Eljay LLC

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*Certified Public Accountants*

# A Report on Shortfalls in Medicaid Funding for Nursing Center Care

**ELJAY, LLC**
**&**
**HANSEN HUNTER & COMPANY, PC**

**FOR THE**
**AMERICAN HEALTH CARE ASSOCIATION**

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# Table of Contents


**Report Highlights** **page 1**

**Medicaid Shortfalls in 2013 and Projected Shortfalls for 2015—Nursing Center Shortfall Study Overview** **page 3**

1. *Methodology* *page 3*
2. *Estimated Medicaid Shortfall: 2013* *page 4*
3. *Projected Medicaid Shortfall: 2015* *page 4*
4. *Medicaid Allowable Costs Compared to Total Costs* *page 5*
5. *State-by-State Data Tables* *page 6*

**Financing Factors Impacting Nursing Centers** **page 9**

1. *The Broader Medicaid Landscape* *page 9*
2. *Financing Factors Impacting Nursing Centers Capacity* *page 9*
3. *Provider Taxes as a Funding Source for Rates* *page 10*
4. *The Role of Medicare in Subsidizing Medicaid Shortfalls* *page 12*
5. *State Budget and Medicaid Programmatic Trends* *page 13*
6. *Outlook for Medicaid Financing* *page 16*

**Trends in Long Term Services and Supports Impacting Nursing Centers** **page 17**

1. *Home and Community-Based Services Expansion* *page 17*
2. *Managed Care* *page 18*
3. *Value-Based Purchasing* *page 20*
4. *Increasing Numbers of Older Adults with Intense Support Needs* *page 20*

**Nursing Center Reimbursement Outlook for 2015** **page 22**

**Appendices** **page 23**

1. *Project Approach and Methodology* *page 24*
2. *Calculation of 2013 and Projected 2015 Weighted Average Medicaid Shortfall State-by-State Comparison* *page 27*
3. *Impact of High Cost Providers on the Medicaid Average Shortfall* *page 32*

## 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.

- Unreimbursed allowable Medicaid costs for 2015 are projected to exceed $7.0 billion. Expressed as a shortfall in reimbursement per Medicaid patient day, the estimated average Medicaid shortfall for 2015 is projected to be $22.46,[1] which is a 6.0 percent increase over the preceding year's projected shortfall of $21.20. The projected shortfall has increased despite Medicaid rate increases just slightly surpassing projected cost increases during the time period from the cost report years used in the study (2013 or 2014) to 2015. However, although Medicaid rate increases outpaced projected allowable cost increases during this period, significant shortfalls still exist.

- Based upon the average annual Medicaid shortfall amount per patient day listed above ($22.46), a typical center with an average daily census of 100 patients, of which 63 are funded by the Medicaid program, would lose $1,415 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 $516,000.

**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 and declining Medicare margins, this program does not fully subsidize the Medicaid shortfall.

**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.

- Twenty of the 44 states with a nursing center provider tax are at the maximum taxable amount of six percent of revenue.[2]

[1] No determination of the actual Medicaid shortfall could be made for 2014 since cost reports for 2014 were unavailable in all but 14 states. The 2015 Medicaid shortfall is a projection based upon trending of the most recently available (2013 or 2014) cost reports to 2015 and comparing these trended costs to current rates.
[2] AHCA survey of state affiliates.

**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.

## Medicaid Shortfalls in 2013 and Projected Shortfalls for 2015 – Nursing Center Shortfall Study Overview

Eljay, LLC (Eljay) and Hansen, Hunter, & Company, PC (HHC) were 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.[3] The report identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available, which in most states was 2013. In some states, cost reports for providers with year ends in 2014 were available and used. Similar to last year's study, a shortfall for the current year (2015) is projected by trending the 2013 costs (or 2014, if available) to the current year and comparing them to current Medicaid rates.

### *1.* Methodology

Thirty-three of AHCA state affiliates participated in the study and provided the most recently available cost reports (2013 for most states) to Eljay and HHC. These 33 represented about 76 percent of the Medicaid patient days in the country including the nine states that represent half of all days covered under the Medicaid program: California, Florida, Illinois, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas. Data from almost two-thirds 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.[4]

Eljay and HHC projected the shortfall in Medicaid reimbursement for the current year (2015) by comparing current year rates to 2013 allowable costs (or 2014, if available) trended to the current year. The trending factor used in projecting 2013 or 2014 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 cost data become available, the actual shortfall for a given year would be higher than what was projected for that year in a prior report. However, for the second time, this was not the case for the base cost report year (2013, or in some cases 2014). The

[3] 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 thirteen 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. Hansen Hunter & Company P.C. (HHC) is a firm of certified public accountants and clinical consultants founded in 1979. Each partner, staff accountant, and clinical consultant has substantial experience in the health care field; the partners leading the HHC team each have 25 years of experience in the field.

[4] In some states, as-filed reports for 2014 were available and used. In others, as-filed Medicaid cost reports or Medicare cost reports were the only available reports in some 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 they were not yet being 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.

authors of this study conducted a state-by-state comparison of the actual 2013 shortfalls and the shortfalls projected for that year in the January 2014 report. The comparison revealed that nearly a third of the states had greater actual shortfalls than projected. The actual average per diem shortfall for 2013 was $22.45, 7.4 percent less than the originally projected shortfall of $24.26. It appears that during the recession, as states imposed tight constraints on rate increases, providers implemented comparable constraints on cost increases.

### *2.* Estimated Medicaid Shortfall: 2013

The estimated average shortfall in Medicaid reimbursement increased from $21.80 per Medicaid patient day in 2012 to $22.45 per Medicaid patient day in 2013, a 3.0 percent increase. During this time period, Medicaid programs reimbursed nursing center providers for approximately 89.1 percent of their allowable costs per Medicaid patient, on average. The 2013 shortfall compilation incorporates data from 33 states.[5] When extrapolated to all 50 states, the shortfall in Medicaid reimbursement to nursing centers was estimated to be over $7.2 billion.

### *3.* Projected Medicaid Shortfall: 2015[6]

Between 2013 and 2015, overall Medicaid rates increased by 3.7 percent, while provider costs are projected to increase by 3.3 percent.[7] The rate increases since the base cost report years represent a combination of improving state economies and increases in provider tax rates as a funding source for rate adjustments during this time period. The estimated 2015 projected shortfall ($22.46) is relatively similar to the 2013 shortfall ($22.45).[8]

The study estimates that in 2015, state Medicaid programs, on average, reimbursed nursing center providers only 89.4 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 2015, Medicaid programs reimbursed, on average, approximately 89 cents. 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.

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[6] No determinations of the Medicaid shortfall could be made for 2014, since 2014 cost reports were unavailable in most states. The 2015 Medicaid shortfall is a projection based upon trending of the most recently available cost reports to 2015 and comparing these trended costs to current rates.

[7] This number represents a two year market basket increase from 2013 to 2015. The projected cost increase of 3.3 percent in the study is different in that the time frame from the cost report period to 2015 was sometimes less than two years, depending upon the fiscal year end of each provider.

[8] This shortfall projection, based upon trending 2013 (or 2014, if available) allowable costs to 2015 by the SNF Market Basket for comparison to 2015 rates is likely to be conservative. Historically, with the exception of 2012 and 2013, allowable costs have increased annually by a greater percentage than the Market Basket.

**Figure 1. Average Annual Medicaid Rate and Shortfall Amount**

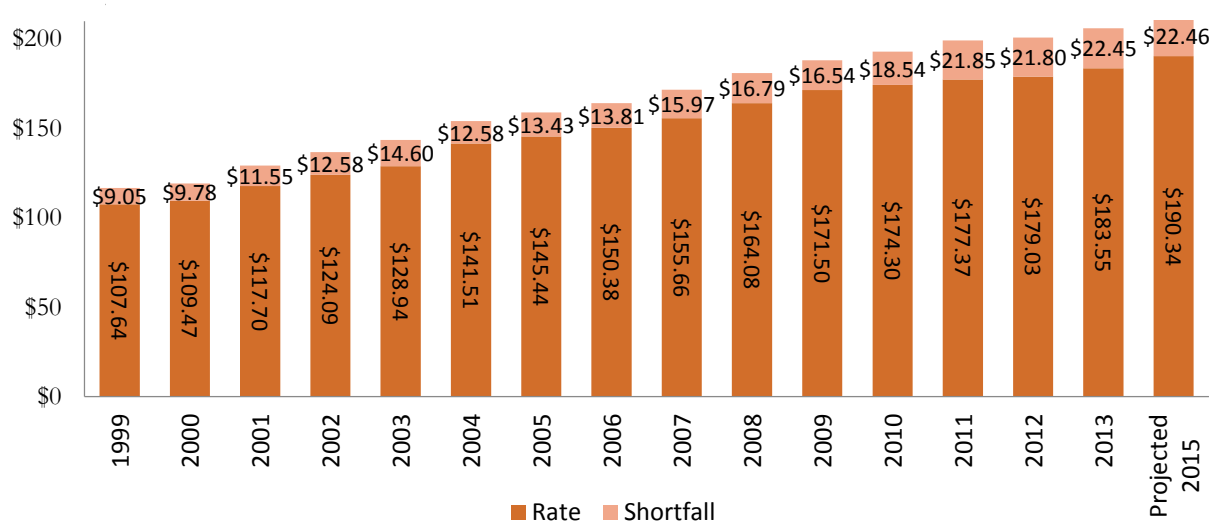
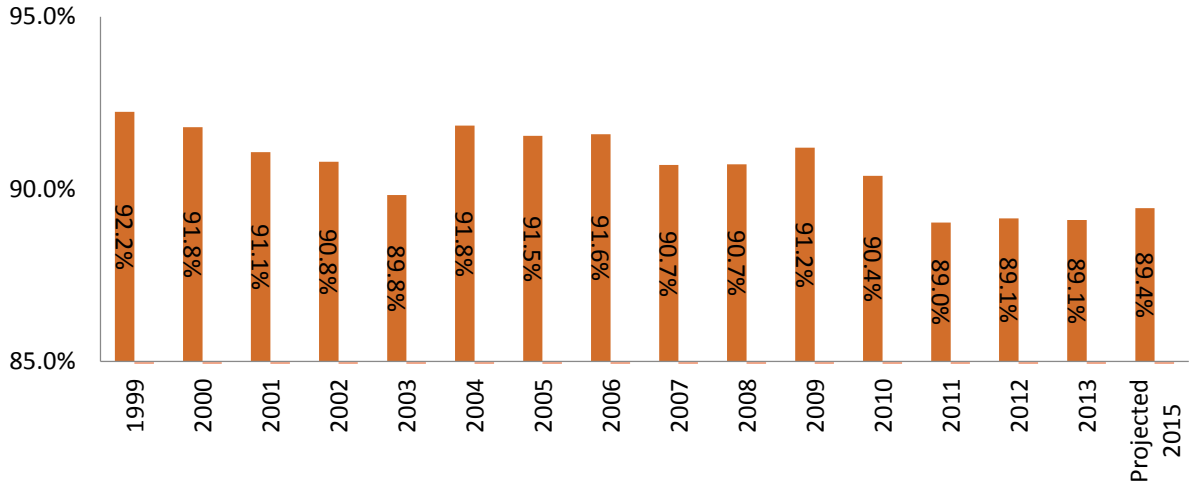



**Figure 2. Percent of Allowable Costs Covered by Medicaid Rates**




### *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 and HHC's experience 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 $4.26 per day based upon total projected 2015 Medicaid allowable costs of $212.81 per day. This would increase the projected 2015 Medicaid shortfall to $26.72 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 2013 rates to 2013 costs and 2015 rates compared to projected 2015 costs, as well as the difference in these amounts for these two years.

| Table 1. State-by-State Comparison of 2013 Rates to 2013 Costs | | | |
|---|---|---|---|
| **State** | **2013 Rate** | **2013 Cost** | **2013 Difference** |
| **Arizona** | $198.53 | $206.93 | ($8.40) |
| **California** | $180.97 | $199.03 | ($18.06) |
| **Colorado** | $220.55 | $226.96 | ($6.41) |
| **Connecticut** | $229.84 | $250.75 | ($20.91) |
| **Delaware** | $249.72 | $250.80 | ($1.09) |
| **Florida** | $218.64 | $226.40 | ($7.75) |
| **Georgia**[9] | $157.33 | $163.76 | ($6.43) |
| **Hawaii**[10] | $259.34 | $272.85 | ($13.50) |
| **Illinois** | $132.82 | $165.87 | ($33.05) |
| **Iowa** | $158.85 | $171.51 | ($12.65) |
| **Kansas** | $152.67 | $164.00 | ($11.34) |
| **Maine** | $183.72 | $206.44 | ($22.72) |
| **Maryland** | $242.44 | $252.36 | ($9.92) |
| **Massachusetts** | $196.46 | $230.22 | ($33.76) |
| **Minnesota** | $170.84 | $205.40 | ($34.56) |
| **Missouri** | $149.01 | $162.50 | ($13.49) |
| **Montana** | $178.88 | $192.79 | ($13.91) |
| **Nebraska** | $157.86 | $182.69 | ($24.82) |
| **Nevada** | $197.96 | $220.84 | ($22.88) |
| **New Jersey** | $204.37 | $235.76 | ($31.38) |
| **New Mexico** | $165.10 | $190.26 | ($25.15) |
| **New York** | $226.03 | $270.53 | ($44.50) |
| **North Dakota** | $232.78 | $240.86 | ($8.08) |
| **Ohio** | $174.52 | $190.88 | ($16.36) |
| **Oklahoma** | $144.26 | $155.38 | ($11.12) |
| **Pennsylvania** | $211.16 | $234.03 | ($22.87) |
| **Texas** | $132.41 | $149.29 | ($16.87) |
| **Utah**[9] | $184.74 | $200.00 | ($15.25) |
| **Vermont** | $214.79 | $231.68 | ($16.89) |
| **Virginia** | $160.56 | $167.93 | ($7.37) |
| **Washington** | $190.75 | $219.93 | ($29.18) |
| **Wisconsin** | $163.29 | $214.09 | ($50.80) |
| **Wyoming** | $219.69 | $237.96 | ($18.28) |

[9] For these states, the Medicaid rates do not include supplemental payments made to the non-state government-owned facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities.

[10] These data do not include certified public expenditures made to state-run facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities in the state.

| Table 2. State-by-State Comparison of 2015 Rates to Projected 2015 Costs | | | |
|---|---|---|---|
| **State** | **2015 Rate** | **Projected 2015 Cost** | **Projected Difference** |
| **Arizona** | $208.12 | $217.10 | ($8.99) |
| **California** | $191.33 | $205.50 | ($14.17) |
| **Colorado** | $225.23 | $232.05 | ($6.82) |
| **Connecticut** | $230.06 | $255.04 | ($24.98) |
| **Delaware** | $256.69 | $258.34 | ($1.65) |
| **Florida** | $225.14 | $231.81 | ($6.67) |
| **Georgia**[11] | $164.02 | $171.81 | ($7.79) |
| **Hawaii**[12] | $260.77 | $281.85 | ($21.08) |
| **Illinois** | $145.99 | $171.08 | ($25.09) |
| **Iowa** | $165.39 | $177.64 | ($12.25) |
| **Kansas** | $158.70 | $169.14 | ($10.45) |
| **Maine** | $200.58 | $213.50 | ($12.92) |
| **Maryland** | $239.37 | $257.99 | ($18.62) |
| **Massachusetts** | $201.44 | $236.70 | ($35.26) |
| **Minnesota** | $179.96 | $214.00 | ($34.04) |
| **Missouri** | $152.66 | $167.57 | ($14.90) |
| **Montana** | $183.34 | $200.48 | ($17.14) |
| **Nebraska** | $161.87 | $186.93 | ($25.06) |
| **Nevada** | $201.41 | $224.12 | ($22.71) |
| **New Jersey** | $207.35 | $242.67 | ($35.32) |
| **New Mexico** | $168.00 | $192.73 | ($24.73) |
| **New York** | $234.16 | $282.59 | ($48.43) |
| **North Dakota** | $250.51 | $248.08 | $2.42 |
| **Ohio** | $175.10 | $196.79 | ($21.69) |
| **Oklahoma** | $144.08 | $158.89 | ($14.81) |
| **Pennsylvania** | $216.75 | $242.18 | ($25.43) |
| **Texas** | $141.64 | $154.18 | ($12.55) |
| **Utah**[11] | $188.70 | $205.21 | ($16.51) |
| **Vermont** | $217.23 | $234.98 | ($17.76) |
| **Virginia**[11] | $173.81 | $173.49 | $0.32 |
| **Washington** | $197.32 | $225.15 | ($27.83) |
| **Wisconsin** | $167.85 | $220.68 | ($52.84) |
| **Wyoming** | $224.12 | $249.04 | ($24.92) |

[11] For these states, the Medicaid rates do not include supplemental payments made to the non-state government-owned facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities.

[12] These data do not include certified public expenditures made to state-run facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities in the state.

## Financing Factors Impacting Nursing Centers

### *1.* The Broader Medicaid Landscape

Over the past few years, and increasing in the coming year, there have 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).[13] 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. In addition, states have started to look at broader delivery system changes, such as the State Innovation Models Initiative and accountable care models, to impact the public health in their state. These models tend to focus, at least initially, on acute care rather than long term services and supports (LTSS) providers.

Payment adequacy for nursing center services continues to be less than 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. And, while this year's report shows improvements in rates paid to centers in many states, payment shortfalls remain significant. Further concerning is the omission of nursing centers from the Centers for Medicare and Medicaid Services (CMS) long-awaited Equal Access final regulation. Under this rule, states must develop an access plan and monitoring protocol for certain provider types for rate reductions. However, states may add long-term care providers to the access monitoring plan at their option.

### *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

[13] 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 states had to implement in 2014, 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.

insurance was projected to be 35.8 percent in 2015, while for nursing centers, private health insurance was projected to account for just 8.0 percent during this same time period.[14]

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. Despite this gap, 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 years,[15] 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, as of January 1, 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. Nursing centers in many states and municipalities further will be challenged to cover labor costs due to new state and/or local minimum wage laws. As these laws are enacted, it is unclear how public payers will respond to increased costs of delivering care.

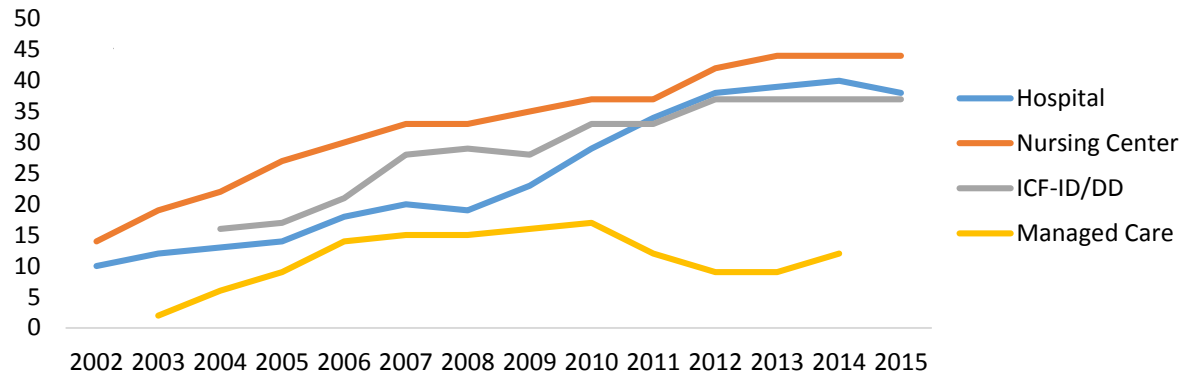
### *3.* Provider Taxes as a Funding Source for Rates

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 2015, more than twice as many – 43 states and the District of Columbia – have implemented nursing center provider tax programs. The majority of states with provider taxes increased them during the time period covered in this report; many adjust their tax estimates annually to account for increasing provider revenues.[16] See Figure 3, on page 11, for information about the number of states using provider taxes for different classes of providers over time.

[14] National Health Expenditure Projections 2013-2023 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
[15] 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
[16] AHCA Survey of State Affiliates

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




**Source:** Medicaid and CHIP Payment and Access Commission March 2012 Report to the Congress and KCMU 50 State Surveys from 2012 through 2014.

Total tax collections among nursing centers are approximately $5 billion annually.[17] While almost 90 percent of the states have implemented nursing center provider tax programs, and many continue to raise tax rates annually within statutory limits, few have used them exclusively to supplement state-funded rate increases, which would reduce Medicaid shortfalls. Instead, most states have used the tax proceeds to fund rate increases in lieu of state funded inflationary increases, to "back-fill" rate reductions or rate freezes from prior years, and/or to fund other areas of the Medicaid program.

Currently, in states with such programs, these taxes help to reimburse an average of approximately $26 per patient day in allowable Medicaid nursing center costs. Unfortunately, as previously stated, the taxes often simply substitute for a lack of commitment of state-share funds for rate increases. In essence, in many states, the taxes are funding the state share of Medicaid costs that should have been funded through state appropriations, but were not, due to budgetary or other economic reasons.

With most states either reducing, freezing, or minimally increasing funding for nursing center care during the recession, provider taxes have been instrumental in helping to avoid what would have been catastrophic shortfalls. However, with provider taxes being used in many states as a substitute for state appropriations, rather than as a supplement to them, such taxes have not had as significant an impact on reducing the shortfalls as might be expected.

In addition, many states are moving all or part of their 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, 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

[17] AHCA survey of state affiliates March 2016.

and federal matching dollars to provide supplemental payments,[18] 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.[19] 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.[20]

In practical terms, this means that states implementing Medicaid managed long term services and supports (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.[21]

### *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 that role has become increasingly difficult as a result of current Medicare rate reductions. According to the Medicare Payment Advisory Commission (MedPAC), the average margin on Medicare payment to freestanding nursing centers in 2014 is estimated to be 12.5 percent, with the 2016 margin projected at 10.7 percent. Of note, MedPAC margin calculations include fee-for-service (FFS) payments only.

[18] 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.
[19] 42 CFR 438.60
[20] 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.
[21] MACPAC. March 2012 Report to Congress.

Specifically, while MedPAC's margin analysis include Medicare, commercial payers and Medicaid, the Commission does not account for the decreasing proportion of overall revenue attributed to Medicare and Medicaid FFS. Decreases in the number of bed days covered by Medicare and Medicaid FFS are driven by increasing Medicare Advantage penetration rates, expansion of Medicaid Managed Care, and will be further impacted by CMS demonstrations such as Accountable Care Organizations and the Comprehensive Care Joint Replacement mandatory demonstration.

Our analysis indicates a 11.8 percent shortfall on Medicaid payment for 2015 (i.e., the weighted average 2015 shortfall of $22.46 divided by the weighted average Medicaid rate of $190.34). Assuming the 2015 Medicare margin is comparable to that projected in 2014, the 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. Estimated Combined Medicare/Medicaid Shortfall for 2015**

| Payer | 2015Average Rate | Days in Millions | Revenue in Billions | Margin (Shortfall as a % of Revenue) | Net Margin (Shortfall) in Billions |
|---|---|---|---|---|---|
| Medicare[22] | $ 513.89 | 71.9 | $36.93 | 12.5% | $4.62 |
| Medicaid | $190.34 | 312.4 | $59.47 | (11.8%) | ($7.02) |
| Net Medicare/Medicaid Shortfall | | | | | ($2.40) |
| Net Medicare/Medicaid Margin as a Percentage of Revenue | | | | | -2.5% |

Source: Medicare Rates based upon AHCA SNF PPS Simulation Model using CMS 2014 Medicare Part A claims data. Medicare Days from June 2015 CASPER data. Medicare margin percentage derived from December 2015 MedPAC meeting. Medicaid rates, days, and margins derived from this report.

If MedPAC's projected 2015 SNF margin of 10.7 percent were used instead of the higher 2014 SNF margin, the net Medicare/Medicaid shortfall would increase to $3.07 billion, or a negative 3.2 percent of revenue.

Anecdotal evidence indicates that both the rates negotiated and lengths of stay under Medicare managed care are lower than under the FFS program. Incorporating their margin data and days would likely result in an even greater net combined Medicare/Medicaid Shortfall than reflected in the table.

### *5.* State Budget and Medicaid Programmatic Trends

*State Fiscal Conditions*. 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. State spending levels are still below pre-recession highs set back in 2008 when factoring in inflation.[23] Looking forward to state fiscal year (SFY) 2016, general fund expenditures are projected

[22] These data are for Medicare Part A and do not reflect nursing center services provided under Part B or Medicare Advantage.

[23] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2015.

to grow moderately based on governors' recommended budgets. However, there is variation across states regarding their fiscal health. For example, energy producing states, such as Alaska, North Dakota, and West Virginia, are in particularly difficult budgetary situations due to oil prices and new environmental protection requirements, respectively.[24]

*State General Fund Expenditures.* In SFY 2016, state general fund expenditures are projected to increase 3.1 percent, a slower rate of growth than the estimated 4.6 percent increase in the previous fiscal year. Overall, budgets show general fund spending projected to increase to $779.6 billion in SFY 2016 as compared to an estimated $756.2 billion in 2015.[25] With reports emerging of uneven recoveries among the states and predicted state budget shortfalls, some states are still looking for ways to achieve savings, from Medicaid or other program areas.[26]

*Medicaid Spending.* Medicaid makes up a significant amount of state budgets currently,[27] and in the future, this will likely increase. For SFY 2015, total Medicaid spending was estimated to grow by 18.2 percent with state and federal funds increasing by 5.2 percent and 24.2 percent, respectively. This increase is driven largely by the Medicaid expansion that went into effect January 1, 2014. This trend is likely to continue as Governors' recommended budgets for SFY 2016 assume an increase in Medicaid spending of 5.2 percent in total funds— a 3.1 percent and 6.9 percent increase in state and federal spending, respectively. In the near term, federal spending on Medicaid has been increasing as the federal government pays for the full cost of the Medicaid expansion. In the future, state Medicaid spending is likely to increase as the federal matching rate for Medicaid expansion phases down to 90 percent between 2017 and 2020.[28]

*Medicaid Enrollment*. During this same time (SFY 2015), Medicaid enrollment was estimated to increase by 13.4 percent and is projected to increase an additional 4.6 percent in SFY 2016.[29] Much of this is likely due to certain states taking up the Medicaid expansion. Among states that had implemented the Medicaid expansion and were covering newly eligible adults in July 2015, Medicaid and CHIP enrollment rose by nearly 30 percent compared to the July-September 2013 baseline period. Among states that have not expanded Medicaid, enrollment increased approximately 9.9 percent over the same period.[30]

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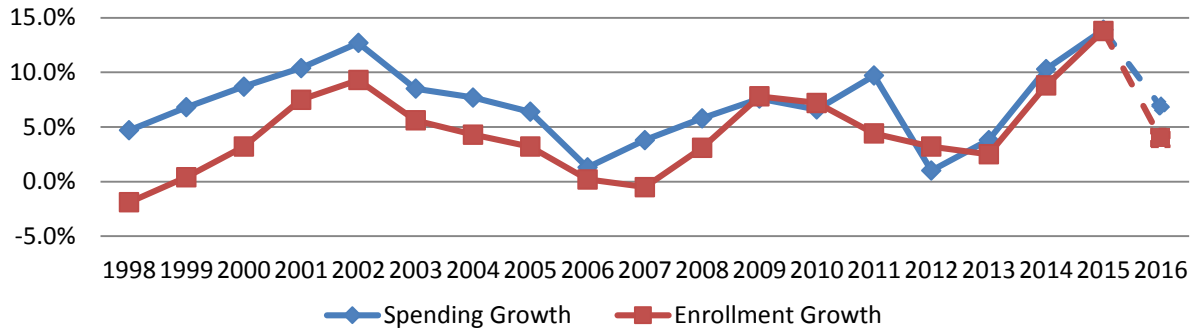
[24] Ibid
[25] Ibid
[26] Health Management Associates Weekly Roundup http://www.healthmanagement.com/publications/hma-weekly-roundup/
[27]Medicaid made up about 24.4 percent of total state spending from all funding sources (including the federal government) in SFY 2013.
[28] As a result of the Affordable Care Act, beginning in January 1, 2014 state Medicaid programs had the option to expand to cover non-pregnant, non-elderly individuals with incomes up to 138 percent of the federal poverty level. As of March 2014, 28 states and the District of Columbia had expanded Medicaid and a number of states continue to debate the issue.
[29] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2014.
[30] Based upon July 2015 enrollment data https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/july-2015-enrollment-report.pdf

Figure 4, below, shows the change in total Medicaid spending and enrollment between years. However, both spending and enrollment changes will vary by state, largely depending on whether or not a state is expanding Medicaid under the ACA.

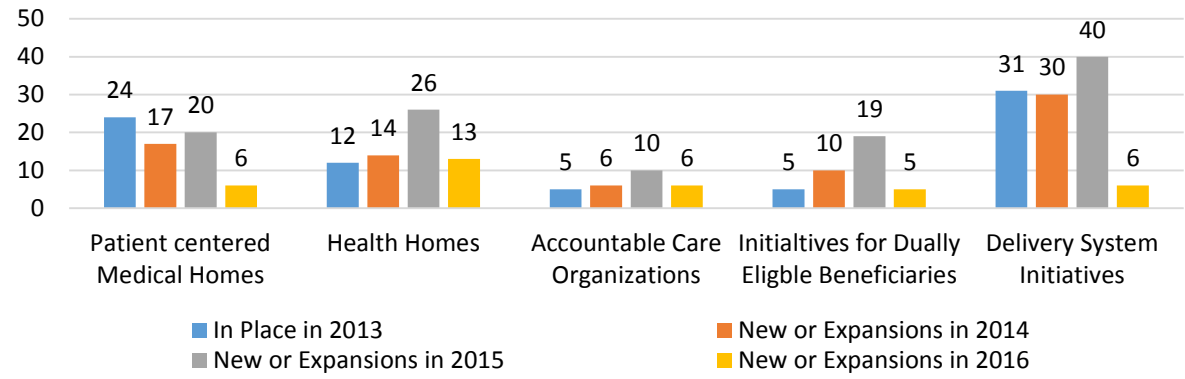
**Figure 4. Percent Change in Total Medicaid Spending and Enrollment, FY1998-FY2014**




**Source:** KCMU. Medicaid Emrollment & Spending Growth: FY 2015 & 2016. October 2015

Medicaid spending and enrollment, along with care delivery, is also driven by delivery system reform. Figure 5 below shows current and planned changes states are working on or anticipate in the coming year.

**Figure 5. Medicaid Delivery System Initiatives**




Source: KCMU. Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016. October 2015.

With states having finite resources relative to both funding and manpower, the competition for these resources among existing and new delivery models will be far more challenging in the future than it is today. In addition, as these initiatives expand to include LTSS, such changes could result in other entities setting nursing center rates and narrowing provider networks, which ultimately could impact beneficiary access to care.

### *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 non-security budget authority.[31] 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, this budget deal did not make large changes to the program. However, in the future, due to continued Medicaid growth and concerns about federal and state program oversight, 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. Already, Congressional hearings have been convened on Medicaid financing and program structure to prepare for 2017 Medicaid reform debates.

Another factor that could potentially influence financing in the future is the number of seniors living in poverty. 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.[32] 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.

[31] Congressional Budget Office. Sequestration Update Report: August 2012.
[32] 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

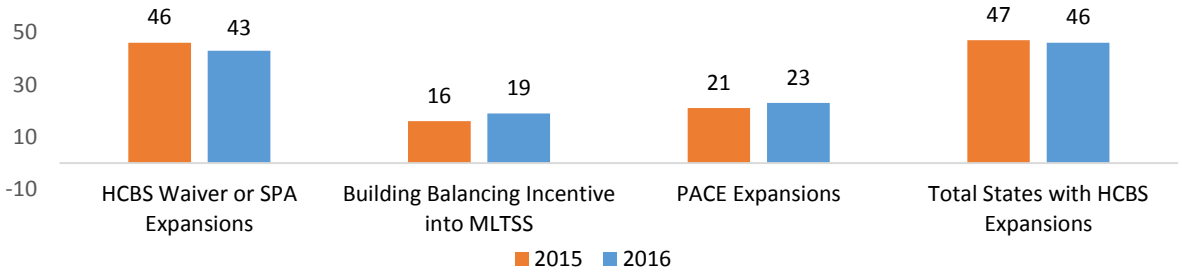
In response to rapidly increasing demand for LTSS and overall Medicare and Medicaid budgetary pressure, a number of trends, some long-standing and others new, will impact nursing centers.

### *1. Home and Community-Based Services Expansion*

States continue to heavily emphasize 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.[33] Recent analyses suggest that spending is now more evenly divided between HCBS and traditional long term care providers—at 51 percent and 49 percent, respectively[34]—a shift which has taken place largely over the past decade.

In 2015 and planned for 2016, states again are investing heavily in HCBS expansion efforts. In SFY 2015 and SFY 2016, 46 states expanded HCBS.[35] 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 2015 and 2016**




Source: KCMU. Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016. October 2015.

[33] Burwell, et. al. Medicaid Long Term Services and Supports Spending 2011. Thomson Reuters.
[34] Truven Health Analytics and Mathematica Policy Institute for the Centers for Medicare and Medicaid Services. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. June 2015.
[35]. KCMU. Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016. October 2015.

In addition, in January 2014, CMS issued a new HCBS rule which made a number of significant program changes. These changes included new requirements that define the qualities of settings and service delivery requirements that are eligible for Medicaid reimbursement under various waiver programs. States have raised questions and concerns regarding the differences in the populations able to receive HCBS and how their needs might vary, as well as how to honor personal choices of beneficiaries given the rule's emphasis on integration. They have also highlighted the difficulty some providers, especially those in rural areas, might face in complying with this new rule, both in terms of cost and physical plant changes.[36] This could impact the availability of Medicaid funding for certain providers if they are determined, based on the criteria laid out in this rule, to not meet definition of a community-based setting. Examples include assisted living and adult day. As a result, beneficiaries would have to find a new setting, either through some other community-based or traditional provider of long term care, for the services they receive.

### 2. ***Managed Care***

Medicaid 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 within the past few years, with an increasing number of states choosing to deliver LTSS through arrangements with managed care organizations (MCOs).[37]

An analysis of 16[38] states that, at the time of the report had implemented MLTSS in Medicaid, found that among the states offering these programs, only seven operated statewide, and in some cases only served specific populations. However, by 2017, researchers estimate that 31 states would have some form of MLTSS.[39] 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).[40]

*State Variation*. MLTSS programs differ widely from state to state, including the populations covered, whether enrollment is mandatory or voluntary, the geographic reach of the program, and the number of contracted plans per region.

Expansion of MLTSS 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

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36. KCMU. Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016. October 2015.

37 Medicaid and CHIP Payment and Access Commission (MACPAC). Vardaman, K., (Presenter). (2014). *Managed Long-Term Services and Supports: Overview and Themes from Site Visits* "Interview Transcript".

38 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.

39 Health Management Associates. MLTSS Network Adequacy: Meeting the Access Requirements of an Emerging Market. February 2016.

40 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 withdrawing.

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.

*Implementation Challenges.* While states have required plans to meet specific criteria relative to systems and processes prior to MLTSS implementation, there have been numerous transition issues impacting providers. Infrastructure and communication issues have resulted in disruptions in claims processing, payment and enrollment verification.

Although managed care is often portrayed as a better way to coordinate a person's care, there is evidence that plan delegation to subcontractors can undermine coordination efforts. This creates a difficult operating environment for providers. Authorizations for services are often delayed because subcontractors may not have signed contracts with their enrollees nor the necessary processes in place to issue authorizations for nursing center. In addition, nursing centers are required to contract with each subcontractor separately instead of entering a single contract with each of the health plans, creating additional administrative difficulty that did not exist under fee for service.

MACPAC noted several themes when staff presented preliminary findings from site visits at their October 2014 public meeting. They noted state variation in the development and implementation of assessment tools, quality measures,[41] the degree to which medical care is integrated (some LTSS programs are not incentivized to consider the full spectrum of Medicaid benefits), and the need for better preparation of the provider community for changes. Overall, staff reported that these visits revealed concerns from the stakeholder community about the inconsistency in LTSS service delivery by MCOs, inconsistent case management across plans, need for improvement in data infrastructure, oversight, and the need for new ways to incentivize better performance.

*State Incentives to Plans to Promote Rebalancing.* Under MLTSS 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.[42] 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.[43]

[41] According to plans and states, oversight primarily relies on process measures; there is a need for better assessment of MCO quality when providing LTSS.
[42] 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
[43] Ibid

*Looking Forward.* 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 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. Currently, ten states have a pay for performance program in place for nursing centers that provides meaningful incentives to providers, and seven of these are funded by provider tax programs. [44] However, 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. As part of a broader initiative to shift from "volume to value," CMS is imbedding value-based purchasing requirements into various regulations including the soon to be final Medicaid managed care regulation, supplemental payment approvals, and requirements for waiver approvals.

Research has raised concerns about VBP arrangements.[45] 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 a heightened demand for post-acute care following a hospital stay. Between 2010 and 2050, the U.S. population over age 65 is projected to double from 40.2 to 88.5 million.[46] The proportion of people

[44] AHCA survey of state affiliates.
[45] 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.
[46] Vincent, G. and Velkoff, V. The Next Four Decades – The Older Population in the United States: 2010 to 2050. U.S. Census Bureau.

age 85 and over will also significantly rise.[47] This, combined with the increased numbers over the past ten years of adults ages 45 to 64 and 65 and older with two or more chronic conditions likely to result in disability, will impact service needs.[48]

A majority of older adults are living longer lives than ever before. The population of seniors 85 and older will especially hold a greater presence in our societal framework than in the past.[49] According to the Census's Bureau's 2010 report, older adults 85 to 94 experienced the fastest growth between 2000 and 2010, expanding by 29.9 percent. The population of individuals 95 and older also experienced a similar growth rate of 25.9 percent.[50] This particular portion of the senior population, often considered the "oldest-old", is currently growing and will continue to increase as Baby Boomers age.

This projected growth in the 85 and older population will likely contribute to a greater need for services. Research has documented that the incidence of disability and support needs increases with age, particularly among those over age 85. 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.[51]

In addition to incidence of disability, the need for assistance with everyday activities also grows as people age. For example, nine percent of those between the ages of 65 and 69 need personal assistance, while up to 50 percent of older Americans over 85 need help with everyday activities.[52] Correlated with increasing age is the share of older adults in nursing centers. In 2010, 0.9 percent of the total population 65 to 74 years old resided in a nursing center compared to 10.4 percent of people ages 85 to 94 and 24.7 percent of people 95 years and over.[53] In terms of absolute numbers and percentages, the 85 and older population are the largest users of nursing center services.

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 and competing priorities will affect states' abilities to meet this demand both now and in the future.

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[47] 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.
[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.
[49] Ortman, J., Velkoff, V. and Hogan, H. An Aging Nation: The Older Population in the United States. U.S. Census Bureau.
[50] Werner, Carrie. The Older Population: 2010. United States Census Bureau. November 2011.
[51] Allen, K. (2005). Long Term Care Financing: Growing Demand and Cost of Services are Straining Federal and State Budgets. Government Accountability Office
[52] The American Psychological Association. "Older Adults' Health and Age-Related Changes: Reality Versus Myth". http://www.apa.org/pi/aging/resources/guides/older-adults.pdf
[53] http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf

## Nursing Center Outlook for 2015

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. The one positive element is the improving economy, which often leads to higher Medicaid rates. However, the research shows that the improvement in states is uneven, and many states are still not increasing rates for nursing centers commensurate with at least the rate of inflation.

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. Additionally, CMS is likely to make changes to the nursing center Medicare prospective payment system (PPS) in the near future, which could reduce current payments.

In the near term, as Congress considers additional changes to Medicare and prepares for a Medicaid debate, it is possible further changes will be considered to bad debt, provider tax, and supplemental payments. If Congress were to make such changes to bad debt and provider tax, state Medicaid agencies and the profession would suffer significant budgetary challenges.

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, while maintaining and/or improving quality of care, 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 increase 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 agreed to participate 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 2013 (or 2014, 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 2013, but between current (FY 2015) rates and 2013 (or 2014, if available) costs trended to the same time period.[54]

Eljay and HHC were 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 almost two-thirds of the participating states. Eljay and HHC 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 2013 (or 2014 if available) were derived for 33 states, representing approximately 76 percent of the Medicaid patient days in the country. Current Medicaid rates by provider were also obtained, allowing us to determine an estimated 2015 shortfall for these states. States included in this report reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide. It also includes the nine states that represent half of all days covered under the Medicaid program: California, Florida, Illinois, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.

[54] 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 $2.67 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 $5.33 per Medicaid patient day.

## Appendix 2

**Calculation of 2013 and Projected 2015**
**Weighted Average Medicaid Shortfall**
**State-by-State Comparison**

| Table A2-1. Calculation of 2013 Weighted Average Medicaid Shortfall | | | | | | | |
|---|---|---|---|---|---|---|---|
| State | 2013 Rate | 2013 Cost | 2013 Difference | Annual Medicaid Days | Gross Revenue | Gross Cost | Total Difference |
| **Arizona** | $198.53 | $206.93 | ($8.40) | 2,436,375 | $483,693,942 | $504,166,733 | ($20,472,791) |
| **California** | $180.97 | $199.03 | ($18.06) | 25,186,460 | $4,557,913,182 | $5,012,792,578 | ($454,879,396) |
| **Colorado** | $220.55 | $226.96 | ($6.41) | 3,587,585 | $791,239,024 | $814,240,897 | ($23,001,873) |
| **Connecticut** | $229.84 | $250.75 | ($20.91) | 6,141,490 | $1,411,556,648 | $1,539,977,437 | ($128,420,789) |
| **Delaware** | $249.72 | $250.80 | ($1.09) | 921,625 | $230,146,685 | $231,148,011 | ($1,001,327) |
| **Florida** | $218.64 | $226.40 | ($7.75) | 15,468,335 | $3,382,048,102 | $3,501,990,505 | ($119,942,403) |
| **Georgia**[55] | $157.33 | $163.76 | ($6.43) | 8,753,430 | $1,377,176,444 | $1,433,427,144 | ($56,250,700) |
| **Hawaii**[56] | $259.34 | $272.85 | ($13.50) | 908,485 | $235,610,539 | $247,877,541 | ($12,267,003) |
| **Illinois** | $132.82 | $165.87 | ($33.05) | 16,907,165 | $2,245,631,636 | $2,804,335,571 | ($558,703,935) |
| **Iowa** | $158.85 | $171.51 | ($12.65) | 4,286,560 | $680,932,108 | $735,169,552 | ($54,237,444) |
| **Kansas** | $152.67 | $164.00 | ($11.34) | 3,826,295 | $584,147,700 | $627,529,790 | ($43,382,091) |
| **Maine** | $183.72 | $206.44 | ($22.72) | 1,523,875 | $279,966,315 | $314,585,206 | ($34,618,892) |
| **Maryland** | $242.44 | $252.36 | ($9.92) | 5,491,790 | $1,331,439,898 | $1,385,921,790 | ($54,481,892) |
| **Massachusetts** | $196.46 | $230.22 | ($33.76) | 9,585,995 | $1,883,245,895 | $2,206,880,629 | ($323,634,735) |
| **Minnesota** | $170.84 | $205.40 | ($34.56) | 5,314,035 | $907,832,539 | $1,091,487,974 | ($183,655,435) |
| **Missouri** | $149.01 | $162.50 | ($13.49) | 8,591,005 | $1,280,123,339 | $1,396,017,487 | ($115,894,148) |
| **Montana** | $178.88 | $192.79 | ($13.91) | 965,425 | $172,698,000 | $186,124,649 | ($13,426,649) |
| **Nebraska** | $157.86 | $182.69 | ($24.82) | 2,313,005 | $365,139,832 | $422,559,645 | ($57,419,813) |
| **Nevada** | $197.96 | $220.84 | ($22.88) | 994,625 | $196,898,897 | $219,655,290 | ($22,756,393) |
| **New Jersey** | $204.37 | $235.76 | ($31.38) | 10,318,550 | $2,108,828,651 | $2,432,660,594 | ($323,831,943) |
| **New Mexico** | $165.10 | $190.26 | ($25.15) | 1,384,080 | $228,515,125 | $263,328,635 | ($34,813,510) |
| **New York** | $226.03 | $270.53 | ($44.50) | 27,117,310 | $6,129,255,358 | $7,336,032,088 | ($1,206,776,729) |
| **North Dakota** | $232.78 | $240.86 | ($8.08) | 1,070,910 | $249,281,224 | $257,937,465 | ($8,656,241) |

[55] For these states, the Medicaid rates do not include supplemental payments made to the non-state government-owned facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities.

[56] These data do not include certified public expenditures made to state-run facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities in the state.

| Table A2-1. Calculation of 2013 Weighted Average Medicaid Shortfall | | | | | | | |
|---|---|---|---|---|---|---|---|
| **State** | **2013 Rate** | **2013 Cost** | **2013 Difference** | **Annual Medicaid Days** | **Gross Revenue** | **Gross Cost** | **Total Difference** |
| **Ohio** | $174.52 | $190.88 | ($16.36) | 17,923,325 | $3,127,953,785 | $3,421,251,491 | ($293,297,706) |
| **Oklahoma** | $144.26 | $155.38 | ($11.12) | 4,951,225 | $714,263,719 | $769,321,341 | ($55,057,622) |
| **Pennsylvania** | $211.16 | $234.03 | ($22.87) | 18,018,955 | $3,804,882,675 | $4,217,016,518 | ($412,133,842) |
| **Texas** | $132.41 | $149.29 | ($16.87) | 21,867,515 | $2,895,555,470 | $3,264,557,728 | ($369,002,258) |
| **Utah**[55] | $184.74 | $200.00 | ($15.25) | 1,042,075 | $192,517,439 | $208,413,121 | ($15,895,682) |
| **Vermont** | $214.79 | $231.68 | ($16.89) | 642,765 | $138,061,586 | $148,918,260 | ($10,856,674) |
| **Virginia** | $160.56 | $167.93 | ($7.37) | 6,264,495 | $1,005,828,095 | $1,052,000,975 | ($46,172,879) |
| **Washington** | $190.75 | $219.93 | ($29.18) | 3,805,855 | $725,952,748 | $837,014,414 | ($111,061,666) |
| **Wisconsin** | $163.29 | $214.09 | ($50.80) | 6,041,845 | $986,568,266 | $1,293,492,631 | ($306,924,365) |
| **Wyoming** | $219.69 | $237.96 | ($18.28) | 501,875 | $110,255,202 | $119,427,095 | ($9,171,893) |
| Totals | | | | 244,154,340 | $44,815,160,067 | $50,297,260,784 | ($5,482,100,717) |
| Weighted Average | | | | | $183.55 | $206.01 | ($22.45) |
| Shortfall Extrapolated to all 50 states and DC | | | | | | | ($7,218,268,105) |
| Total States | | | | | | | 33 |
| Percentage of days | | | | | | | 76.3% |

[55] For these states, the Medicaid rates do not include supplemental payments made to the non-state government-owned facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities.

| Table A2-2. Calculation of Projected 2015 Weighted Average Medicaid Shortfall | | | | | | | |
|---|---|---|---|---|---|---|---|
| State | 2015 Rate | 2015 Cost | 2015 Difference | Annual Medicaid Days | Gross Revenue | Gross Cost | Total Difference |
| **Arizona** | $208.12 | $217.10 | ($8.99) | 2,507,915 | $521,936,855 | $544,480,552 | ($22,543,697) |
| **California** | $191.33 | $205.50 | ($14.17) | 24,314,475 | $4,652,046,659 | $4,996,687,971 | ($344,641,313) |
| **Colorado** | $225.23 | $232.05 | ($6.82) | 3,632,480 | $818,131,367 | $842,920,995 | ($24,789,628) |
| **Connecticut** | $230.06 | $255.04 | ($24.98) | 5,987,095 | $1,377,408,558 | $1,526,965,118 | ($149,556,560) |
| **Delaware** | $256.69 | $258.34 | ($1.65) | 945,350 | $242,660,856 | $244,225,007 | ($1,564,151) |
| **Florida** | $225.14 | $231.81 | ($6.67) | 15,181,810 | $3,418,043,352 | $3,519,290,713 | ($101,247,361) |
| **Georgia**[57] | $164.02 | $171.81 | ($7.79) | 8,704,520 | $1,427,713,582 | $1,495,539,560 | ($67,825,978) |
| **Hawaii**[58] | $260.77 | $281.85 | ($21.08) | 808,475 | $210,827,318 | $227,871,490 | ($17,044,172) |
| **Illinois** | $145.99 | $171.08 | ($25.09) | 15,923,125 | $2,324,663,036 | $2,724,099,774 | ($399,436,737) |
| **Iowa** | $165.39 | $177.64 | ($12.25) | 4,388,760 | $725,855,907 | $779,637,062 | ($53,781,155) |
| **Kansas** | $158.70 | $169.14 | ($10.45) | 3,609,485 | $572,807,625 | $610,511,826 | ($37,704,201) |
| **Maine** | $200.58 | $213.50 | ($12.92) | 1,514,020 | $303,685,580 | $323,249,618 | ($19,564,038) |
| **Maryland** | $239.37 | $257.99 | ($18.62) | 5,467,335 | $1,308,742,676 | $1,410,522,930 | ($101,780,254) |
| **Massachusetts** | $201.44 | $236.70 | ($35.26) | 9,275,015 | $1,868,334,141 | $2,195,380,248 | ($327,046,107) |
| **Minnesota** | $179.96 | $214.00 | ($34.04) | 5,080,800 | $914,334,989 | $1,087,301,455 | ($172,966,466) |
| **Missouri** | $152.66 | $167.57 | ($14.90) | 8,867,675 | $1,353,783,332 | $1,485,932,104 | ($132,148,773) |
| **Montana** | $183.34 | $200.48 | ($17.14) | 968,345 | $177,541,083 | $194,137,905 | ($16,596,822) |
| **Nebraska** | $161.87 | $186.93 | ($25.06) | 2,327,605 | $376,769,580 | $435,087,733 | ($58,318,153) |
| **Nevada** | $201.41 | $224.12 | ($22.71) | 1,002,655 | $201,943,071 | $224,712,457 | ($22,769,386) |
| **New Jersey** | $207.35 | $242.67 | ($35.32) | 10,027,280 | $2,079,158,015 | $2,433,358,088 | ($354,200,073) |
| **New Mexico** | $168.00 | $192.73 | ($24.73) | 1,366,560 | $229,585,432 | $263,375,322 | ($33,789,890) |
| **New York** | $234.16 | $282.59 | ($48.43) | 26,284,380 | $6,154,773,882 | $7,427,662,763 | ($1,272,888,881) |
| **North Dakota** | $250.51 | $248.08 | $2.42 | 1,030,760 | $258,212,124 | $255,715,018 | $2,497,106 |
| **Ohio** | $175.10 | $196.79 | ($21.69) | 17,101,345 | $2,994,434,787 | $3,365,347,092 | ($370,912,306) |

[57] For these states, the Medicaid rates do not include supplemental payments made to the non-state government-owned facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities.

[58] These data do not include certified public expenditures made to state-run facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities in the state.

| Table A2-2. Calculation of Projected 2015 Weighted Average Medicaid Shortfall | | | | | | | |
|---|---|---|---|---|---|---|---|
| **State** | **2015 Rate** | **2015 Cost** | **2015 Difference** | **Annual Medicaid Days** | **Gross Revenue** | **Gross Cost** | **Total Difference** |
| **Oklahoma** | $144.08 | $158.89 | ($14.81) | 4,663,970 | $671,984,798 | $741,058,193 | ($69,073,396) |
| **Pennsylvania** | $216.75 | $242.18 | ($25.43) | 18,005,450 | $3,902,641,343 | $4,360,530,748 | ($457,889,405) |
| **Texas** | $141.64 | $154.18 | ($12.55) | 21,264,535 | $3,011,813,057 | $3,278,638,865 | ($266,825,808) |
| **Utah**[57] | $188.70 | $205.21 | ($16.51) | 1,079,670 | $203,736,594 | $221,559,187 | ($17,822,593) |
| **Vermont** | $217.23 | $234.98 | ($17.76) | 638,385 | $138,674,235 | $150,010,834 | ($11,336,599) |
| **Virginia**[57] | $173.81 | $173.49 | $0.32 | 6,126,525 | $1,064,876,464 | $1,062,911,042 | $1,965,422 |
| **Washington** | $197.32 | $225.15 | ($27.83) | 3,720,080 | $734,037,279 | $837,583,774 | ($103,546,495) |
| **Wisconsin** | $167.85 | $220.68 | ($52.84) | 5,950,230 | $998,720,637 | $1,313,123,110 | ($314,402,473) |
| **Wyoming** | $224.12 | $249.04 | ($24.92) | 517,570 | $115,997,303 | $128,895,047 | ($12,897,744) |
| Totals | | | | 238,283,680 | $45,355,875,519 | $50,708,323,603 | ($5,352,448,084) |
| Weighted Average | | | | | $190.34 | $212.81 | (22.46) |
| Shortfall Extrapolated to all 50 states | | | | | | | ($7,018,283,095) |
| Total States | | | | | | | 33 |
| Percentage of days | | | | | | | 76.3% |

[57] For these states, the Medicaid rates do not include supplemental payments made to the non-state government-owned facilities. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by privately owned and operated facilities.

## Appendix 3

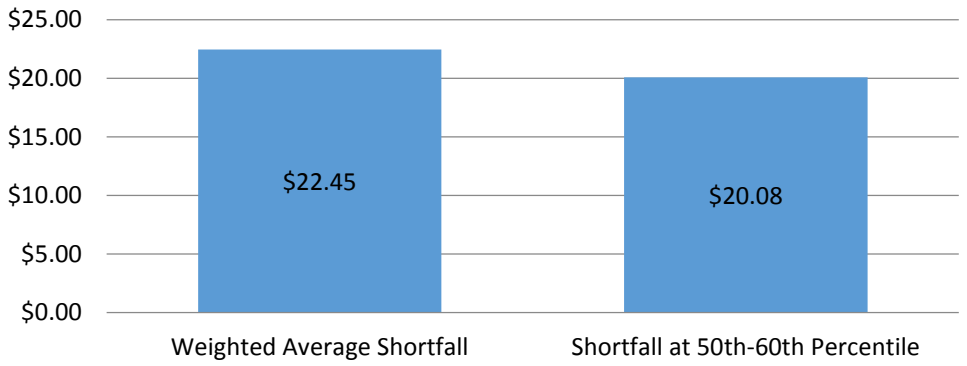
## Impact of High Cost Providers on the Medicaid Average Shortfall

## 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 2013 costs between the 50th and 60th percentile is reflected in Figure A3-1, below.

**FIGURE A3-1. 2013 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 $2.38 less than average shortfall nationwide. This analysis demonstrates that Medicaid payment is substantially inadequate in reimbursing even reasonable cost providers.