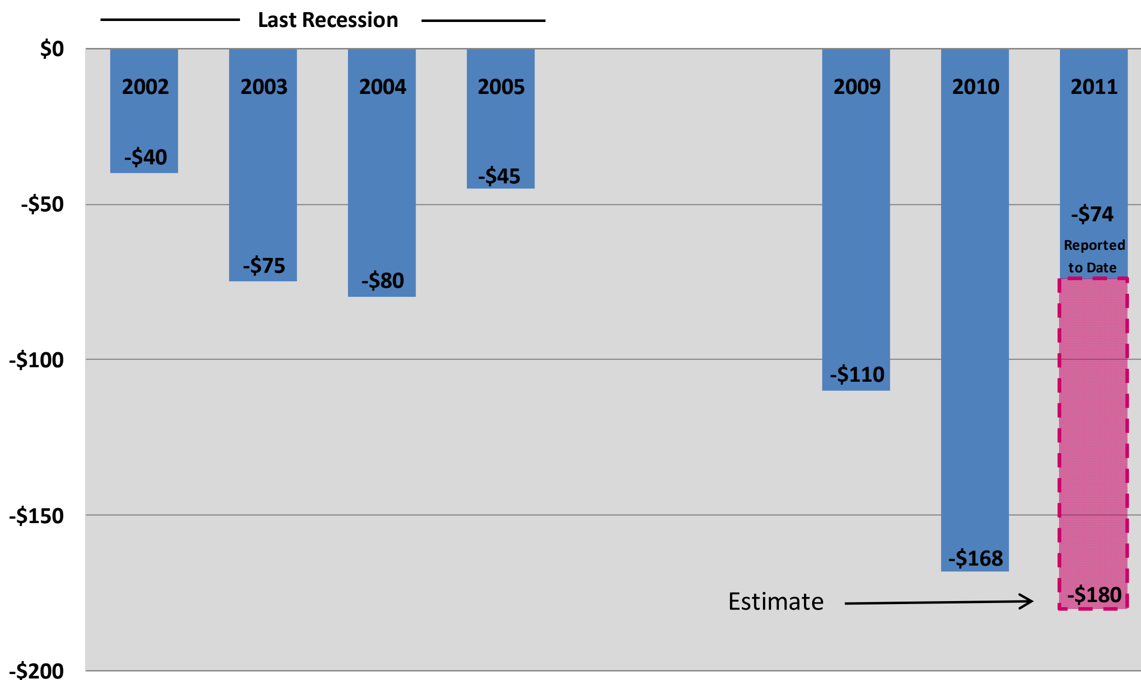
Payer	2007 Average Rate	Days in Millions	Revenue in Billions	Revenue in Billions	Margin (Shortfall) as a % of Revenue	Net Margin (Shortfall) in Billions
Medicare	$ 386.43	66.6	$ 25,736	$ 25.74	14.5%	$ 3.73
Medicaid	$ 155.66	335.2	$ 52,178	$ 52.20	(9.0%)	$ (4.70)
			$ 77,914			
October 1, 2009 Medicare payment reduction				$ (1.05)		$ (1.05)
				$ 76.89		$ (2.02)
Net Medicare/Medicaid Shortfall as a Percentage of Revenue						(2.6%)

Sources: Medicare Rates and Days based upon AHCA Reimbursement and Research Department SNF PPS Simulation Model using 2007 SNF claims data. Medicare margin percentage derived from March 2009 Medicare Payment Advisory Commission Report to Congress. October 1, 2009. Medicare payment reduction derived from Medicare FY 2010 PPS Final Rule for Skilled Nursing Facilities, FR August 11, 2009, page 40358. Medicaid rates, days and margins derived from this Shortfall Report.

NURSING HOME REIMBURSEMENT OUTLOOK FOR 2010 AND 2011

According to a September 3, 2009 Report by the Center on Budget and Policy Priorities (CBPP)), 48 states and the District of Columbia, faced an estimated $168 billion in combined shortfalls in their budgets for FY 2010. CBPP indicates that “if, as is widely expected, the economy does not begin to significantly recover until some time in CY 2010, and unemployment remains high through 2010, state shortfalls are likely to be even larger in FY 2011 (which begins in July 2010 in most states). The deficits over the next two fiscal years — 2010 and 2011 — are likely to be more than $350 billion.” Figure X compares the budget shortfalls during the last recession to “how bad it will get” in 2010 and 2011.

FIGURE X
Total State Budget Shortfall in Each Fiscal Year, in Billions

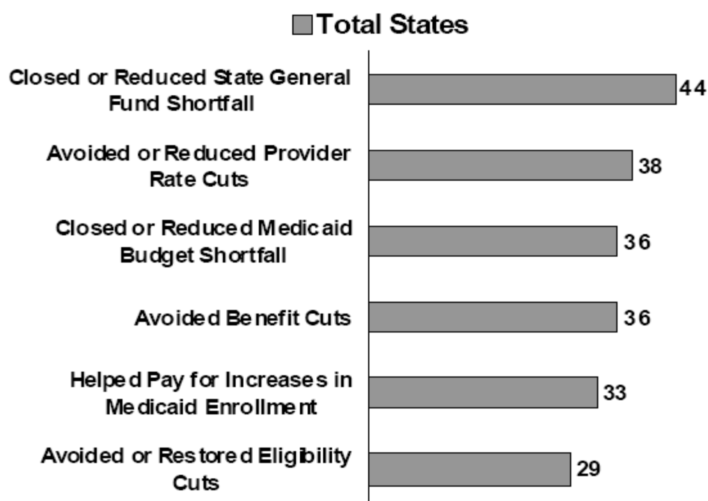


Source: "CBPP Survey of States"

The budget problems in 2010 and 2011 are compounded by the expiration of the temporary increase in the federal share of Medicaid costs (i.e. the temporary FMAP rate increase) under the ARRA of 2009, which for 9 quarters ending December 31, 2010, is pumping approximately $87 billion into state economies per Government Accountability Office (GAO) estimates.[10] Figure XI on the following page reflects how the states used the funds. As indicated on the chart, to a great extent they were used to reduce state deficits and avoid or mitigate provider rate cuts. States will have to replace these federal funds with state tax revenues which, according to both the Kaiser Commission and CBPP, are likely to be substantially inadequate well into 2011. The end result is that providers will likely face another round of rate reductions or rate freezes as we move forward into 2010 and 2011.

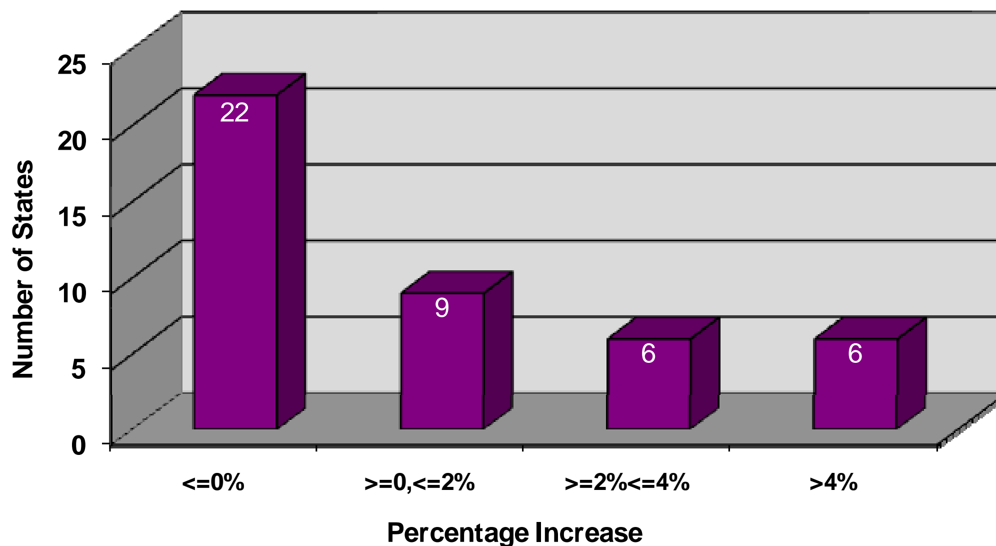
[10] GAO-09-371R Estimated Adjusted Medicaid Allocations.

FIGURE XI



Medicaid nursing home rate increases are already trending downward even with states receiving the additional federal funds under ARRA. As part of our data gathering, we requested FY 2010 provider rates from the state affiliates, or at a minimum, the average change in Medicaid rates between FY 2009 and FY 2010. The Medicaid day-weighted average increase for the 43 states reporting was only nine-tenths of one percent. This compares to an average annual Medicaid rate increase of 3.1% over the past two years. As reflected in Figure XII, over half the states reported either no rate increases or a decrease for FY 2010.

FIGURE XII
2010 Percentage Increase in Medicaid Rates



Assuming nursing home costs continue to climb at the same pace as the last two years (3% per year), the shortfall will likely increase by another $3.50 per Medicaid patient day in FY 2010 and the percentage of cost covered by the Medicaid rates is expected to drop below 90%. Ironically, the last time cost coverage dipped below 90% was in 2003 during the last recession. State deficits at that time approximated only $80 billion (see Figure X), and as discussed previously, new provider tax programs were a major element in maintaining rate stability and growth during that recessionary period. With projected deficits in 2010 and 2011 being more than double that of the prior recession, and with almost all of the high volume Medicaid states being at or near federal limits on provider taxes, it is likely that this recession will negatively impact nursing home rate growth and cost coverage far more than in the previous recession.

SUMMARY

Since 2004, Medicaid rate increases have kept pace with nursing home cost increases due to a healthy economy and enactment or increases in provider taxes in numerous states. This has resulted in cost coverage (the percent of allowable cost covered by the rate) remaining relatively stable, hovering around 92%.

This positive trend has now ended. State tax revenues are in decline; unemployment remains high; and states project massive deficits through at least FY 2011. These negative trends have already had an adverse impact on nursing facility Medicaid rates in FY 2010 with less than half the states providing Medicaid rate increases. As a result, we project that the shortfall between Medicaid rates and allowable costs will increase significantly in FY 2010 with cost coverage dropping below 90% for the first time since 2003.

Unfortunately, FY 2011 looks even worse. Higher state budget deficits are projected. The enhanced federal matching funds provided under ARRA expire. Most states already have nursing home provider tax programs and the taxes currently generated are at or near federal limits. As a result, many states may be forced to implement rate reductions in FY 2011, as opposed to rate freezes as was the case in the majority of states in FY 2010. In fact, the sagging economy may require some states to implement mid-year rate reductions in FY 2010.

At a time where so much emphasis is placed on improving quality and performance, providers, especially those with higher Medicaid volume, will likely have to meet these expectations with lesser revenues and fewer resources over the next few years. The extent and magnitude of future rate reductions will be the determining factor as to whether that can be accomplished.

Charts

Chart 1 **Average Medicaid Shortfall Per Patient Day and Average Disparity by State Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs**

Chart 2 **Disparity By State Between Total Medicaid Revenue and Total Medicaid Allowable Costs**

CHART 1

In 2007, on Average, the Shortfall in Medicaid Reimbursement Was $14.00 Per Medicaid Patient Day

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

-$13.90
-$1.91
-$3.28
-$24.36
-$14.22
-$14.18
-$13.66
$0.64
-$2.69
-$27.12
-$28.66
-$3.45
-$21.45
-$17.51
-$11.06
-$26.31
-$10.62
-$13.23
-$22.78
-$11.95
-$11.22
-$9.79
-$15.84
-$17.83
-$15.23
-$13.50
-$6.39
DC -$13.76
-$11.58
-$12.79
-$27.07
-$6.66
-$4.15
-$10.53
-$5.72
-$6.89
-$8.81
-$12.54
-$9.37
-$8.69

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 2009 Shortfall in Medicaid Reimbursement Is $14.17 Per Medicaid Patient Day

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

-$16.37
-$5.20
-$0.14
-$20.31
-$16.29
-$16.20
$2.74
-$0.79
-$23.06
-$12.27
-$28.41
$3.69
-$24.10
-$19.09
-$13.09
-$12.27
-$14.05
-$1.75
-$12.21
-$19.15
-$20.80
-$16.46
-$13.88
-$24.95
-$18.80
-$18.23
-$6.66
-$25.13
-$8.89
-$9.42
-$7.03
-$3.73
-$1.47
DC $3.16
-$4.91
-$8.56
-$1.92
-$12.96
-$15.57
-$1.79

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

2007 Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs (In Millions)

$4.7 Billion Medicaid Funding Shortfall Nationwide

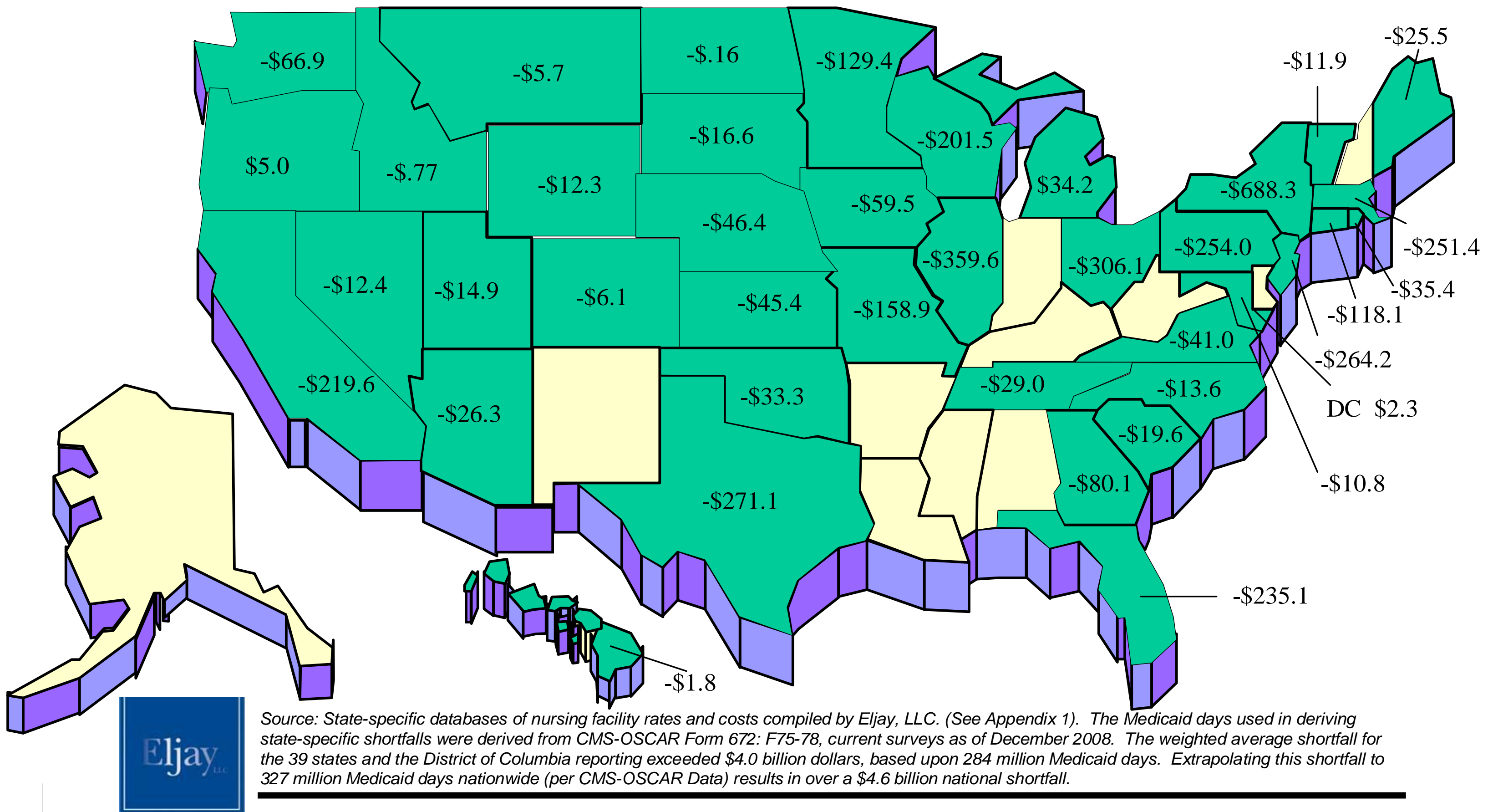
-$59.9
-$2.2
-$3.9
-$163.7
-$9.9
-$22.2
-$18.0
-$216.9
$1.1
-$2.7
-$14.5
-$33.8
-$626.4
-$52.6
-$44.2
-$240.1
-$248.3
-$458.2
-$200.9
-$12.4
-$11.9
-$34.6
-$59.6
-$154.5
-$29.3
-$87.2
-$41.5
-$292.2
-$31.8
-$102.0
DC -$10.1
-$35.2
-$38.4
-$32.0
-$23.3
-$66.3
-$49.4
-$272.3
-$144.9
-$9.2

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 2007. The weighted average shortfall for the 39 states and the District of Columbia reporting exceeded $3.9 billion dollars, based upon almost 283 million Medicaid days. Extrapolating this shortfall to 335 million Medicaid days nationwide (per CMS-OSCAR Data) results in almost a $4.7 billion national shortfall.

CHART 2

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

$4.6 Billion Medicaid Funding Shortfall Nationwide



Source: State-specific databases of nursing facility rates and costs compiled by Eljay, LLC. (See Appendix 1). The Medicaid days used in deriving state-specific shortfalls were derived from CMS-OSCAR Form 672: F75-78, current surveys as of December 2008. The weighted average shortfall for the 39 states and the District of Columbia reporting exceeded $4.0 billion dollars, based upon 284 million Medicaid days. Extrapolating this shortfall to 327 million Medicaid days nationwide (per CMS-OSCAR Data) results in over a $4.6 billion national shortfall.

Appendix I

Project Approach and Methodology

PROJECT APPROACH AND METHODOLOGY

The American Health Care Association initially surveyed its state affiliates as to the availability of a database of state-specific Medicaid rate and allowable cost information. Those that responded in the affirmative were asked to complete "data collection spreadsheets" reflecting the Medicaid rates and allowable costs for each provider based upon the provider's fiscal or calendar years ending in 2007 (or 2008 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 2007, but between current (FY 2009) rates and 2007 (or 2008 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 almost two-thirds of the states in 2007. 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 2007 were derived for 39 states and the District of Columbia, representing over 84% of the Medicaid patient days in the country. Current Medicaid rates by provider were obtained from 39 states and the District of Columbia allowing us to determine an estimated 2009 shortfall for these states that represent almost 87% 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 Mexico, the state Medicaid contractor provided shortfall data for 2007 but did not provide 2009 rate information. Thus, a 2007 shortfall was determined but a 2009 shortfall could not be determined due to missing 2009 rate data. In New Jersey, the state agency provided 2009 rate data but no 2007 data in that the 2007 cost reports were not used for rate setting. As such, we projected a 2009 shortfall for New Jersey by projecting 2006 cost report data to 2009 and comparing these projected costs to 2009 rates. However no 2007 shortfall determination could be made.

Appendix II

Calculation of 2007 and Projected 2009 Weighted Average Medicaid Shortfall

State-by-State Comparison

Calculation of 2007 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	$ 151.96	$ 164.75	$ (12.79)	2,751,941	$ 418,185,025	$ 453,382,356	$ (35,197,331)
California	$ 150.69	$ 162.27	$ (11.58)	25,233,726	$ 3,802,470,177	$ 4,094,676,725	$ (292,206,548)
Colorado	$ 166.24	$ 176.03	$ (9.79)	3,537,551	$ 588,082,443	$ 622,715,065	$ (34,632,622)
Connecticut	$ 212.47	$ 225.97	$ (13.50)	6,455,661	$ 1,371,634,200	$ 1,458,785,618	$ (87,151,418)
District of Columbia	$ 222.96	$ 236.72	$ (13.76)	735,897	$ 164,075,567	$ 174,201,508	$ (10,125,941)
Florida	$ 175.00	$ 184.37	$ (9.37)	15,462,697	$ 2,705,971,950	$ 2,850,857,420	$ (144,885,470)
Georgia	$ 127.43	$ 134.32	$ (6.89)	9,629,407	$ 1,227,075,364	$ 1,293,421,980	$ (66,346,616)
Hawaii	$ 212.98	$ 221.67	$ (8.69)	1,062,041	$ 226,193,525	$ 235,422,663	$ (9,229,138)
Idaho	$ 163.99	$ 166.68	$ (2.69)	992,853	$ 162,818,002	$ 165,488,777	$ (2,670,775)
Illinois	$ 103.89	$ 130.20	$ (26.31)	17,416,515	$ 1,809,401,786	$ 2,267,630,306	$ (458,228,520)
Iowa	$ 116.52	$ 127.58	$ (11.06)	4,751,459	$ 553,639,971	$ 606,191,105	$ (52,551,134)
Kansas	$ 125.07	$ 140.91	$ (15.84)	3,760,536	$ 470,330,211	$ 529,897,097	$ (59,566,887)
Maine	$ 168.58	$ 182.76	$ (14.18)	1,568,908	$ 264,486,595	$ 286,733,717	$ (22,247,122)
Maryland	$ 194.10	$ 202.91	$ (8.81)	5,611,397	$ 1,089,172,078	$ 1,138,608,482	$ (49,436,404)
Massachusetts	$ 191.30	$ 214.08	$ (22.78)	10,541,147	$ 2,016,521,483	$ 2,256,648,819	$ (240,127,336)
Michigan	$ 180.92	$ 184.37	$ (3.45)	9,789,252	$ 1,771,071,442	$ 1,804,844,361	$ (33,772,919)
Minnesota	$ 147.68	$ 172.04	$ (24.36)	6,719,320	$ 992,309,174	$ 1,155,991,809	$ (163,682,635)
Missouri	$ 116.20	$ 134.03	$ (17.83)	8,663,019	$ 1,006,642,764	$ 1,161,104,386	$ (154,461,622)
Montana	$ 153.40	$ 155.31	$ (1.91)	1,139,074	$ 174,733,976	$ 176,909,607	$ (2,175,632)
Nebraska	$ 134.76	$ 152.27	$ (17.51)	2,526,459	$ 340,465,551	$ 384,703,840	$ (44,238,289)
Nevada	$ 168.53	$ 180.48	$ (11.95)	1,034,635	$ 174,367,083	$ 186,730,974	$ (12,363,892)
New Mexico	$ 140.74	$ 167.81	$ (27.07)	1,419,614	$ 199,796,514	$ 238,225,472	$ (38,428,959)
New York	$ 203.21	$ 224.66	$ (21.45)	29,200,609	$ 5,933,855,657	$ 6,560,208,710	$ (626,353,053)
North Carolina	$ 136.54	$ 147.07	$ (10.53)	9,690,262	$ 1,323,108,336	$ 1,425,146,792	$ (102,038,456)
North Dakota	$ 162.12	$ 165.40	$ (3.28)	1,203,802	$ 195,160,431	$ 199,108,903	$ (3,948,472)
Ohio	$ 163.96	$ 174.58	$ (10.62)	18,921,670	$ 3,102,397,004	$ 3,303,345,139	$ (200,948,135)
Oklahoma	$ 124.55	$ 131.21	$ (6.66)	4,810,153	$ 599,104,498	$ 631,140,114	$ (32,035,616)
Oregon	$ 195.62	$ 194.98	$ 0.64	1,747,465	$ 341,839,194	$ 340,720,816	$ 1,118,378
Pennsylvania	$ 190.83	$ 204.06	$ (13.23)	18,771,636	$ 3,582,191,207	$ 3,830,539,945	$ (248,348,738)
Rhode Island	$ 181.75	$ 196.98	$ (15.23)	1,926,230	$ 350,092,293	$ 379,428,775	$ (29,336,482)
South Carolina	$ 143.40	$ 149.12	$ (5.72)	4,073,148	$ 584,089,481	$ 607,387,890	$ (23,298,409)
South Dakota	$ 118.73	$ 132.39	$ (13.66)	1,316,142	$ 156,265,504	$ 174,244,000	$ (17,978,496)
Tennessee	$ 136.12	$ 140.27	$ (4.15)	7,668,081	$ 1,043,779,149	$ 1,075,601,684	$ (31,822,535)
Texas	$ 106.48	$ 119.02	$ (12.54)	21,716,374	$ 2,312,359,455	$ 2,584,682,779	$ (272,323,324)
Utah	$ 154.92	$ 166.14	$ (11.22)	1,061,245	$ 164,408,003	$ 176,315,167	$ (11,907,164)
Vermont	$ 182.98	$ 197.20	$ (14.22)	695,872	$ 127,330,660	$ 137,225,960	$ (9,895,300)
Virginia	$ 137.72	$ 144.11	$ (6.39)	6,488,798	$ 893,637,254	$ 935,100,673	$ (41,463,419)
Washington	$ 145.47	$ 159.37	$ (13.90)	4,306,426	$ 626,455,781	$ 686,315,101	$ (59,859,321)
Wisconsin	$ 136.13	$ 164.79	$ (28.66)	7,567,665	$ 1,030,186,236	$ 1,247,075,515	$ (216,889,279)
Wyoming	$ 148.84	$ 175.96	$ (27.12)	534,715	$ 79,587,015	$ 94,088,492	$ (14,501,477)
	TOTALS			282,503,400	$ 43,975,292,040	$ 47,930,848,543	$ (3,955,556,503)
	Weighted Averages				$ 155.66	$ 169.66	$ (14.00)
	Shortfall extrapolated to all 50 states						$ (4,693,643,856)
	Total States plus District of Columbia				40		
	Percentage of Days				84.3%		

Calculation of Projected 2009 Weighted Average Medicaid Shortfall

State	Rate	Cost	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Arizona	$ 159.56	$ 168.98	$ (9.42)	2,796,713	$ 446,243,561	$ 472,588,600	$ (26,345,039)
California	$ 162.45	$ 171.34	$ (8.89)	24,703,382	$ 4,013,064,369	$ 4,232,677,432	$ (219,613,064)
Colorado	$ 188.15	$ 189.90	$ (1.75)	3,503,457	$ 659,175,412	$ 665,306,462	$ (6,131,050)
Connecticut	$ 220.42	$ 238.65	$ (18.23)	6,480,275	$ 1,428,382,209	$ 1,546,517,622	$ (118,135,413)
District of Columbia	$ 250.36	$ 247.20	$ 3.16	728,505	$ 182,388,410	$ 180,086,336	$ 2,302,075
Florida	$ 180.05	$ 195.62	$ (15.57)	15,102,170	$ 2,719,145,694	$ 2,954,286,480	$ (235,140,786)
Georgia	$ 135.59	$ 144.15	$ (8.56)	9,354,825	$ 1,268,420,745	$ 1,348,498,048	$ (80,077,303)
Hawaii	$ 229.22	$ 231.01	$ (1.79)	981,120	$ 224,892,326	$ 226,648,531	$ (1,756,205)
Idaho	$ 180.85	$ 181.64	$ (0.79)	973,813	$ 176,114,027	$ 176,883,339	$ (769,312)
Illinois	$ 117.09	$ 137.89	$ (20.80)	17,290,460	$ 2,024,539,906	$ 2,384,181,465	$ (359,641,558)
Iowa	$ 121.34	$ 134.43	$ (13.09)	4,548,779	$ 551,948,834	$ 611,492,350	$ (59,543,516)
Kansas	$ 135.82	$ 148.03	$ (12.21)	3,719,689	$ 505,208,122	$ 550,625,521	$ (45,417,399)
Maine	$ 176.94	$ 193.14	$ (16.20)	1,573,338	$ 278,386,357	$ 303,874,426	$ (25,488,069)
Maryland	$ 218.25	$ 220.17	$ (1.92)	5,601,927	$ 1,222,620,472	$ 1,233,376,171	$ (10,755,699)
Massachusetts	$ 192.01	$ 216.96	$ (24.95)	10,077,025	$ 1,934,889,593	$ 2,186,311,370	$ (251,421,777)
Michigan	$ 195.03	$ 191.34	$ 3.69	9,278,872	$ 1,809,658,469	$ 1,775,419,430	$ 34,239,039
Minnesota	$ 162.58	$ 182.89	$ (20.31)	6,370,517	$ 1,035,718,699	$ 1,165,103,905	$ (129,385,206)
Missouri	$ 122.20	$ 141.35	$ (19.15)	8,296,837	$ 1,013,873,469	$ 1,172,757,896	$ (158,884,427)
Montana	$ 158.81	$ 164.01	$ (5.20)	1,087,503	$ 172,706,336	$ 178,361,351	$ (5,655,015)
Nebraska	$ 138.05	$ 157.14	$ (19.09)	2,429,398	$ 335,378,347	$ 381,755,548	$ (46,377,201)
Nevada	$ 179.75	$ 192.02	$ (12.27)	1,006,968	$ 181,002,469	$ 193,357,965	$ (12,355,495)
New Jersey	$ 204.96	$ 230.09	$ (25.13)	10,514,972	$ 2,155,148,626	$ 2,419,389,868	$ (264,241,242)
New York	$ 217.59	$ 241.69	$ (24.10)	28,561,329	$ 6,214,659,542	$ 6,902,987,567	$ (688,328,025)
North Carolina	$ 155.69	$ 157.16	$ (1.47)	9,285,135	$ 1,445,602,610	$ 1,459,251,758	$ (13,649,148)
North Dakota	$ 177.82	$ 177.96	$ (0.14)	1,169,517	$ 207,963,502	$ 208,127,235	$ (163,732)
Ohio	$ 166.72	$ 183.18	$ (16.46)	18,597,944	$ 3,100,649,149	$ 3,406,771,299	$ (306,122,151)
Oklahoma	$ 128.47	$ 135.50	$ (7.03)	4,730,382	$ 607,712,237	$ 640,966,826	$ (33,254,589)
Oregon	$ 206.17	$ 203.43	$ 2.74	1,827,088	$ 376,690,767	$ 371,684,545	$ 5,006,222
Pennsylvania	$ 202.09	$ 215.97	$ (13.88)	18,300,220	$ 3,698,291,531	$ 3,952,298,589	$ (254,007,058)
Rhode Island	$ 182.25	$ 201.05	$ (18.80)	1,884,420	$ 343,435,577	$ 378,862,676	$ (35,427,099)
South Carolina	$ 148.11	$ 153.02	$ (4.91)	3,996,960	$ 591,989,781	$ 611,614,856	$ (19,625,075)
South Dakota	$ 127.60	$ 139.87	$ (12.27)	1,351,002	$ 172,387,886	$ 188,964,683	$ (16,576,797)
Tennessee	$ 144.30	$ 148.03	$ (3.73)	7,766,394	$ 1,120,690,666	$ 1,149,659,316	$ (28,968,650)
Texas	$ 112.87	$ 125.83	$ (12.96)	20,915,993	$ 2,360,788,113	$ 2,631,859,380	$ (271,071,267)
Utah	$ 157.18	$ 171.23	$ (14.05)	1,061,438	$ 166,836,749	$ 181,749,947	$ (14,913,197)
Vermont	$ 184.26	$ 200.55	$ (16.29)	732,786	$ 135,023,089	$ 146,960,168	$ (11,937,079)
Virginia	$ 146.22	$ 152.88	$ (6.66)	6,162,135	$ 901,027,452	$ 942,067,274	$ (41,039,822)
Washington	$ 151.06	$ 167.43	$ (16.37)	4,087,898	$ 617,517,842	$ 684,436,729	$ (66,918,887)
Wisconsin	$ 144.73	$ 173.14	$ (28.41)	7,090,974	$ 1,026,276,613	$ 1,227,731,173	$ (201,454,561)
Wyoming	$ 160.37	$ 183.43	$ (23.06)	533,276	$ 85,521,523	$ 97,818,874	$ (12,297,352)
TOTALS				284,475,433	$ 47,511,971,081	$ 51,543,313,012	$ (4,031,341,931)
Weighted Averages					$ 167.02	$ 181.19	$ (14.17)
Shortfall extrapolated to all 50 states							$ (4,637,347,322)
Total States plus District of Columbia					40		
Percentage of Days					86.9%		

Appendix III

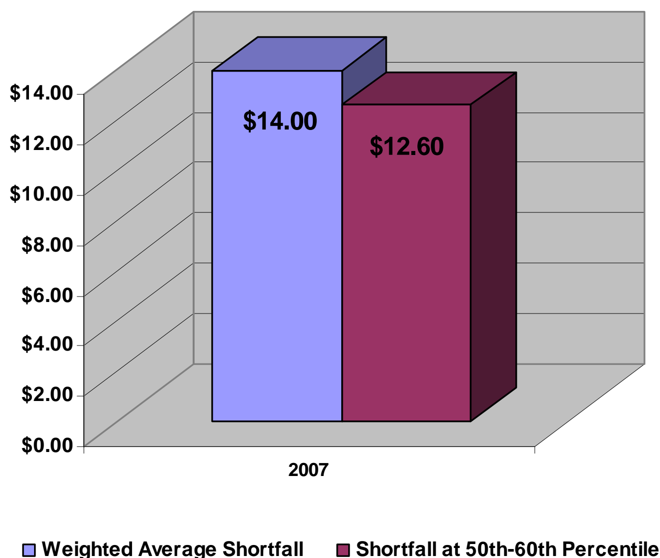
Impact of High Cost Providers on the Medicaid Average Shortfall

IMPACT OF HIGH COST PROVIDERS ON THE MEDICAID AVERAGE SHORTFALL

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

It was found that extremely high cost providers, such as hospital-based units, tended to skew the average shortfall upward to a greater degree than the tendency of the lowest cost providers to skew the average downward. As such, we also examined the Medicaid shortfall of those providers whose per diem costs rank at or around the mid-range of all providers in each state. We determined the weighted average Medicaid shortfall of providers with per diem costs that rank between the 50th and 60th percentile of per diem costs of all providers. In each state, we found that providers at these cost levels would be considered efficient and economical under any reasonable cost standard. A graphic comparison between the weighted average shortfall for all providers and the weighted average shortfall for providers with costs between the 50th and 60th percentile is reflected in Figure XIII for 2007.

FIGURE XIII
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 $12.60 in 2007. This is only $1.40 per patient day less than the average shortfall for all providers and demonstrates that Medicaid payment is substantially inadequate in reimbursing even reasonable cost providers.

Appendix IV

Data Collection Document

(For 2007 and For Current Rates)

AHCA DATA COLLECTION INSTRUCTIONS FOR 2007 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 2007 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 2007 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 2007 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 2007 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 2009. If rates are set by care level, average the rates by weighting them by the percentage of Medicaid days at each care level.

AHCA DATA COLLECTION (SUMMARY)

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

FACILITY	PROVIDER NUMBER	OWNERSHIP TYPE1	FACILITY YEAR END	# OF MONTHS COVERED BY COST REPORT	AVERAGE MEDICAID RATE	AVERAGE MEDICAID COST	DIFFERENCE	TOTAL MEDICAID DAYS	TOTAL MEDICAID REVENUE	TOTAL MEDICAID COST	TOTAL MEDICAID PROFIT/ SHORTFALL
Facility 1	*123456*	*1*	*12/31/2007*	*12*	*154.32*	*174.59*	*(20.27)*	*26,080*	*4,024,697*	*4,553,435*	*(528,738)*

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*	*12/31/2007*	*150.48*	-	-	*154.12*	*15,148*	*2,334,610*

MEDICAID RATE (3)	DAYS APPLICABLE **	SUBTOTAL	TOTAL MEDICAID REVENUE	TOTAL MEDICAID DAYS	WEIGHTED AVERAGE MEDICAID RATE PER DAY
154.60	*10,932*	*1,690,087*	*4,024,697*	*26,080*	*154.32*

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*	*12/31/2007*	*12*	*750,000*	*1,500,000*	*2,000,000*	*3,500,000*	*745,000*	*4,245,000*

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*	*4,032,750*	*75,000*	*12,000*	*80,000*	*30,000*	*300,000*	*350,000*

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*	*150,000*	*50,000*	*300,000*	*400,000*	*50,000*	*70,000*	*85,000*	*900,000*	*600,000*	*45,000*

TOTAL NON-NURSING EXPENSE	TOTAL ADJUSTED EXPENSE	TOTAL DAYS	MEDICAID ALLOWABLE EXPENSE PPD	TOTAL MEDICAID DAYS
3,574,000	*7,606,750*	*43,568*	*174.59*	*26,080*