A Report on Shortfalls in Medicaid Funding for Nursing Center Care

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FOR THE
AMERICAN HEALTH CARE ASSOCIATION

JANUARY 2014

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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 Medicaid shortfall has reached historic levels.

- Unreimbursed allowable Medicaid costs for 2013 are projected to exceed $7.7 billion. Expressed as a shortfall in reimbursement per Medicaid patient day, the estimated average Medicaid shortfall for 2013 is projected to be $24.26,[1] which is 8.6 percent higher than the preceding year's projected shortfall of $22.34.

- Based upon the average annual Medicaid shortfall amount per patient day listed above ($24.26), a typical center with an average daily census of 100 patients, of which 63 are funded by the Medicaid program, would lose $1,528 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 $550,000.

- Medicaid rate increases historically have not kept up with allowable cost increases, and this was no exception in 2013. Between the time periods covered by the cost reports used in the study and 2013, this study projects costs will increase an average of 3.8 percent, while rates increased an average of 2.9 percent.

Medicare does not mend 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 no longer fully subsidizes increasing Medicaid shortfalls.

[1] No determination of the actual Medicaid shortfall could be made for 2012 since cost reports for 2012 were unavailable in all but 12 states. The 2013 Medicaid shortfall is a projection based upon trending of the most recently available (2011 or 2012) cost reports to 2013 and comparing these trended costs to current rates.

Providers have been forced to leverage provider taxes heavily 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 state budgets.

- Between 2011 and 2013, seven states implemented new provider taxes for nursing centers and in 2013, eight states increased the provider tax rate for nursing centers.[2] Twenty-one of the 44 states with a nursing center provider tax are at the maximum taxable amount of six percent of revenue.[3]

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.

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

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

[2] KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.
[3] AHCA survey of state affiliates.

Medicaid Shortfalls in 2011 and Projected Shortfalls for 2013 – 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 2011. In some states, cost reports for providers with year ends in 2012 were available and used. Similar to last year's study, a shortfall for the current year (2013) is projected by trending the 2011 costs (or 2012, if available) to the current year and comparing them to current Medicaid rates.

1. Methodology

Thirty-six of AHCA state affiliates participated in the study and provided the most recently available cost reports (2011 for most states) to Eljay. These 36 states represented about 80 percent of the Medicaid patient days in the country including the nine states that represent more than half of all days covered under the Medicaid program: California, Florida, Illinois, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas. Data from over 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]

Eljay projected the shortfall in Medicaid reimbursement for the current year (2013) by comparing current year rates to 2011 allowable costs (or 2012, if available) trended to the current year. The trending factor used in projecting 2011 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.

Historically, allowable Medicaid costs have increased annually by a greater percentage than the Market Basket, meaning that once actual 2013 cost data become available, the actual shortfall for 2013 will likely be higher than what is projected in this report. To illustrate, authors of this study conducted a state-by-state comparison of the actual 2011 shortfalls and the shortfalls projected for that year in the December 2011 report. The comparison revealed that 25 of the 35 states had greater

[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 eleven 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.

actual shortfalls than projected. The actual average per diem shortfall for 2011 was $21.85, 11.8 percent higher than the originally projected shortfall of $19.55.

2. Estimated Medicaid Shortfall: 2011

The estimated average shortfall in Medicaid reimbursement increased from $18.54 per Medicaid patient day in 2010 to $21.85 per Medicaid patient day in 2011; a 17.9 percent increase. During this time period, Medicaid programs reimbursed nursing center providers for approximately 89.0 percent of their allowable costs per Medicaid patient, on average. The 2011 shortfall compilation incorporates data from 36 states.[6] When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing centers was estimated to be over $7.0 billion.

3. Projected Medicaid Shortfall: 2013[7]

Between 2011 and 2013, overall Medicaid rates increased by 2.9 percent, much lower than the Market Basket inflationary projections for the same time period, which was 4.5 percent.[8] The estimated 2013 projected shortfall climbed to $24.26 from $21.85 in 2011, an 11.0 percent increase in the shortfall amount.[9] This study estimates that in 2013, state Medicaid programs, on average, reimbursed nursing center providers only 88.3 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 2013, Medicaid programs reimbursed, on average, approximately 88 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 2011 was not made available by the state agency in New Jersey. Therefore, in computing the 2011 shortfall for this state, the latest available cost reports data—2009 reports—were trended to 2011 and compared to the 2011 rates.

[7] No determinations of the Medicaid shortfall could be made for 2012, since 2012 cost reports were unavailable in most states. The 2013 Medicaid shortfall is a projection based upon trending of the most recently available cost reports to 2013 and comparing these trended costs to current rates.

[8] This number represents a two year market basket increase from 2011 to 2013. The projected cost increase of 3.8 percent in the study is different in that the time frame from the cost report period to 2013 was sometimes less than two years, depending upon the fiscal year end of each provider.

[9] This shortfall projection, based upon trending 2011 (or 2012, if available) allowable costs to 2013 by the SNF Market Basket for comparison to 2013 rates is conservative. The actual 2013 shortfall will likely be greater once actual 2013 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

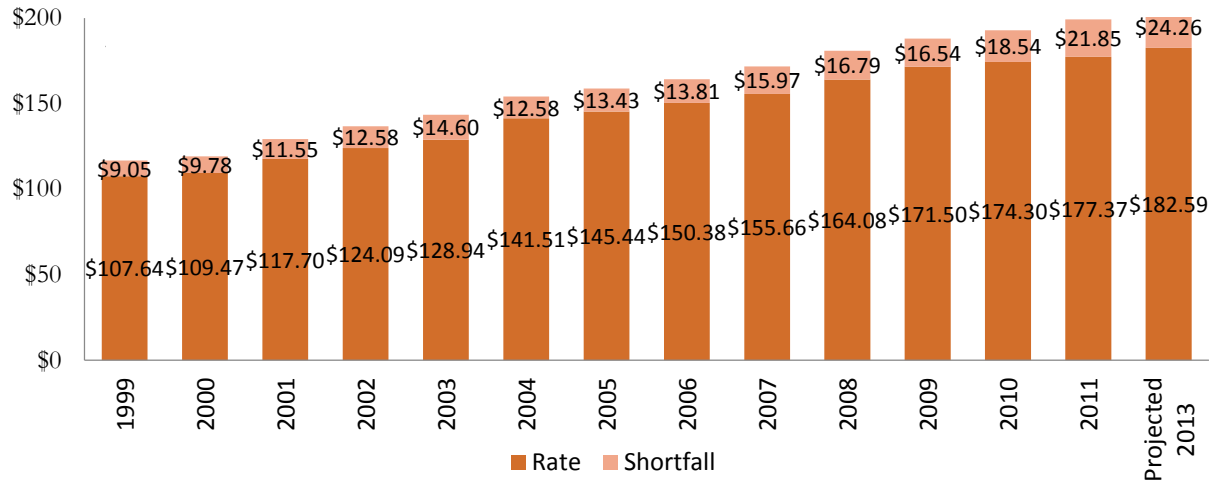
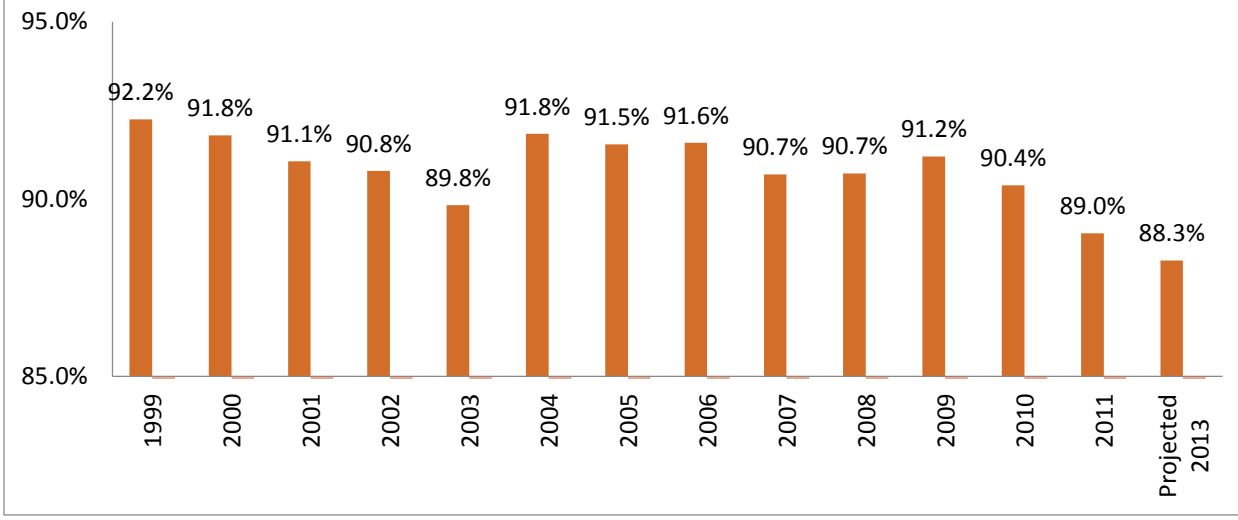


Figure 2. Percent of Allowable Costs Covered by Medicaid Rates



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 39 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 $4.14 per day based upon total projected 2013 Medicaid allowable costs of $206.85 per day. This would increase the projected 2013 Medicaid shortfall to $28.40 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 2011 rates to 2011 costs and 2013 rates compared to projected 2013 costs, as well as the difference in these amounts for these two years.

Table 1. State-by-State Comparison of 2011 Rates to 2011 Costs			
State	**2011 Rate**	**2011 Cost**	**2011 Difference**
Arizona	$ 167.95	$ 188.79	$ (20.84)
California	$ 175.24	$ 189.72	$ (14.48)
Colorado	$ 199.98	$ 207.85	$ (7.87)
Connecticut	$ 223.25	$ 242.89	$ (19.65)
Delaware	$ 207.36	$ 232.96	$ (25.60)
Florida	$ 205.61	$ 220.03	$ (14.42)
Georgia	$ 141.59	$ 153.37	$ (11.78)
Hawaii	$ 231.96	$ 246.36	$ (14.41)
Illinois	$ 130.47	$ 155.63	$ (25.17)
Iowa	$ 147.86	$ 159.96	$ (12.10)
Kansas	$ 149.34	$ 160.92	$ (11.58)
Maine	$ 179.23	$ 198.52	$ (19.29)
Maryland	$ 231.81	$ 246.21	$ (14.40)
Massachusetts	$ 197.40	$ 227.84	$ (30.43)
Michigan	$ 211.44	$ 210.86	$ 0.59
Minnesota	$ 165.82	$ 195.17	$ (29.35)
Missouri	$ 134.35	$ 155.15	$ (20.80)
Montana	$ 175.46	$ 187.36	$ (11.90)
Nebraska	$ 152.07	$ 175.43	$ (23.35)
Nevada	$ 189.37	$ 206.48	$ (17.11)
New Jersey	$ 203.13	$ 243.25	$ (40.12)
New Mexico[10]	$ 169.10	$ 191.71	$ (22.61)
New York	$ 217.80	$ 262.02	$ (44.23)
North Dakota	$ 210.47	$ 215.24	$ (4.77)
Ohio	$ 172.33	$ 188.22	$ (15.89)
Oklahoma	$ 127.68	$ 145.31	$ (17.64)
Oregon	$ 222.43	$ 234.64	$ (12.21)
Pennsylvania	$ 204.63	$ 226.96	$ (22.34)
South Dakota	$ 128.65	$ 157.19	$ (28.54)
Texas	$ 126.87	$ 142.92	$ (16.05)
Utah	$ 177.66	$ 202.52	$ (24.86)
Vermont	$ 202.01	$ 221.04	$ (19.03)
Virginia	$ 153.43	$ 163.89	$ (10.46)
Washington	$ 168.65	$ 196.67	$ (28.02)
Wisconsin	$ 154.54	$ 195.08	$ (40.53)
Wyoming	$ 183.08	$ 201.76	$ (18.68)

[10] Rates for New Mexico are estimated since managed care organizations would not provide provider-specific rates. They are based upon those in effect prior to the program shift to managed care and increased by legislative-mandated rate increases.

Table 2. State-by-State Comparison of 2013 Rates to Projected 2013 Costs			
State	**2013 Rate**	**Projected 2013 Cost**	**Projected Difference**
Arizona[11]	$ 189.60	$ 202.17	$ (12.57)
California	$ 178.61	$ 198.15	$ (19.54)
Colorado	$ 202.79	$ 210.65	$ (7.86)
Connecticut	$ 230.09	$ 255.52	$ (25.43)
Delaware[11]	$ 249.58	$ 254.73	$ (5.14)
Florida	$ 211.98	$ 225.32	$ (13.34)
Georgia	$ 156.10	$ 165.81	$ (9.71)
Hawaii[11]	$ 257.82	$ 264.51	$ (6.69)
Illinois	$ 129.30	$ 164.18	$ (34.88)
Iowa	$ 154.68	$ 166.24	$ (11.56)
Kansas	$ 153.73	$ 166.18	$ (12.45)
Maine	$ 183.81	$ 205.95	$ (22.14)
Maryland	$ 237.86	$ 251.17	$ (13.31)
Massachusetts	$ 197.91	$ 234.86	$ (36.96)
Michigan[12]	$ 223.76	$ 219.29	$ 4.47
Minnesota	$ 169.63	$ 204.07	$ (34.44)
Missouri	$ 147.45	$ 162.74	$ (15.29)
Montana	$ 176.36	$ 185.98	$ (9.62)
Nebraska	$ 154.07	$ 179.25	$ (25.17)
Nevada	$ 193.37	$ 209.76	$ (16.40)
New Jersey	$ 203.85	$ 250.90	$ (47.05)
New Mexico[13]	$ 186.38	$ 198.52	$ (12.15)
New York	$ 220.55	$ 272.52	$ (51.96)
North Dakota	$ 224.00	$ 224.92	$ (0.92)
Ohio	$ 174.64	$ 192.44	$ (17.79)
Oklahoma	$ 138.42	$ 150.36	$ (11.94)
Oregon	$ 222.43	$ 240.57	$ (18.14)
Pennsylvania	$ 209.65	$ 235.57	$ (25.92)
South Dakota	$ 127.64	$ 163.04	$ (35.40)
Texas	$ 131.61	$ 147.93	$ (16.32)
Utah	$ 189.05	$ 208.51	$ (19.45)
Vermont	$ 206.08	$ 223.97	$ (17.89)
Virginia	$ 160.09	$ 170.02	$ (9.93)
Washington	$ 178.73	$ 212.61	$ (33.88)
Wisconsin	$ 160.24	$ 201.79	$ (41.54)
Wyoming[11]	$ 217.47	$ 222.72	$ (5.25)

[11] The significant reduction in shortfalls between 2011 and 2013 in Arizona, Delaware, Hawaii, and Wyoming is due to the implementation of provider tax programs in these states between 2011 and 2013.

[12] In projecting the FY 13 shortfall for Michigan, as with other states, costs were projected to increase by market basket. However, over the past 4 years, costs in Michigan have historically increased by an average of 2.7 percent annually. If this historical inflation average were applied rather than market basket, the projected margin in Michigan drops to $1.36.

[13] Rates for New Mexico are estimated since managed care organizations would not provide provider-specific rates. They are based upon those in effect prior to the program shift to managed care and increased by legislative-mandated rate increases.

Financing Factors Impacting Nursing Centers

1. The Broader Medicaid Landscape

Over the past few years, and increasing in the coming year, there has been a large number of broad changes taking place within the Medicaid program, driven largely by reforms included in the Affordable Care Act of 2009 (ACA).[14] While some of these changes will have a direct impact on nursing centers (and are discussed later in this report), others, which may not appear to directly affect the profession, will affect the environment in which centers operate and the priorities and focus of state Medicaid agencies, thereby indirectly impacting providers.

State Medicaid programs historically have operated with limited resources and staffing, which in recent years has been exacerbated by state budget shortfalls, hiring freezes, and staff retiring—all occurring at the same time that the agencies are working to implement the numerous changes required under the ACA. Payment adequacy for nursing center services is not likely to be a top priority for states in the near term due to increased Medicaid enrollment, implementation of new programs, services, and systems, and continued emphasis on rebalancing towards non-institutional services.

2. 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 on 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 36.4 percent in 2013, while for nursing centers, private health insurance is projected to account for just 8.8 percent during this same time period.[15]

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. Nursing centers continue to prioritize high quality care despite the continued struggle to manage operating costs within reimbursement constraints and pressure to improve the physical environment for patients. The average age of a nursing center is 29

[14] Although the Medicaid expansion effectively became optional for states to implement based on the June 2012 Supreme Court decision, there are a number of other significant changes to the program that all state must implement, regardless of their decision to expand Medicaid. These include transitioning to a uniform income eligibility standard using Modified Adjusted Gross Income (MAGI), transitioning children with family income above 100 and up to 138 percent FPL from CHIP to Medicaid, and implementing new streamlined application, enrollment, and renewal processes. Medicaid agencies will also be required to coordinate with new Health Insurance Marketplaces, which includes providing outreach to educate people about new health care options and assist consumers in navigating the enrollment process.

[15] National Health Expenditure Projections 2012-2022 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf

years[16], and most state Medicaid programs in recent years have not had the resources to fund programs that adequately compensate providers who replace or substantially renovate their centers.

In addition, starting in 2015, 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 likely not be adequately covered through Medicaid rates.

3. Provider Taxes as a Funding Source for Rates

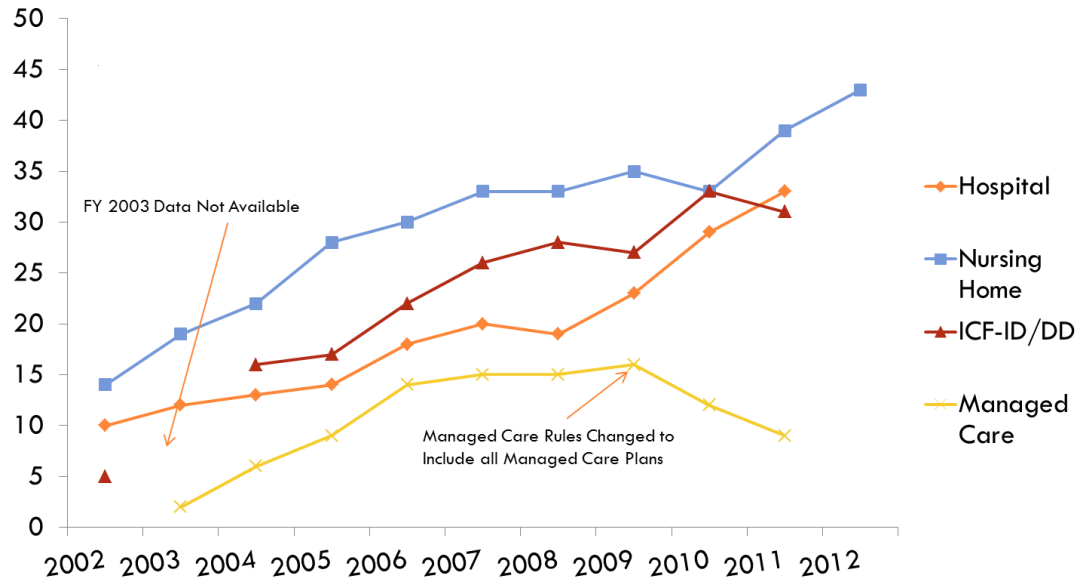
Most states use provider taxes to help finance the states' share of Medicaid costs, and this financing mechanism continues to serve as a major funding source for Medicaid payment rates in many states. In particular, during the Great Recession (fiscal years (FYs) 2007-2009) and continuing into the ongoing 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 2013, more than twice as many – 43 states and the District of Columbia – have implemented nursing center provider tax programs. In addition, eight states increased the rate at which they tax nursing centers.[17] See Figure 3, on page 11, for information about the number of states using provider taxes for different classes of providers over time.

[16] 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

[17] KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.

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.[18] In states with such programs, these taxes help to reimburse an average of approximately $24 per patient day in allowable Medicaid nursing center costs, in addition to funding other Medicaid services and being used outside the Medicaid program. Still, a number of states with a tax at 6 percent have a shortfall, which indicates that even when fully leveraging this financing mechanism, Medicaid rates remain inadequate.

The use of provider tax funds has changed dramatically as a result of massive state budget deficits in recent years. Many new or expanded tax programs no longer solely 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, many of these programs have recently been used 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 them from keeping pace with increasing costs of providing care to Medicaid beneficiaries. In fact, many states are using a greater portion of existing provider tax revenues and provider tax increases to help balance their budgets or fund non-institutional programs, rather than to enhance rates for providing care in nursing centers.

In addition, many states are moving all or part of their long term services and supports (LTSS) to managed care, especially in states participating in demonstrations to integrate care for people enrolled in both Medicare and Medicaid (dual eligibles). However, there are certain restrictions that,

[18] AHCA survey of state affiliates.

depending on how a state structures its provider tax program(s), will come into play in a managed care environment. Under managed care, if the state establishes either rate floors or fee schedule rates that managed care plans must pay nursing centers, providers are able to receive payments as usual. However, in states that utilize provider taxes and federal matching dollars to provide supplemental payments,[19] nursing center payment methodology changes must be made if assessed nursing centers are to continue receiving assessment-derived payments. Federal regulations indicate that supplemental payments cannot be managed by the state and paid outside the managed care capitation rate nor can states dictate the methodology for distribution of these payments.[20] These payments must be rolled into the per member, per month (PMPM) capitation rate, as well as the appropriate component of the capitation rate (e.g., the nursing center component). These payments may not be handled differently from all other provider payments required in the contract between the state and the plan.[21]

In practical terms, this means that states implementing Medicaid MLTSS that historically have used supplemental payments for their provider tax program will need to either:

1. Incorporate the supplemental payments into providers' daily rates that serve as the payment "floor" for provider contracting with the plans. This requires a greater level of estimation on the part of the state because of changes during the rate year in patient census and Medicaid census, which impact tax collections and Medicaid payments; or
2. Accept the risk that the managed care plans will allocate supplemental payments in a fashion similar to what the state had done in the past.

Looking towards the future, the stability of the provider tax program is unclear. As part of the discussions around federal deficit reduction, both the President and some members of Congress have at various times proposed reductions in the amount of provider tax revenue eligible for federal matching dollars as a way to save federal funds. Although the provider tax safe harbor threshold is currently set at 6.0 percent of revenue, various proposals have suggested reducing it to 3.5 percent or 5.5 percent of provider revenues. 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.[22]

4. The Role of Medicare in Subsidizing Medicaid Shortfalls

Medicare's cross-subsidization of Medicaid deficits has historically played an important role in sustaining nursing center care, but this is changing with current rate reductions. According to the Medicare Payment Advisory Commission (MedPAC), the average margin on Medicare payment to

[19] Supplemental payments are lump sum payments that providers receive periodically (e.g., annually, at the end of a quarter) and are driven by Medicaid volume or percentage and based on historical utilization.
[20] 42 CFR 438.60
[21] To date, CMS has indicated that with regards to nursing center payments, the only exception allowing direct payments to providers or mandated plan payments would be those associated with pay for performance criteria.
[22] MACPAC. March 2012 Report to Congress.

freestanding nursing centers in 2013 is projected to be between 12 and 14 percent,[23, 24] while our analysis indicates a 13.3 percent shortfall on Medicaid payment for that year (i.e., the weighted average 2013 shortfall of $24.26 divided by the weighted average Medicaid rate of $182.59). The 2013 weighted average 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).

Table 3. Combined Medicare/Medicaid Shortfall for 2013

Payer	2013 Average Rate	Days in Millions	Revenue in Billions	Margin (Shortfall as a % of Revenue)	Net Margin (Shortfall) in Billions
Medicare[25]	$468.19	69.0	$32.32	14.0%	$4.53
Medicaid	$182.59	318.8	$58.21	-13.3%	($7.73)
Net Medicare/Medicaid Shortfall					($3.21)
Net Medicare/Medicaid Margin as a Percentage of Revenue					-3.5%

Source: Medicare Rates and Days based upon AHCA SNF PPS Simulation Model using CMS 2011 Medicare Part A claims data. Medicare margin percentage derived from March 2013 MedPAC Report to the Congress: Medicare Payment Policy. Medicaid rates, days and margins derived from this report.

5. State Budget and Medicaid Programmatic Trends

Following the most serious economic conditions since the Great Depression, state fiscal conditions are improving modestly overall, but recovery is ongoing and uneven across the states, with total state spending in state fiscal year (SFY) 2013 still below the fiscal 2008 pre-recession peak after accounting for inflation.[26] Looking forward to SFY 2014, general fund expenditures are projected to increase by an average of 4.1 percent, less than the historical average, but in line with the estimated 4.0 percent increase in SFY 2013.[27]

Although total state tax collections appear to be growing and the national unemployment rate has fallen to 7.3 percent, there were still 1.9 million fewer jobs compared to when the Great Recession

[23] MedPAC. March 2013 Report to Congress.
[24] At the December 2013 MedPAC meeting, MedPAC reported that they project the 2014 margin to be 12 percent, which is very similar to their 2013 projection.
[25] These data are for Medicare Part A and do not reflect nursing center services provided under Part B or Medicare Advantage.
[26] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2013.
[27] Ibid

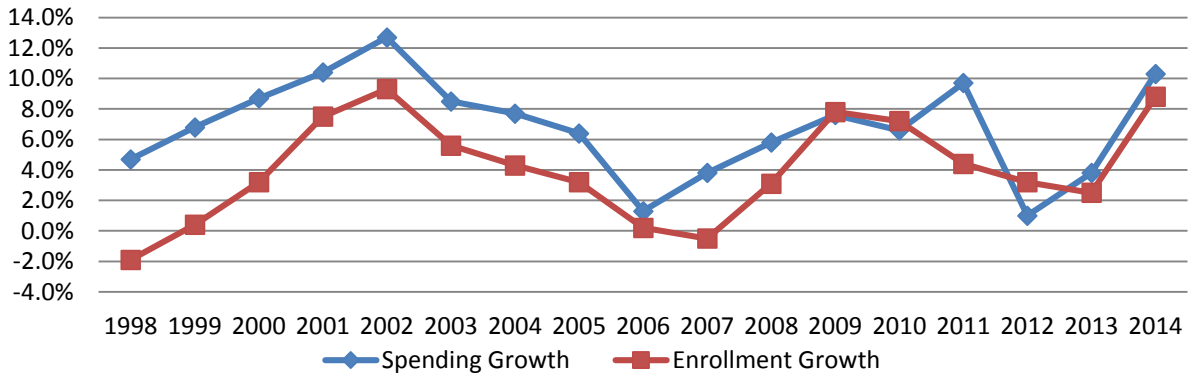
began.[28] And, while unemployment has fallen in a number of states, four states had unemployment rates at or above nine percent, highlighting the uneven nature of the recovery.[29]

In summary, tough budgetary choices remain for many states in SFY 2014. Over the longer term, many state budgets will be affected by the cost of pensions and health care for state employees, and in the near term, states remain concerned about the slow pace of recovery as well as deficit reduction actions at the federal level. [30]

With regards to Medicaid, although state spending increased substantially in SFY 2012, total Medicaid spending decreased because federal spending declined due to the expiration of the enhanced federal matching rates that was temporarily authorized by American Recovery and Reinvestment Act of 2009 (ARRA). In SFY 2013, spending growth was modest compared to historical trends and in SFY 2014, it will be driven by Medicaid expansion,[31] delivery system reforms, implementation or expansions of managed care, and targeted cost containment actions.[32] However, both spending and enrollment changes will vary by state, largely depending on whether or not a state is expanding Medicaid under the ACA.

In states that are expanding Medicaid, total Medicaid spending (both federal and state share) growth is expected to be an average of 13.0 percent. In contrast, in states that are not expanding Medicaid at this time, total spending growth is expected to be an average of 6.8 percent. Similarly, enrollment growth is expected to be an average of 11.8 percent in Medicaid expansion states, while it is expected to be an average 5.3 percent in state not participating in the expansion.[33] Some of this

Figure 4. Percent Change in Total Medicaid Spending and Enrollment, FY1998-FY2014



Source: KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal

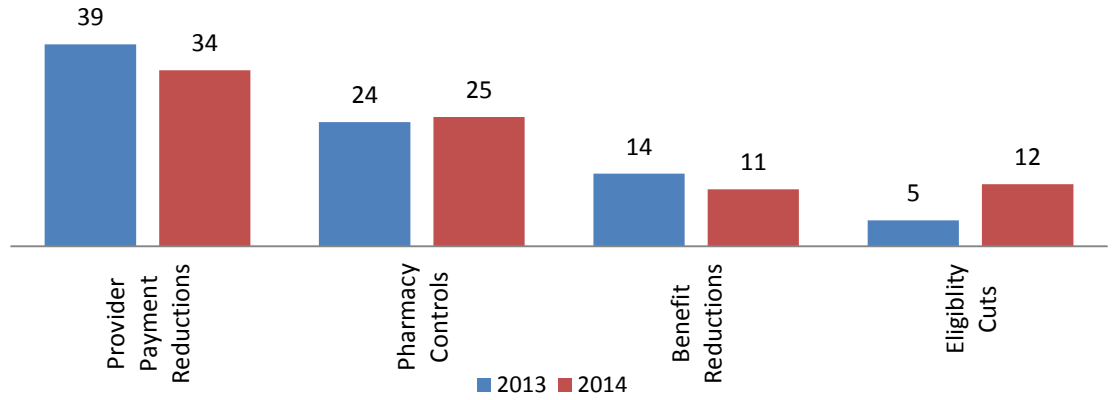
[28] KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.
[29] Ibid
[30] Ibid
[31] The Medicaid expansion population will be 100 percent funded by the federal government initially, and eventually phase down to 90 percent federal match in 2020.
[32] KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.
[33] Ibid

growth will be from people enrolling in the program because they are newly eligible for Medicaid with their state's participation in the expansion. However, the Congressional Budget Office has indicated that people who were already eligible for the program will enroll in Medicaid, which will affect all states, regardless of whether or not they elect to expand the program. Ultimately, these enrollment increases could put a strain on finite Medicaid dollars, prompting program changes that could impact beneficiaries and the providers who care for them. Figure 4, on page 14, shows the change in total Medicaid spending and enrollment between years.

Over the past year, 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. In 2013, 10 states expanded eligibility and in 2014, eligibility expansion will be driven by Medicaid expansion under the ACA, with 25 states taking up this option. States also are expanding LTSS, primarily for home and community-based services (HCBS); in 2013, 31 HCBS expansions took place while in 2014, 35 expansions are planned. A number of states are also taking up options to expand HCBS offered through the ACA, as well as looking to managed care organizations to provide LTSS,[34] which will be discussed in greater detail in the "Managed Care" section of this report. No expansion is expected for institutional long term care.

In addition to these programmatic changes, there are a number of common cost containment efforts underway. These strategies tend to focus on new or enhanced program integrity efforts, reducing costs and imposing limits for prescription drugs, limiting benefits, and freezing or reducing provider rates.[35] Figure 5 provides an overview of these activities.

Figure 5. 2013 and 2014 State Cost Containment Actions



Source: KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.

[34] KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.
[35] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2013.

6. Outlook for Medicaid Financing

In an effort to control growth of the federal deficit, Congress enacted the Budget Control Act of 2012 (BCA), which set caps on security and nonsecurity budget authority.[36] Since 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 went into effect to reduce both discretionary and mandatory spending during that period (e.g., sequestration), with $1.2 trillion in cuts going into effect in March 2013, including cuts to Medicare but not Medicaid, which was excluded.

Although concerns had been raised about how the Medicaid program might be impacted by deficit reduction discussions, the recent budget deal does not make large changes to the program. However, in the future, it is likely that Congress may consider changes that could result in shifting Medicaid program costs to states, beneficiaries, and providers. This could have a devastating impact on a profession already struggling to deliver care and supports at Medicaid payment rates that do not adequately cover the costs of such care.

Another factor that could potentially influence financing in the future is the number of seniors living in poverty. Recent research based on the Census Bureau's supplemental poverty measure indicates that the poverty rate among people ages 65 and older may be higher than is reflected in the official poverty measure, and is particularly high in some states. Although there are notable differences between the two measures, there is ongoing interest in assessing these methods for measuring poverty.[37] If these data prove correct and more seniors are living in poverty than expected, this could have significant implications on any policy changes Congress considers to entitlement programs such as Social Security and Medicare, which could in turn affect the Medicaid program.

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

[37] Levinson, Z. et al. A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure. May, 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8442-state-by-state-snapshot-of-poverty-among-seniors-may.pdf

Trends in Long Term Services and Supports Impacting Nursing Centers

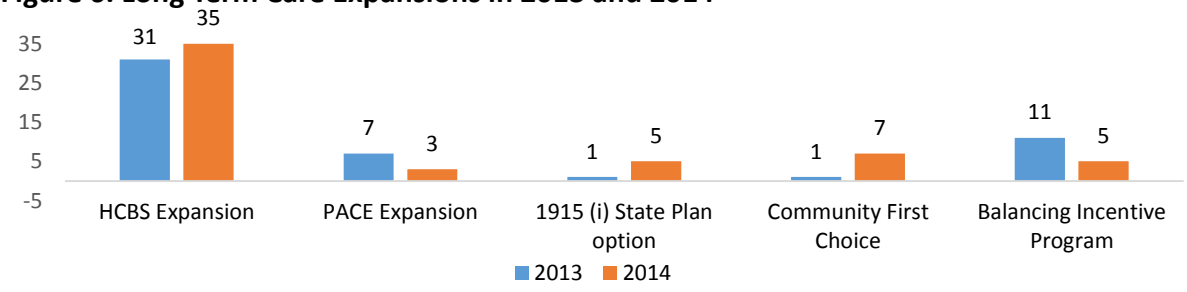
In response to rapidly increasing demand for LTSS and overall Medicare and Medicaid budgetary pressure, a number of trends, some long-standing and others new, will impact nursing centers.

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.[38] Recent analyses suggest that spending is now more evenly divided between HCBS and nursing center services—at 45 percent and 55 percent, respectively—a shift which has taken place largely over the past decade.[39]

In 2013 and planned for 2014, states again are investing heavily in HCBS expansion efforts. In FFY 2013, 31 states expanded HCBS while 35 states plan expansions in 2014.[40] These changes are, in part, driven by opportunities made available under the ACA that are aimed at expanding the use of HCBS. Many of these programs offer enhanced federal Medicaid matching percentage (EFMAP) for HCBS above the states' traditional matching rate, helping to make them of particular interest to states. No such EFMAP opportunities exist for center-based LTSS.

Figure 6. Long Term Care Expansions in 2013 and 2014



Source: KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.

[38] Burwell, et. al. Medicaid Long Term Services and Supports Spending 2011. Thomson Reuters.
[39] Commission on Long Term Care. Report to the Congress. September, 2013.
[40] KCMU. Medicaid in a Historic Time of Transformation: Results from a 50-State Survey for State Fiscal Years 2013 and 2014. October 2013.

2. *Managed Care*

Medicaid managed long term services and supports (MLTSS) is a rapidly growing payment and systems transformation effort. State use of this model has not historically been widespread, but this has started to change. An analysis of states that, at the time of the report had implemented MLTSS in Medicaid found that among the 16[41] states offering these programs, only seven operated statewide, and in some cases only served specific populations. However, by 2014, this same report showed that 26 states would have some form of MLTSS.[42] Much of this expansion is being driven by the Medicare-Medicaid integration efforts that were included in the ACA, with the duals demonstrations trying to better align financing and integrate services for people eligible for both Medicare and Medicaid (dual eligibles).[43]

Managed care expansion will dramatically alter the environment in which nursing centers operate. 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. Another key factor that will affect nursing center payments are how provider taxes are structured in states that implement MLTSS. This is discussed in "Provider Taxes as a Funding Source for Rates" section of the report.

Under these arrangements, states often build incentives into managed care plan contracts emphasizing HCBS over center-based services. Examples of this can include paying plans the same rate regardless of setting (nursing center or HCBS), which encourages plans to promote HCBS because the cost of care tends to be less expensive, or rewarding plans for appropriate transitions from nursing centers to the community or for keeping a certain number of beneficiaries in community settings and out of nursing centers.[44] The Medicare-Medicaid integration efforts will also provide further incentives to states to promote HCBS for dual eligibles enrolled in managed care by applying savings achieved from avoided services (e.g., hospital readmissions or emergency department visits) to expand HCBS, which are often only offered to people in waiver programs that have capped enrollment.[45]

While the goal of better integrating care and services for dual eligibles is laudable, the current approach poses an array of challenges and unknowns for nursing centers. Under the dual demonstrations, rates paid by plans to participating providers will vary by state. In some cases, the

[41] The 16 states in the study were Arizona, California, Delaware, Florida, Hawaii, Massachusetts, Michigan, Minnesota, New Mexico, New York, North Carolina, Pennsylvania, Tennessee, Texas, Washington and Wisconsin.
[42] 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.
[43] Moving towards these changes has been a challenge, with some states that originally submitted proposals withdrawing them, citing concerns about plan reimbursement, unclear conditions in the memorandum of understanding (MOU), and administrative challenges among the reasons for this change.
[44] Gore, S. and Klebonis, J. Medicaid Rate-Setting Strategies to Promote Home- and Community-Based Services, CHCS, May 2012. http://www.chcs.org/usr_doc/Incentivizing_HCBS_in_MLTS_Programs_05_01_12.pdf
[45] Ibid

existing state plan methodology will serve as the Medicaid rate floor, while in other states, a negotiated rate approach will be used. Providers will likely experience lower long-stay occupancy rates and experience shorter average lengths of stay for Medicare-financed post-acute care. The end result for nursing centers is likely a future of financial uncertainty due to a lack of bargaining leverage in rate negotiation and the likelihood of slower payment from managed care plans than under a state-administered system.

3. Value-Based Purchasing

Currently, little to no federal guidance exists on Medicaid value-based purchasing (VBP), resulting in states having considerable discretion in developing Medicaid payment methods. Over the years, states have experimented with a variety of approaches, including add-on or supplemental payments for providers that achieve certain structure, process and/or outcome measures.

These programs are often funded without additional state appropriation; either by allocating a portion of the existing rate appropriation to VBP or utilizing provider taxes as the funding source. When existing rate dollars are carved out and used for VBP, providers are effectively receiving only a deferred payment for the costs of care they have already incurred, rather than an incentive payment or bonus over and above their costs to deliver quality care and services.

Research has raised concerns about VBP arrangements.[46] Specifically, researchers question whether the size of the incentive payments are sufficient to stimulate change by providers. Additionally, many Medicaid VBP programs create little or no incentive for improvement so that only the highest performers are rewarded, or the rewards are on a sliding scale basis, again disproportionately rewarding the highest performers. Still other critics question whether the metrics used in VBP programs are what matters most to consumers or are simply cost drivers.

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.[47] Additionally, over the past ten years, the percentage of adults age 45 to 64 and 65 and older with two or more of nine chronic conditions likely to result in disability increased notably.[48] 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

[46] Becky A. Briesacher, Ph.D., Terry S. Field, D.Sc., Joann Baril, and Jerry H. Gurwitz, M.D. Pay-for-Performance in Nursing Homes. Health Care Finance Rev. 2009 Spring;30(3):1-13.
[47] Vincent, G. and Velkoff, V. The Next Four Decades – The Older Population in the United States: 2010 to 2050. U.S. Census Bureau.
[48] 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.

significantly increase in coming years.[49] Finally, more recent analysis of the prevalence of disability among persons age 65 and older suggests that disability rates have been increasing.[50,51] Estimates suggest the future number of the older adult population who are unable to perform basic daily activities such as walking, dressing, and eating without assistance may as much as double from 2000 through 2040, resulting in a large increase in demand for LTSS. Due to demographics alone, LTSS spending for older adults may increase by more than 2.5 times between 2000 and 2040, and could nearly quadruple spending between 2000 and 2050 to $379 billion.[52]

These factors raise serious questions about the capacity of our nation's LTSS system to provide future demand for services. Policymakers will be challenged to respond to the growing need for LTSS and to assure that adequate safeguards are in place to protect the frailest LTSS beneficiaries across various care settings and delivery systems. Budget constraints will affect states' abilities to meet this demand both now and in the future.

[49] 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.
[50] 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.
[51] National Institutes of Health. Fact Sheet – Disability in Older Adults. October 2010.
[52]Allen, K. (2005). Long Term Care Financing: Growing Demand and Cost of Services are Straining Federal and State Budgets. Government Accountability Office

Nursing Center Outlook for 2014

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 includes some reductions in Medicare reimbursement, impacting 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. While it is unclear how these approaches will impact the nursing center sector in the long term, providers are raising preliminary concerns about excessive pressures to reduce overall spending associated with these payment reform movements.

In conclusion, current financial challenges and future uncertainty paints a difficult picture for the nursing center sector. As the number of older 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 and participated 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 year ending in 2011 (or 2012, 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 2011, but between current (FY 2013) rates and 2011 (or 2012, if available) costs trended to the same time period.[53]

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 over 70 percent of the states in 2011. 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 2011 were derived for 36 states, representing approximately 80 percent of the Medicaid patient days in the country. Current Medicaid rates by provider were obtained from 36 states, allowing us to determine an estimated 2013 shortfall for these states, again representing approximately 80 percent of Medicaid days nationwide.[54] States included in this report reflect all regions of the country and are a fair representation of Medicaid

[53] Some state affiliates did not participate either through their own choice or because the data were not available. If we assume their shortfalls to be half the national average, the shortfall would decline by only $2.42 per Medicaid patient day. Using the most conservative approach possible, that on average, these states reflect a break even relative to Medicaid rates and costs, the national shortfall would only decline by $4.84 per Medicaid patient day.

[54] Cost report data for 2011 was not made available by the state agency in New Jersey. Therefore, in computing the 2011 shortfall for this state, the latest available cost reports data—2009 reports—were trended to 2011 and compared to the 2011 rates.

shortfalls nationwide. It also includes the eleven states that represent over half of all days covered under the Medicaid program: California, Florida, Illinois, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.

Appendix 2

Calculation of 2011 and Projected 2013 Weighted Average Medicaid Shortfall State-by-State Comparison

Table A2-1. Calculation of 2011 Weighted Average Medicaid Shortfall							
State	2011 Rate	2011 Cost	2011 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
Arizona	$167.95	$188.79	($20.84)	2,581,525	$433,579,219	$487,370,799	($53,791,580)
California	$175.24	$189.72	($14.48)	24,941,478	$4,370,779,954	$4,732,009,165	($361,229,211)
Colorado	$199.98	$207.85	($7.87)	3,487,831	$697,485,837	$724,933,900	($27,448,063)
Connecticut	$223.25	$242.89	($19.65)	6,344,895	$1,416,481,417	$1,541,143,046	($124,661,630)
Delaware	$207.36	$232.96	($25.60)	881,766	$182,840,662	$205,416,134	($22,575,473)
Florida	$205.61	$220.03	($14.42)	15,368,035	$3,159,782,881	$3,381,437,278	($221,654,397)
Georgia	$141.59	$153.37	($11.78)	8,992,860	$1,273,319,688	$1,379,272,108	($105,952,420)
Hawaii	$231.96	$246.36	($14.41)	938,999	$217,809,431	$231,336,324	($13,526,894)
Illinois	$130.47	$155.63	($25.17)	17,115,857	$2,233,036,798	$2,663,781,549	($430,744,752)
Iowa	$147.86	$159.96	($12.10)	4,318,677	$638,540,411	$690,798,264	($52,257,853)
Kansas	$149.34	$160.92	($11.58)	3,740,174	$558,566,055	$601,864,246	($43,298,190)
Maine	$179.23	$198.52	($19.29)	1,542,166	$276,399,663	$306,154,094	($29,754,431)
Maryland	$231.81	$246.21	($14.40)	5,511,593	$1,277,626,566	$1,356,998,391	($79,371,825)
Massachusetts	$197.40	$227.84	($30.43)	9,782,865	$1,931,175,136	$2,228,881,115	($297,705,979)
Michigan	$211.44	$210.86	$0.59	8,990,615	$1,901,011,834	$1,895,734,554	$5,277,280
Minnesota	$165.82	$195.17	($29.35)	5,748,426	$953,231,367	$1,121,936,379	($168,705,012)
Missouri	$134.35	$155.15	($20.80)	8,425,445	$1,131,944,401	$1,307,187,645	($175,243,243)
Montana	$175.46	$187.36	($11.90)	966,838	$169,639,828	$181,146,112	($11,506,285)
Nebraska	$152.07	$175.43	($23.35)	2,408,669	$366,294,848	$422,549,005	($56,254,157)
Nevada	$189.37	$206.48	($17.11)	941,773	$178,346,138	$194,459,523	($16,113,385)
New Jersey	$203.13	$243.25	($40.12)	10,360,347	$2,104,481,383	$2,520,151,514	($415,670,131)
New Mexico[55]	$169.10	$191.71	($22.61)	1,345,219	$227,479,115	$257,891,593	($30,412,478)
New York	$217.80	$262.02	($44.23)	27,938,303	$6,084,872,654	$7,320,488,126	($1,235,615,472)
North Dakota	$210.47	$215.24	($4.77)	1,086,220	$228,618,017	$233,796,976	($5,178,959)
Ohio	$172.33	$188.22	($15.89)	18,159,130	$3,129,421,638	$3,417,882,048	($288,460,410)
Oklahoma	$127.68	$145.31	($17.64)	4,670,682	$596,332,048	$678,704,479	($82,372,431)
Oregon	$222.43	$234.64	($12.21)	1,656,408	$368,437,443	$388,659,649	($20,222,206)

[55] Rates for New Mexico are estimated since managed care organizations would not provide provider-specific rates. They are based upon those in effect prior to the program shift to managed care and increased by legislative-mandated rate increases.

Table A2-1. Calculation of 2011 Weighted Average Medicaid Shortfall							
State	**2011 Rate**	**2011 Cost**	**2011 Difference**	**Annual Medicaid Days**	**Gross Revenue**	**Gross Cost**	**Total Difference**
Pennsylvania	$204.63	$226.96	($22.34)	18,335,180	$3,751,858,859	$4,161,408,795	($409,549,935)
South Dakota	$128.65	$157.19	($28.54)	1,277,993	$164,414,899	$200,893,682	($36,478,782)
Texas	$126.87	$142.92	($16.05)	21,203,490	$2,690,101,619	$3,030,415,882	($340,314,264)
Utah	$177.66	$202.52	($24.86)	1,044,326	$185,539,393	$211,499,240	($25,959,847)
Vermont	$202.01	$221.04	($19.03)	651,448	$131,598,425	$143,994,568	($12,396,143)
Virginia	$153.43	$163.89	($10.46)	6,265,649	$961,337,606	$1,026,883,591	($65,545,985)
Washington	$168.65	$196.67	($28.02)	3,898,260	$657,435,062	$766,661,864	($109,226,802)
Wisconsin	$154.54	$195.08	($40.53)	6,459,637	$998,303,585	$1,260,122,352	($261,818,767)
Wyoming	$183.08	$201.76	($18.68)	532,830	$97,549,887	$107,505,043	($9,955,156)

Totals	257,915,609	$45,745,673,766	$51,381,369,033	($5,635,695,267)
Weighted Average		$177.37	$199.22	($21.85)
Shortfall Extrapolated to all 50 states and DC				($7,016,435,613)
Total States				36
Percentage of days				80.3%

Table A2-2. Calculation of Projected 2013 Weighted Average Medicaid Shortfall							
State	2013 Rate	2013 Cost	2013 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
Arizona[56]	$189.60	$202.17	($12.57)	2,479,704	$470,147,696	$501,320,089	($31,172,393)
California	$178.61	$198.15	($19.54)	24,868,317	$4,441,720,439	$4,927,625,603	($485,905,164)
Colorado	$202.79	$210.65	($7.86)	3,494,978	$708,738,347	$736,220,940	($27,482,593)
Connecticut	$230.09	$255.52	($25.43)	6,028,185	$1,387,033,273	$1,540,322,726	($153,289,453)
Delaware[56]	$249.58	$254.73	($5.14)	910,993	$227,369,983	$232,053,200	($4,683,217)
Florida	$211.98	$225.32	($13.34)	15,415,833	$3,267,887,716	$3,473,560,975	($205,673,259)
Georgia	$156.10	$165.81	($9.71)	8,839,859	$1,379,882,015	$1,465,716,011	($85,833,996)
Hawaii[56]	$257.82	$264.51	($6.69)	888,240	$229,008,868	$234,952,244	($5,943,376)
Illinois	$129.30	$164.18	($34.88)	16,639,710	$2,151,507,171	$2,731,853,168	($580,345,997)
Iowa	$154.68	$166.24	($11.56)	4,262,115	$659,245,205	$708,534,460	($49,289,254)
Kansas	$153.73	$166.18	($12.45)	3,726,573	$572,875,407	$619,282,205	($46,406,799)
Maine	$183.81	$205.95	($22.14)	1,542,621	$283,546,825	$317,698,740	($34,151,915)
Maryland	$237.86	$251.17	($13.31)	5,479,351	$1,303,314,299	$1,376,268,336	($72,954,038)
Massachusetts	$197.91	$234.86	($36.96)	9,560,947	$1,892,165,569	$2,245,523,237	($353,357,668)
Michigan[57]	$223.76	$219.29	$4.47	8,913,504	$1,994,509,927	$1,954,640,654	$39,869,273
Minnesota	$169.63	$204.07	($34.44)	5,400,960	$916,149,607	$1,102,152,115	($186,002,509)
Missouri	$147.45	$162.74	($15.29)	8,521,982	$1,256,605,546	$1,386,866,348	($130,260,802)
Montana	$176.36	$185.98	($9.62)	967,515	$170,635,286	$179,938,746	($9,303,460)
Nebraska	$154.07	$179.25	($25.17)	2,320,203	$357,483,598	$415,894,492	($58,410,893)
Nevada	$193.37	$209.76	($16.40)	982,635	$190,010,001	$206,121,881	($16,111,880)
New Jersey	$203.85	$250.90	($47.05)	10,362,845	$2,112,449,386	$2,600,055,765	($487,606,379)
New Mexico[58]	$186.38	$198.52	($12.15)	1,310,806	$244,303,332	$260,225,068	($15,921,737)
New York	$220.55	$272.52	($51.96)	27,696,397	$6,108,502,215	$7,547,739,529	($1,439,237,314)

[56] The significant reduction in shortfalls between 2011 and 2013 in Arizona, Delaware, Hawaii, and Wyoming is due to the implementation of provider tax programs in these states between 2011 and 2013.

[57] In projecting the FY 13 shortfall for Michigan, as with other states, costs were projected to increase by market basket. However, over the past 4 years, costs in Michigan have historically increased by an average of 2.7 percent annually. If this historical inflation average were applied rather than market basket, the projected margin in Michigan drops to $1.36.

[58] Rates for New Mexico are estimated since managed care organizations would not provide provider-specific rates. They are based upon those in effect prior to the program shift to managed care and increased by legislative-mandated rate increases.

Table A2-2. Calculation of Projected 2013 Weighted Average Medicaid Shortfall							
State	**2013 Rate**	**2013 Cost**	**2013 Difference**	**Annual Medicaid Days**	**Gross Revenue**	**Gross Cost**	**Total Difference**
North Dakota	$224.00	$224.92	($0.92)	1,072,596	$240,265,863	$241,253,467	($987,604)
Ohio	$174.64	$192.44	($17.79)	17,801,791	$3,108,928,738	$3,425,693,704	($316,764,966)
Oklahoma	$138.42	$150.36	($11.94)	4,693,402	$649,673,202	$705,690,769	($56,017,568)
Oregon	$222.43	$240.57	($18.14)	1,582,916	$352,090,419	$380,797,816	($28,707,396)
Pennsylvania	$209.65	$235.57	($25.92)	18,154,908	$3,806,219,377	$4,276,725,586	($470,506,209)
South Dakota	$127.64	$163.04	($35.40)	1,234,880	$157,614,621	$201,331,431	($43,716,809)
Texas	$131.61	$147.93	($16.32)	21,600,092	$2,842,774,164	$3,195,286,352	($352,512,188)
Utah	$189.05	$208.51	($19.45)	1,048,777	$198,274,783	$218,677,717	($20,402,934)
Vermont	$206.08	$223.97	($17.89)	644,173	$132,751,856	$144,278,299	($11,526,443)
Virginia	$160.09	$170.02	($9.93)	6,227,334	$996,935,752	$1,058,746,870	($61,811,119)
Washington	$178.73	$212.61	($33.88)	3,800,307	$679,216,219	$807,986,217	($128,769,998)
Wisconsin	$160.24	$201.79	($41.54)	6,165,350	$987,948,770	$1,244,081,526	($256,132,756)
Wyoming[56]	$217.47	$222.72	($5.25)	503,346	$109,463,395	$112,106,951	($2,643,556)
Totals				255,144,148	$46,587,248,868	$52,777,223,238	($6,189,974,370)
Weighted Average					$182.59	$206.85	($24.26)
Shortfall Extrapolated to all 50 states and DC							($7,734,084,729)
Total States							36
Percentage of days							80.0%

Appendix 3

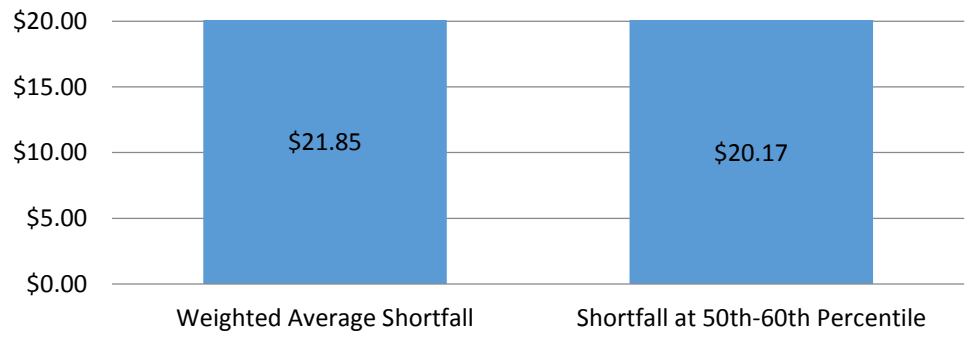
Impact of High Cost Providers on the Medicaid Average Shortfall

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 2011 costs between the 50th and 60th percentile is reflected in Figure A3-1, below.

FIGURE A3-1. 2011 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 only $1.68 less than average shortfall nationwide. This analysis demonstrates that Medicaid payment is substantially inadequate in reimbursing even reasonable cost providers.