Shortfalls in Medicaid Funding and Economic Impact of Long-Term Care

Minnesota 2011
Summary
The American Health Care Association (AHCA) engaged Eljay, LLC, to work with its state affiliates, like Care Providers of Minnesota, and other sources to compile information on the shortfall between Medicaid reimbursement and allowable Medicaid costs.

As in the previous eight reports commissioned by AHCA, the Report on Shortfalls in Medicaid Funding for Nursing Home Care (December 2011) once again illustrated the substantial gap between the rates paid by Medicaid for nursing home residents and the actual cost of caring for nursing home residents.

- According to the report, the national average shortfall in Medicaid nursing home reimbursement was projected to be $19.55 per Medicaid patient day in 2011 or 6.3 billion in total dollars.

- The shortfall for Minnesota’s nursing homes in 2011 is estimated to be $28.30 per Medicaid patient day or 166.4 million in total dollars.

What are some of the consequences of the Medicaid shortfall for Minnesota’s nursing homes?

- Limited staff wage increases
- Reduced step or merit increases for staff
- Reduced health care benefits (i.e., reducing benefits, increasing deductibles or co-pays)
- Cross-subsidization of Medicaid by Medicare and third-party payors
- Delayed building physical plant expenditures
- Spending of reserves
- Reserves tapped out
- Line of credit used to meet obligations
- Fundraising
- Reduced or eliminated long-term disability insurance
- Reduced or eliminated retirement benefits
- Reduced non-direct care staff hours
- Reduced direct care staff hours
- Staff layoffs
- De-licensed beds for bed closure incentives
- Closure of facility

Shortfall between Medicaid reimbursement and allowable Medicaid costs—neighboring states (Projected 2011 shortfall)

Minnesota, when compared to the other 38 participating states, has the 7th largest shortfall between Medicaid reimbursement and allowable Medicaid costs. While Minnesota’s Medicaid funding shortfall for nursing homes is less than Wisconsin’s (see chart above), Wisconsin has the ability to make up the gap with private pay dollars. Other neighboring states, such as Iowa, have a smaller shortfall between Medicaid reimbursement and allowable Medicaid costs. North Dakota has a very small surplus.

Nursing homes in Minnesota and North Dakota charge private-paying residents basically the same rates that Medicaid pays for similar services—a policy unique to these two states known as rate equalization.

Iowa, South Dakota, and Wisconsin do not have rate equalization.

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Why does Minnesota have such a large difference between the rates paid by Medicaid and the actual cost of caring for nursing home residents?

Minnesota has not set Medicaid nursing home payment rates according to actual and allowable costs since 1995. Over the years, the gap between costs and Medicaid rates has grown. Analysis of actual cost coverage by Medicaid in Minnesota ranks Minnesota as having the 5th largest shortfall.

A healthy Medicaid payment system will provide at least 95% cost coverage. A state like Minnesota with rate equalization needs cost coverage of 97% to be considered healthy. North Dakota, the only other state with rate equalization, is estimated in 2011 to have cost coverage of 100.12%.

The importance of Medicare

Nursing homes maintain their ability to operate by subsidizing their Medicaid deficits with the margins attained on the Medicare program. With such an equilibrium created by the combination of these two payers, any increase in Medicaid deficits or decrease in Medicare margins could have serious adverse financial implications for the industry.

According to the Medicare Payment Advisory Commission (MedPAC), the average margin on Medicare payment to freestanding nursing homes in 2009 was 18.1%, while our analysis indicates a 9.6% shortfall on Medicaid payment for that year (i.e., weighed average 2009 shortfall of $16.54 divided by weighted average Medicaid rate of $171.50). The weighted average 2010 margin from the two government-funded programs combined is essentially a break-even.

On October 1, 2008 Minnesota began an eight-year phase-in of the rebasing of operating rates. Rebasings and other increases on October 1, 2008 allowed for some closing of the Medicaid underfunding gap. However, in 2009, the Legislature suspended rebasing as a budget-saving measure. In 2011, the Legislature repealed rebasing. With this repeal, Minnesota can expect the growth of the Medicaid shortfall to increase.

Medicaid nursing home residents comprise over 58% of the typical nursing home’s clients. Medicaid and Medicare comprise nearly 67% of nursing home resident days and are paid for by the State of Minnesota and the federal government. With Minnesota’s unique policy of limiting rates charged to private residents to basically the same rates that Medicaid pays, nearly all of the payment rates for Minnesota nursing homes are controlled by government.
Economic impact of long-term care facilities in Minnesota

The Lewin Group was commissioned by the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) to estimate the economic impact of LTC facilities on the U.S. and state economies.

According to the 2009 Report, nursing facilities, assisted living, and other residential care facilities contribute significantly to the State of Minnesota’s economy.

The direct economic impact on Minnesota represents:
- 1.5% of economic activity
- 1.4% of labor income
- 2.5% of employment

The total economic impact on Minnesota supports:
- 2.6% of economic activity
- 1.9% of labor income
- 3.2% of employment

Generates $1.1 billion in tax revenue:
- $0.4 billion in state/local taxes
- $0.7 billion in federal taxes

Shortfalls in Medicaid Funding for Nursing Home Care

This year’s compilation, like in the previous nine reports, identifies the shortfall for the latest year for which audited or desk-reviewed cost reports were available, which for most states was 2009. In a few states, 2010 year-end cost reports for providers were available and used. A shortfall for the current year of 2011 is projected by trending costs from 2009 (or 2010, if available) to the current year and then comparing those costs to current Medicaid rates.

Methodology

Overall, data were obtained from 37 states, plus the District of Columbia for 2009 (or 2010, if available), which represents more than 83% of the Medicaid patient days nationwide. Data from almost two-thirds of the states reporting in 2009 were based upon audited or desk-reviewed cost reports, or a blend of both audited and desk-reviewed reports. As-filed Medicaid cost reports or Medicare cost reports were used for the remaining states.

Information and data provided in “Shortfalls in Medicaid Funding” is based on a report prepared by ELJAY, LLC for the AMERICAN HEALTH CARE ASSOCIATION (AHCA). Long-Term Care National Economic Impact Statistics in the United States was prepared for AHCA/NCAL by the Lewin Group, Inc. 2009.

Long-term care facilities support $6.7 billion in economic activity*

Long-term care facilities contribute to approximately 112,600 Jobs*

*Long-Term Care (LTC) facilities include nursing homes, assisted living, and other residential care facilities. These facilities do not include government-owned or hospital-based facilities.

The Economic Impact of LTC Facilities for Minnesota was prepared by the Lewin Group for AHCA/NCAL using Impact Analysis for Planning (IMPLAN) software, Minnesota IMPLAN Group, Inc, 2007 data.

**Source: The American Health Care Association, August 3, 2011