

# **A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care**

---

**American Health Care Association**

**August 30, 2001**

**Prepared By**

**BDO Seidman, LLP**

---

# **A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care**

# Table of Contents

---

<u>Chart Title</u>	<u>Page</u>
◆ 1999 Average Medicaid Shortfall Per Patient Day by Region	1
◆ 1999 Average Disparity by State Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs	2
◆ 15 States with the Greatest Disparity in 1999 Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs	3
◆ Disparity By State Between Total Medicaid Revenue and Total Allowable Medicaid Costs	4
◆ Medicaid Shortfall Extrapolated To All 50 States	5

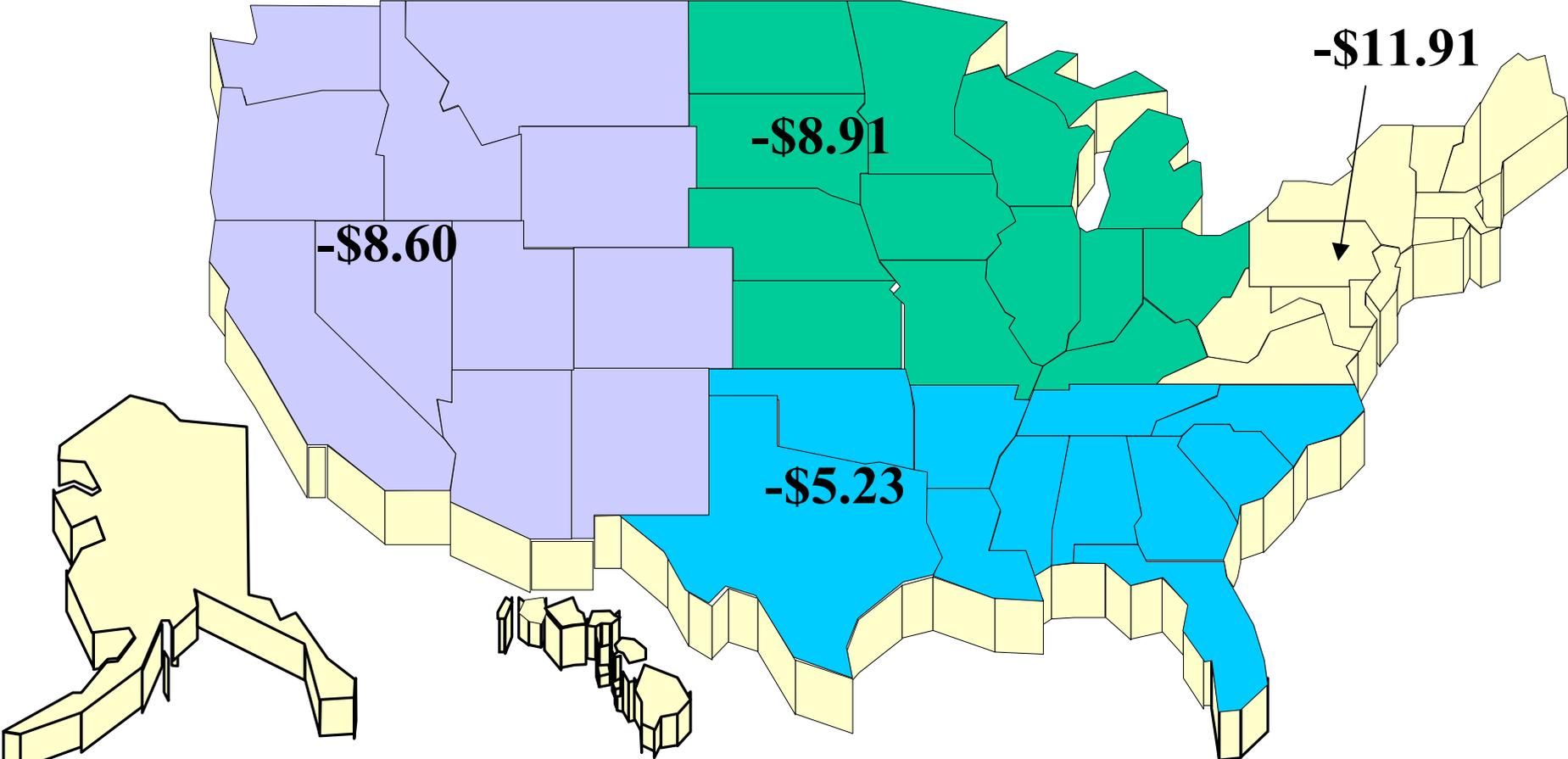
# Table of Contents (Continued)

---

<u>Chart Title</u>	<u>Page</u>
◆ Appendix 1: BDO Seidman, LLP Observations and Comments	7
◆ Appendix 2: Project Approach and Methodology	11
◆ Appendix 3: Data Collection Document	13
◆ Appendix 4: Calculation of 1999 Weighted Average Medicaid Shortfall	15

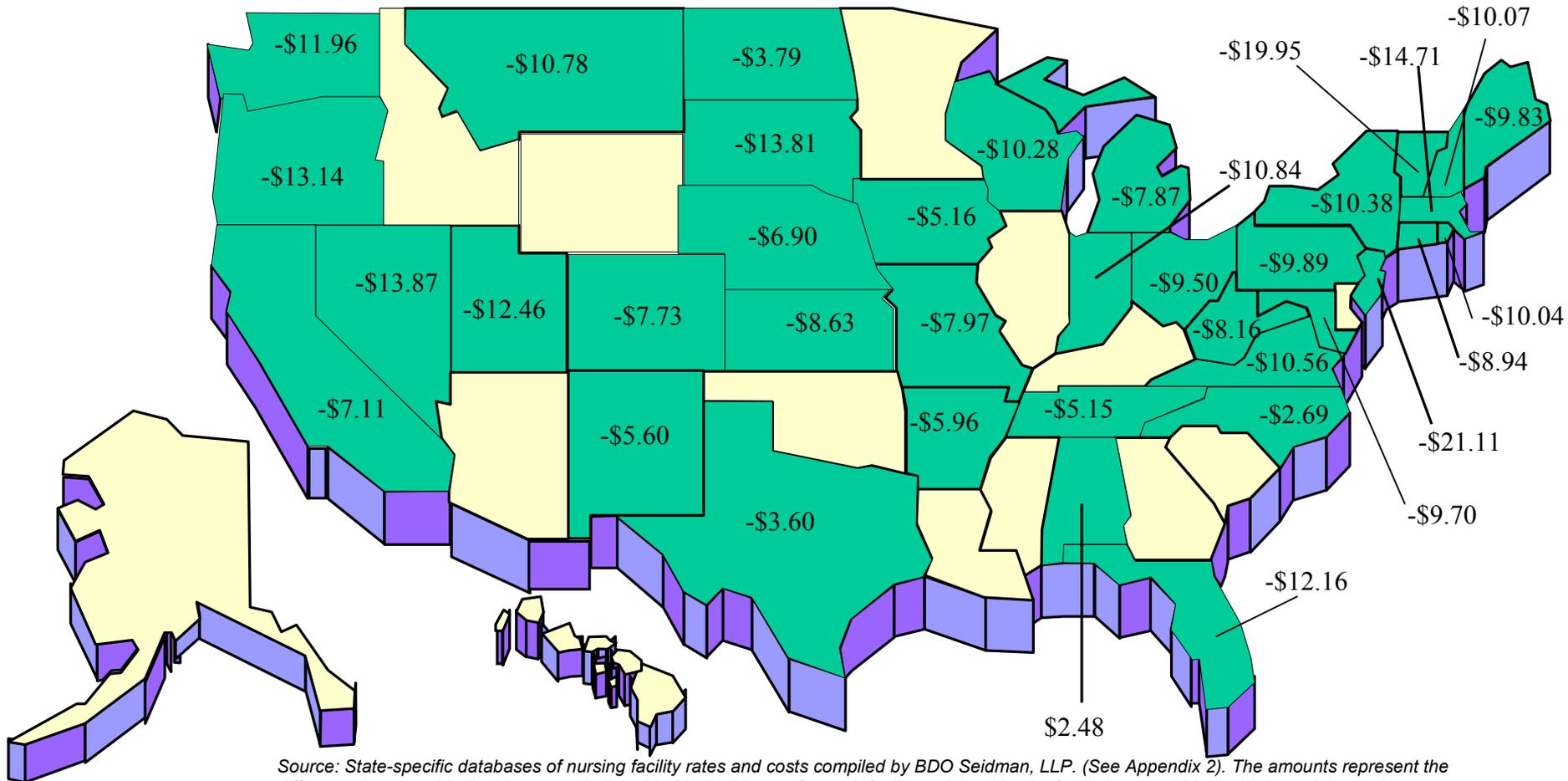
# In 1999, on Average, the Shortfall in Medicaid Reimbursement Exceeded \$9 Each Day on Every Medicaid Patient

## 1999 Average Unreimbursed Allowable Medicaid Cost Per Patient Day by Region



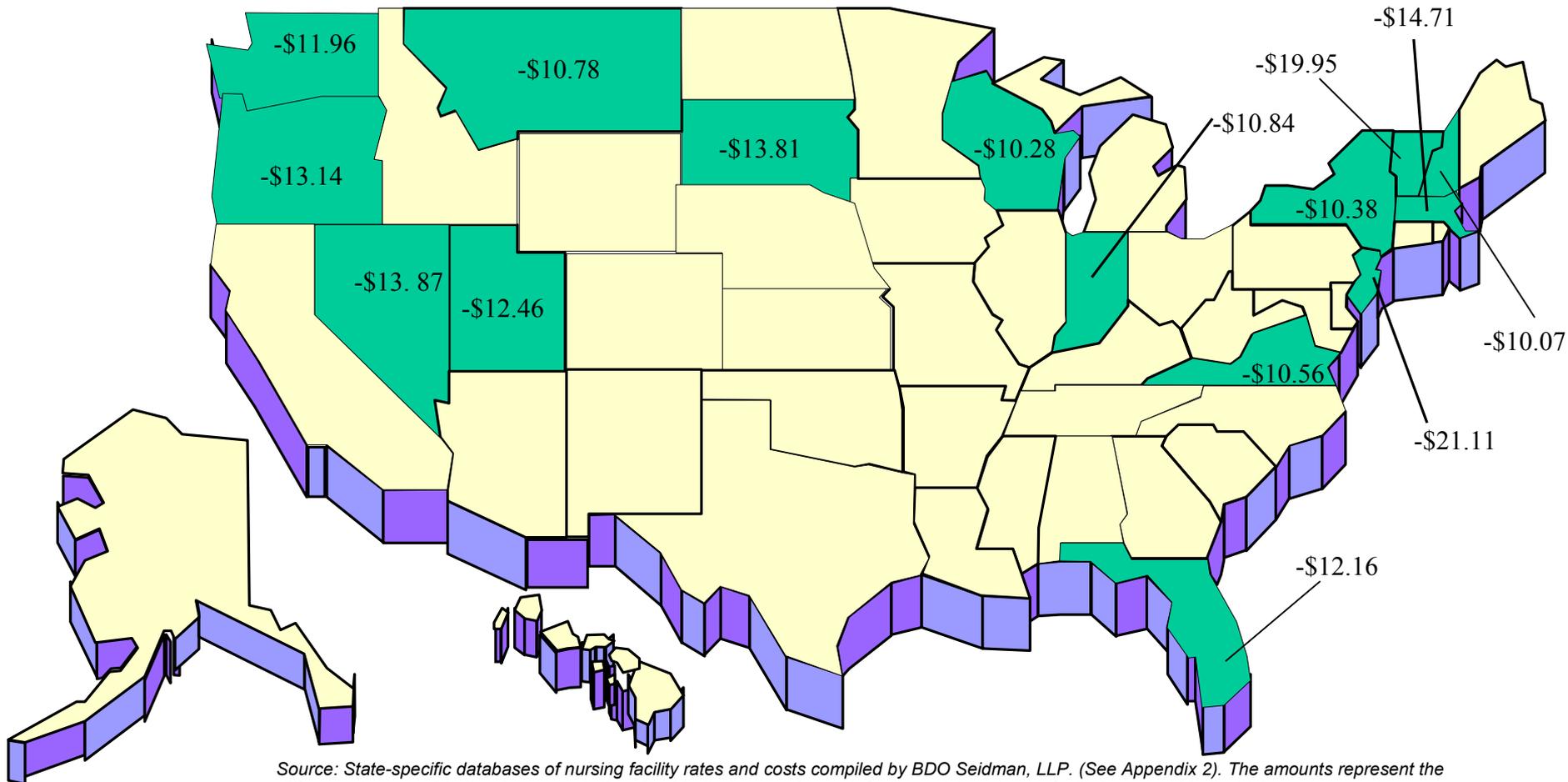
Source: State-specific databases of nursing facility rates and costs compiled by BDO Seidman, LLP. (See Appendix 2). The amounts represent the difference between Medicaid rates and allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case, the shortfalls would be much higher.

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



Source: State-specific databases of nursing facility rates and costs compiled by BDO Seidman, LLP. (See Appendix 2). The amounts represent the difference between Medicaid rates and allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case, the shortfalls would be much higher.

# 15 States with the Greatest Disparity Between Medicaid Rates and Allowable Medicaid Per Patient Day Costs<sup>1</sup>

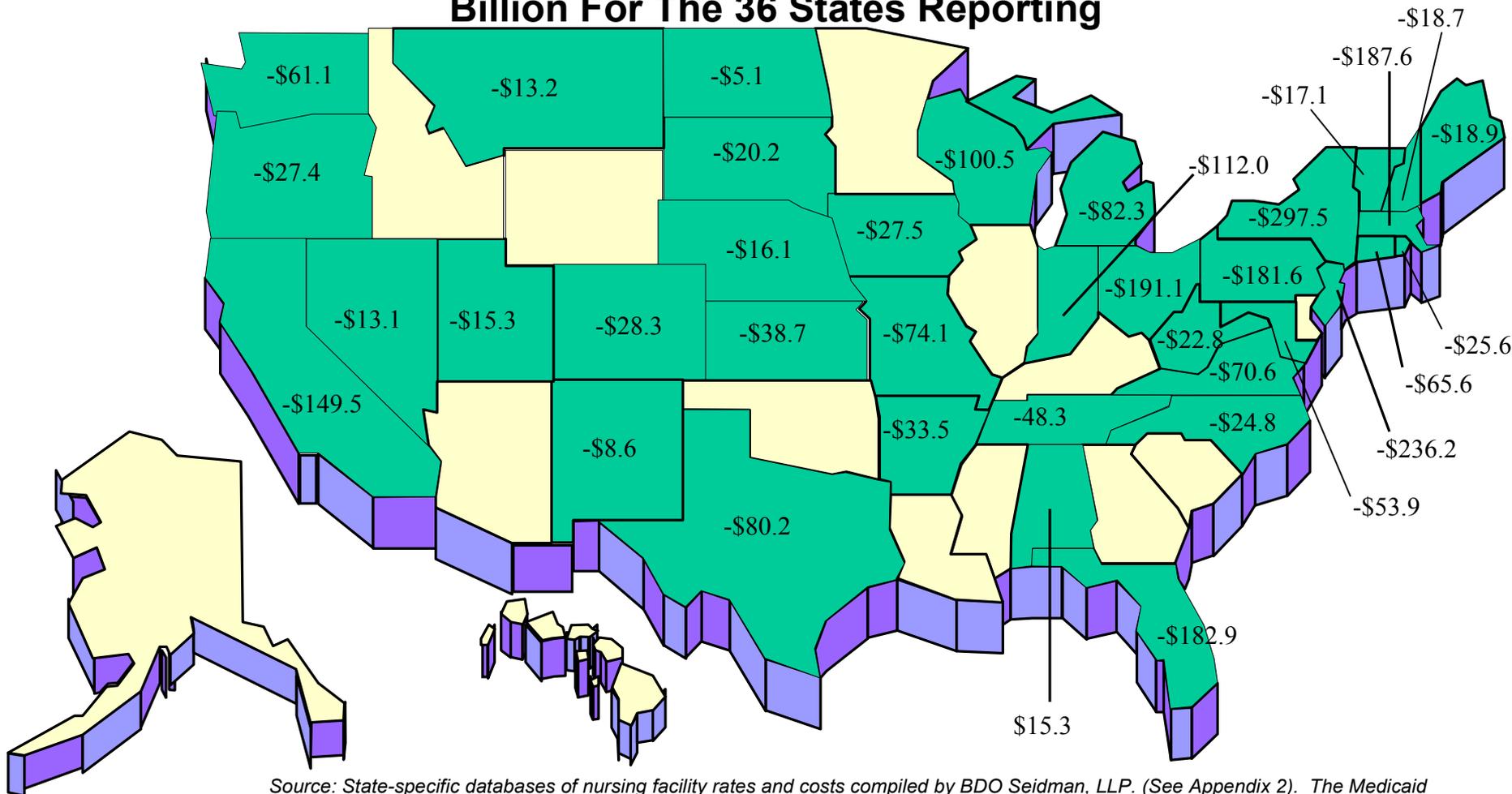


Source: State-specific databases of nursing facility rates and costs compiled by BDO Seidman, LLP. (See Appendix 2). The amounts represent the difference between Medicaid rates and allowable Medicaid costs for each facility weighted by the facility's annual Medicaid days. It is not the average disparity between Medicaid rates and costs for only those facilities experiencing shortfalls in Medicaid reimbursement. If this were the case, the shortfalls would be much higher.

(1) Florida, Nevada, Oregon, Virginia and Wisconsin all provided significant funding increases since 1999. However, their current shortfalls continue to be significant given escalating staffing costs resulting from the current labor shortage and skyrocketing liability insurance costs especially in Florida.

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

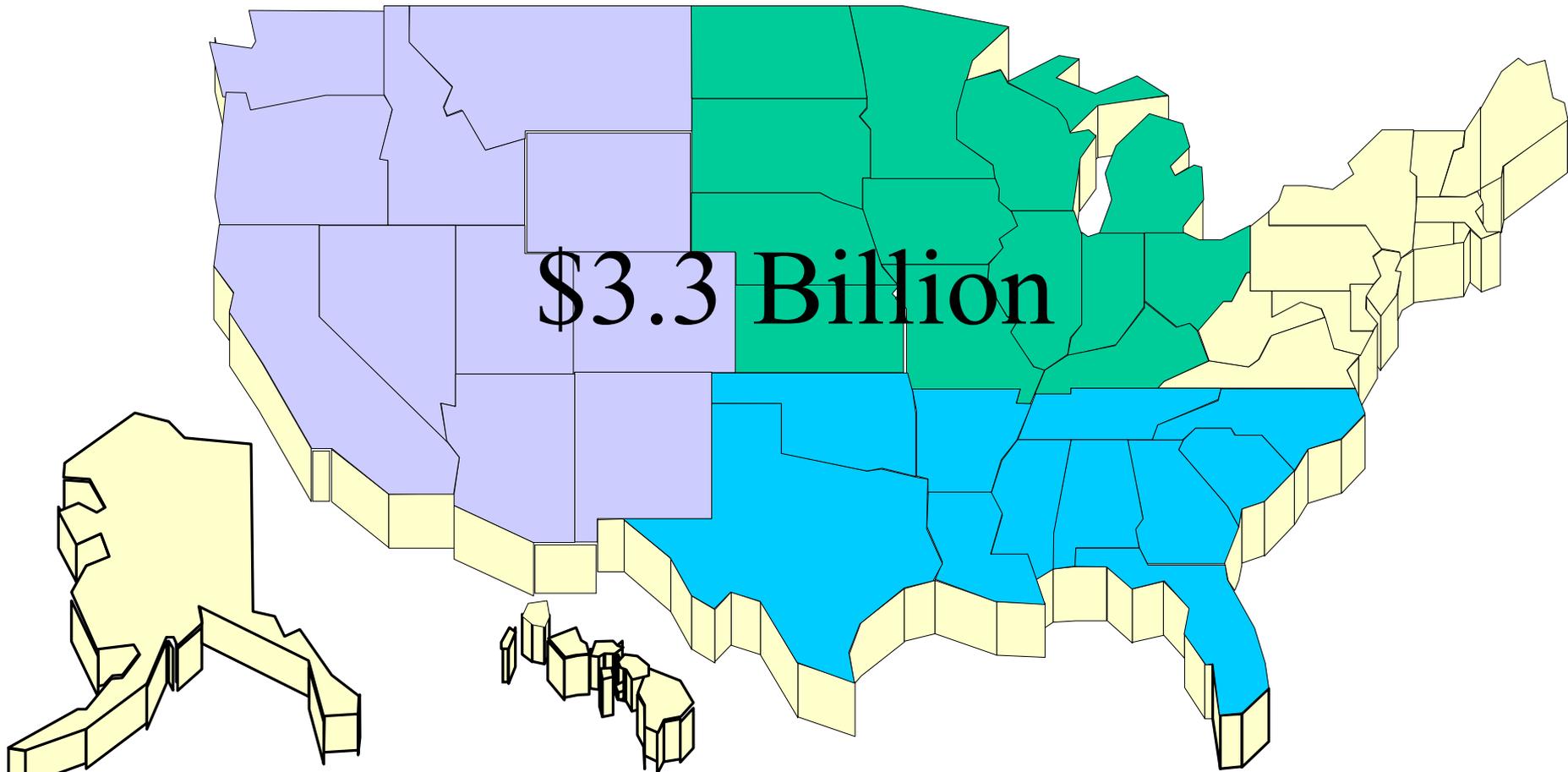
**Unreimbursed Medicaid Allowable Costs Exceeded \$2.5 Billion For The 36 States Reporting**



Source: State-specific databases of nursing facility rates and costs compiled by BDO Seidman, LLP. (See Appendix 2). The Medicaid days used in deriving state-specific shortfalls were derived from the data collection instrument or HCFA-OSCAR Form 671: F 75-78, current surveys as of September, 2000

# Medicaid Shortfall Extrapolated To All 50 States

Unreimbursed Medicaid Allowable Cost of . . . .



Source: The weighted average shortfall for the 36 states reporting was \$2.5 billion dollars, based upon 279.9 million Medicaid days. Extrapolating this shortfall to 368.5 million Medicaid days nationwide (per HCFA-OSCAR Data) results in a \$3.3 billion national shortfall.

---

# Appendix 1

## BDO Observations and Comments

# BDO Observations and Comments

---

BDO Seidman LLP, (BDO) was engaged by the American Health Care Association (AHCA) to work with their state affiliates and other sources to compile information on the shortfall between Medicaid reimbursement and allowable Medicaid costs in as many states as feasibly possible. The compilation was derived from 1999 rate and cost report data; the latest year in which audited or desk-reviewed cost report information was available for most states.

The results, based upon data from 36 states, indicate that nationwide, the average shortfall in Medicaid reimbursement exceeded \$9 each day on every Medicaid patient. In 1999, unreimbursed Medicaid allowable costs exceeded \$2.5 billion for these 36 states and over \$3.3 billion when the results are extrapolated to all 50 states. If all costs of operations were considered, not just Medicaid allowable costs (see Appendix 2), the \$3.3 billion shortfall would be significantly greater. BDO's experience is that Medicaid cost disallowances typically represents 2-4% of total reported costs.

While historically, Medicaid programs have always cost-shifted to other payors, increasing Medicaid shortfalls and greater emphasis on higher staffing and better outcomes have made cost-shifting increasingly difficult in that:

1. Medicaid is the payor source for approximately 60-70% of residents in any state;
2. Cost shifting to Medicare is less plausible given that it is no longer a "cost-based" program; payment rates are fixed; and Medicare residents only account for approximately 7-10% of total patient census in a nursing home; and
3. Private pay occupancy is declining due to the proliferation of other service delivery options such as assisted living and home and community-based programs. Increasing choices for the elderly have reduced private census in nursing homes and made the charges for nursing home services far more competitive.

Based upon our experience in consulting on payment issues in over 25 states, and having been involved in the redesign or modification of payment systems in 10 states over the past three years, shortfalls in Medicaid reimbursement are truly increasing for a number of reasons.

## State Budget Limitations

According to information from The National Council of State Legislatures (NCSL) released in January 2001, 23 states reflected a Medicaid shortfall in their budget. Revenue growth has slowed with only 31 states indicating that revenues were on target or above forecasted levels; down from 44 states just two months earlier. Previously, with Medicaid enrollees down and revenues up – states could manage their Medicaid programs. Now, Medicaid utilization is increasing again (especially relative to non nursing home services) and the economy is softening - all adding up to tough times for states to fund their Medicaid programs.

# BDO Observations and Comments

---

With less prosperous times on the horizon, states have felt pressure to slow the growth in nursing home rates and to reduce services. Major Medicaid funding battles have occurred in state legislatures all over the country including, but not limited to, California, Florida, Indiana, Kentucky, Nevada, New Jersey, North Carolina, Ohio, and Wisconsin. In the three Medicaid rate system redesigns that BDO has been involved in this year (Wisconsin, New Jersey, and Nevada), budget limitations have not allowed rates to be set at levels that would have been mandated under recently repealed federal requirements for adequate reimbursement rates.

## Lack of Statutory Protections

Long-term care facilities currently have no federal statutory protections for adequate reimbursement rates. Providers have little assurance that the rates paid to them by the Medicaid program will adequately cover their costs. The Balanced Budget Act of 1997 repealed the “Boren Amendment”, which required states to make findings and assurances that rates were “reasonable and adequate to meet the costs that must be incurred by efficiently and economically-operated facilities”. In its place is a public notice and comment process affording providers and beneficiaries opportunities to only comment on proposed rates and methodologies. States no longer have to conduct findings or prepare any reasoned analysis to demonstrate the adequacy of their rates.

For example, the states of New Jersey, Wisconsin, and Nevada recently proposed implementation of a Medicaid payment system which paid a “price” for a given patient debility level; a plan similar to the Medicare Prospective Payment System (PPS). However, in all three cases, the price was driven by the budget, without an examination or empirical analysis as to whether the price was adequate to fund the resources required to deliver quality care and services and meet the expectations of both regulators and consumers. In other words, state budgets are now solely driving payment rather than an identification of the cost of resources necessary to deliver quality patient care.

## CMS Restrictions on Intergovernmental Transfers

The Center for Medicare and Medicaid Services (formerly HCFA), has issued regulations to restrict the amount of federal dollars that can be obtained through intergovernmental transfers. Though providing for transition periods, these new regulations will severely limit the amount of additional federal dollars that states can obtain through this mechanism. Many states are highly dependent on these funds and will possibly have to implement rate and/or service cuts to providers and beneficiaries to compensate for reduced federal funding.

## Escalating Nursing Home Costs

Nursing home costs are increasing faster than the general rate of inflation and/or increases specified in most state budgets. This is due to a number of factors:

# BDO Observations and Comments

---

1. A shift of “lower care” Medicaid residents from nursing home environments to other settings, leaving the more frail and debilitated residents who require greater staffing and services;
2. An extreme labor shortage requiring salary and benefit increases beyond normal price inflation as well as increased use of more expensive temporary nursing agency help;
3. Increasing pressure from consumers, other advocates and regulators to increase staffing and improve patient outcomes;
4. Skyrocketing costs in certain non-labor areas such as liability insurance and utility costs;
5. Lower occupancy due to other elderly service delivery options resulting in higher “fixed costs” per diem; and
6. A higher “cost of capital” due a lack of confidence and uncertainty by both lenders and the capital markets relative to long-term care.

Most states fail to adequately account for these escalating costs by using cost inflators that are not reflective of actual nursing home cost increases and by using cost data that is often many years old. New York, for example, uses cost data from 1983 in rate setting for most facilities, rather than more current nursing home cost data.

Other states may use more current cost data but often lower the maximum level of payment to meet budgetary constraints. If, for example, nursing home costs are increasing 6% per annum and the budget calls for a 2% increase in funding, the maximum payment level must be reduced to make the payment system “fit” the budget. The result is fewer facilities being fully compensated for their costs of care for Medicaid patients and increasing Medicaid shortfalls. Wisconsin is a perfect example, where over a decade, the maximum payment level in the direct patient care area dropped by almost 13%, net of inflation.

Even when states provide substantial increases in funding in a given year, as seen very recently in Wisconsin, Nevada, and Oregon; the increase is still not adequate to assure that at least half of the providers, let alone a substantial majority, are fully reimbursed their actual allowable Medicaid costs.

---

## **Appendix 2**

# **Project Approach and Methodology**

# Project Approach and Methodology

---

The American Health Care Association initially surveyed their state affiliates as to the availability of a database of state-specific Medicaid rate and allowable cost information. Those that responded in the affirmative were asked to complete a “data collection document” reflecting the weighted average Medicaid rates and allowable costs for those years for which data was available. The data collection document is included as Appendix 3.

BDO Seidman, LLP, (BDO) was engaged to assist in this process by:

1. Developing the data collection document;
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; and
5. Compiling the results into a report.

In all cases, the state affiliates indicated that the data was derived from a database of Medicaid rates and allowable costs obtained from their state agency. Allowable costs include only those costs recognized by the state agency as directly or indirectly related to patient care and typically excluded necessary operating costs including, but not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of facilities, and out-of-state travel. In almost all cases, the cost database reflected costs that have been audited or desk-reviewed by the Medicaid state agency. BDO did not replicate the calculations nor trace individual facility cost or rate data to Medicaid cost reports, rate worksheets, or state agency databases.

Comparisons of Medicaid rates and allowable costs for 1999 were derived for 36<sup>1</sup> states representing over 75% of the Medicaid patient days in the country. The remaining states not reflected in the comparisons indicated that the data was not readily available. However, as can be seen by the chart on page two, these 36 states reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide. The comparisons include most of the states representing the largest Medicaid populations including New York, California, Florida, Pennsylvania and Ohio. Based upon the high percentage of nationwide Medicaid patient days represented by the 36 states, it is likely that the overall results would not materially change had all states been represented.

Data from prior years was also requested in an attempt to identify trends in Medicaid shortfalls. However, information from prior years was not easily accessible and the response rate was not significant enough to generate meaningful trend analysis.



---

(1) Cost report data was also received from the Minnesota state affiliate but was excluded from the computations. The data represents a minority of providers who still file cost reports. The majority of providers are paid a percentage increase on their prior year rate and are not required to file cost reports.

---

# **Appendix 3**

## **Data Collection Document**

# Data Collection Document

Where appropriate, for each element requested, attach an excel file which reflects your computations.

**1) Weighted Average Medicaid Allowable Rate and Costs Per Patient Day**

For each year indicated, please provide the weighted average Medicaid allowable cost per patient day (PPD) for all nursing facilities in the data base with cost reports ending during that year as well as the weighted average Medicaid rate paid PPD to these providers for the same year. Insure that the average rate and cost is reflective of the same covered services and indicate whether the Medicaid allowable cost data is "as reported" or "audited / desk reviewed". Complete only those years for which you have data and indicate the data source; i.e., state data file, etc.

Data Element	1999	1998	1997	1996	1995
Weighted Average Medicaid Rate PPD*					
Weighted Average Medicaid Allowable Cost PPD*					
Are the data "audited/desk reviewed" (Indicate Yes or No)	__ Yes __ NO	Yes NO	Yes NO	Yes NO	__ Yes __ NO
Number of facilities	N=	N=	N=	N=	N=
Data Source (please write in)					

**2) Weighted Average Medicaid Allowable *Direct Care* Rate and Costs Per Patient Day**

Please provide the same information as in question one, but for direct patient care, assuming your state has a separate direct care rate component. If this is not the case, or the data are unavailable, enter non-applicable or not available in the spaces below.

Data Element	1999	1998	1997	1996	1995
Weighted Average Medicaid <i>Direct Care</i> Rate PPD*					
Weighted Average Medicaid <i>Direct Care</i> Cost PPD*					

\*PPD = per patient day

# Data Collection Document (Continued)

### 3) Percentage of Total Operating Costs (excluding capital) Accounted for by Labor Costs

For the most current cost reporting year available, what percentage does labor costs, including benefits and nursing pool, represent of total operating costs (excluding capital)?

Cost Reporting Year \_\_\_\_\_

Labor cost as a percentage of total operating costs \_\_\_\_\_ %

### 4) Summary Data on All Nursing Facilities

For each year, please provide the following statistical information:

Data Element	1999	1998	1997	1996	1995
Total number of facilities					
Bed days available (all beds)					
Total patient days (all payers)					
Total Medicaid days					
Total Medicare days					

---

## **Appendix 4**

# **Calculation of 1999 Weighted Average Medicaid Shortfall State by State Comparison**

# Calculation of 1999 Weighted Average Medicaid Shortfall

Calculation of Average Medicaid Shortfall							
State	Rate (1)	Cost (1)	Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Difference x Medicaid Days
Alabama	\$ 102.78	\$ 100.30	\$ 2.48	6,172,100	634,368,438	619,061,630	15,306,808
Arkansas	\$ 64.52	\$ 70.48	\$ (5.96)	5,615,525	362,313,673	395,782,202	(33,468,529)
California	\$ 88.47	\$ 95.58	\$ (7.11)	21,032,998	1,860,789,333	2,010,333,949	(149,544,616)
Colorado	\$ 111.39	\$ 119.12	\$ (7.73)	3,663,859	408,117,254	436,438,884	(28,321,630)
Connecticut	\$ 156.06	\$ 165.00	\$ (8.94)	7,335,405	1,144,763,304	1,210,341,825	(65,578,521)
Florida	\$ 106.99	\$ 119.15	\$ (12.16)	15,041,945	1,609,337,696	1,792,247,747	(182,910,051)
Indiana	\$ 92.80	\$ 103.64	\$ (10.84)	10,333,882	958,984,250	1,071,003,530	(112,019,281)
Iowa	\$ 84.83	\$ 89.99	\$ (5.16)	5,324,620	451,687,515	479,162,554	(27,475,039)
Kansas	\$ 85.28	\$ 93.91	\$ (8.63)	4,481,538	382,185,561	420,861,234	(38,675,673)
Maine	\$ 113.04	\$ 122.87	\$ (9.83)	1,927,608	217,896,808	236,845,195	(18,948,387)
Maryland	\$ 123.46	\$ 133.16	\$ (9.70)	5,553,476	685,632,147	739,500,864	(53,868,717)
Massachusetts	\$ 120.76	\$ 135.47	\$ (14.71)	12,755,531	1,540,357,924	1,727,991,785	(187,633,861)
Michigan	\$ 103.94	\$ 111.81	\$ (7.87)	10,460,003	1,087,212,712	1,169,532,935	(82,320,224)
Missouri	\$ 93.06	\$ 101.03	\$ (7.97)	9,297,280	865,204,877	939,304,198	(74,099,322)
Montana	\$ 92.26	\$ 103.04	\$ (10.78)	1,221,640	112,708,506	125,877,786	(13,169,279)
Nebraska	\$ 99.13	\$ 106.03	\$ (6.90)	2,337,065	231,673,253	247,799,002	(16,125,749)
Nevada	\$ 102.15	\$ 116.02	\$ (13.87)	941,000	96,123,150	109,174,820	(13,051,670)
New Hampshire	\$ 117.43	\$ 127.50	\$ (10.07)	1,853,015	217,599,551	236,259,413	(18,659,861)
New Jersey	\$ 124.95	\$ 146.06	\$ (21.11)	11,189,586	1,398,138,771	1,634,350,931	(236,212,160)
New Mexico	\$ 99.72	\$ 105.32	\$ (5.60)	1,539,374	153,506,375	162,126,870	(8,620,494)
New York (2)	\$ 154.09	\$ 164.47	\$ (10.38)	28,665,432	4,417,056,417	4,714,603,601	(297,547,184)
North Carolina	\$ 94.31	\$ 97.00	\$ (2.69)	9,225,591	870,065,487	894,882,327	(24,816,840)
North Dakota	\$ 95.91	\$ 99.70	\$ (3.79)	1,333,626	127,908,070	132,962,512	(5,054,443)
Ohio	\$ 115.81	\$ 125.31	\$ (9.50)	20,113,668	2,329,363,891	2,520,443,737	(191,079,846)
Oregon	\$ 91.10	\$ 104.24	\$ (13.14)	2,084,938	189,937,852	217,333,937	(27,396,085)
Pennsylvania	\$ 125.14	\$ 135.03	\$ (9.89)	18,366,845	2,298,426,983	2,480,075,080	(181,648,097)
Rhode Island	\$ 111.79	\$ 121.83	\$ (10.04)	2,551,882	285,274,889	310,895,784	(25,620,895)
South Dakota	\$ 79.99	\$ 93.80	\$ (13.81)	1,459,781	116,767,882	136,927,458	(20,159,576)
Tennessee	\$ 81.48	\$ 86.63	\$ (5.15)	9,377,312	764,063,382	812,356,539	(48,293,157)
Texas	\$ 78.47	\$ 82.07	\$ (3.60)	22,277,985	1,748,153,483	1,828,354,229	(80,200,746)
Utah	\$ 88.55	\$ 101.01	\$ (12.46)	1,226,258	108,585,146	123,864,321	(15,279,175)
Vermont	\$ 103.02	\$ 122.97	\$ (19.95)	856,599	88,246,829	105,335,979	(17,089,150)
Virginia	\$ 82.12	\$ 92.68	\$ (10.56)	6,681,652	548,697,262	619,255,507	(70,558,245)
Washington (3)	\$ 106.96	\$ 118.92	\$ (11.96)	5,108,085	546,360,772	607,453,468	(61,092,697)
West Virginia	\$ 109.10	\$ 117.26	\$ (8.16)	2,790,790	304,475,189	327,248,035	(22,772,846)
Wisconsin	\$ 99.57	\$ 109.85	\$ (10.28)	9,779,399	973,734,758	1,074,266,980	(100,532,222)
				<b>279,977,293</b>	<b>30,135,719,389</b>	<b>32,670,256,848</b>	<b>(2,534,537,460)</b>
							<b>(9.05)</b>
							<b>(3,334,925,000)</b>

(1) The rates and costs are weighted averages calculated by multiplying the per diem rates and costs of each facility by their respective Medicaid days and dividing the result by total Medicaid days of the facilities in the statewide database.

(2) The data represents single level nursing facilities only. Multi-level facilities providing non-nursing home services such as housing, adult day care and home health were excluded since the reported costs did not reflect allocations between nursing home and non-nursing home services.

(3) Rates and costs are exclusive of property costs and property rates which were not included in the available database.

(4) Based upon 368.5 million estimated annual Medicaid payment days derived from HCFA-OSCAR Form 671: F75-78 current surveys as of September 2000.

