DEPARTMENT OF HUMAN SERVICES

Legislative Report

Nursing Facility Rate Study Recommendation Report

Nursing Facility Rates and Policy Division

May 2025

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $100,000.

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Contents

I. Executive summary

In May of 2023, the Minnesota Legislature directed the Department of Human Services (DHS) to contract with an independent organization to investigate information about nursing facility (NF) payment rates in the State compared to neighboring states. DHS contracted with Myers and Stauffer, LC ("Contractor") to perform an analysis of the requested states and compile publicly available information to fulfill this legislative request. The contractor used a variety of approaches including an environmental scan, all-payer and Medicaid-specific cost coverage analysis, an assessment of funding sources, and an analysis of related-party information.

The contractor's conclusions emphasize that Medicaid payment rates to NFs are not expected to produce 100% cost coverage, as Medicaid is the payer of last resort. However, after incorporating data from a multitude of sources, the contractor found that Minnesota's Medicaid NF rates and cost coverage are competitive with bordering states. Their study concludes with four recommendations. DHS agrees with each:

- **Recommendation 1:** An adjustment to Medicaid nursing facility rates strictly for competitive alignment with other state Medicaid programs is not deemed necessary or recommended at this time.
- **Recommendation 2:** The State continues to move towards implementation of a Patient-Driven Payment Model (PDPM)-based resident classification system, as recommended in its separately contracted PDPM Rate Study, in order to preserve its acuity-based payment strategy and promote the continued care of Medicaid recipients with comparably higher levels of need.
- **Recommendation 3:** The State makes no other adjustment to its NF reimbursement methodology at this time other than continuing to move toward implementing a PDPM-based resident classification system for rate setting purposes. It would likely be difficult to fully evaluate the impact of transitioning to PDPM if other changes to the reimbursement system were implemented concurrently.
- **Recommendation 4:** The State include additional Medicaid reporting requirements to capture related-party information. By doing so, the State can help ensure residents have access to quality care, facilities are encouraged to operate efficiently, and the State can manage its Medicaid budget effectively.

II. Legislation

Minnesota 2023 Session Law Ch. 61 Section 41

132.28 Sec. 41. NURSING FACILITY RATE STUDY.

(a) The commissioner of human services shall contract with an independent organization with subject matter expertise in nursing facility accounting to conduct a study of nursing facility rates that includes:

(1) a review of nursing facility rates of all states bordering Minnesota and the states included in the Centers for Medicare and Medicaid Services Region V;

(2) the data necessary to determine the total net income and the operating margin of a nursing facility;

(3) the data necessary to determine whether a nursing facility can generate sufficient revenue to cover the nursing facility's operating expenses;

(4) the average reimbursement rate per resident day in each state and the data used to compute that rate;

(5) facility-level data on all types of Medicaid payments to NFs, including but not limited to:

(i) supplemental rate add-ons;

(ii) rate components;

(iii) data on the sources of the nonfederal share of spending necessary to determine the net Medicaid payment at the facility level; and

(iv) disclosure of transactions from a related party; and

(6) any other information determined necessary by the commissioner to complete the study.

(b) Upon request, a nursing facility must provide information to the commissioner pertaining to the nursing facility's financial operations.

(c) By January 1, 2025, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services policy and finance recommending adjustments to the nursing facility rate methodology under Minnesota Statutes, chapter 256R, based on the results of the study in paragraph (a). The commissioner shall consult with the Office of the Legislative Auditor Financial Audit Division and Program Evaluation Division on study design methods.

III. Introduction

Purpose of report

In May of 2023, the Minnesota Legislature directed the Department of Human Services (DHS) to contract with an independent organization to investigate information about nursing facility (NF) payment rates in the State compared to neighboring states. Several factors have driven interest in this report:

- Minnesota sets NF rates for privately paying individuals to equal Medicaid rates for comparable services in semi-private rooms. This statutory authority has historically led to concern about cost coverage for NF providers in Minnesota, when compared to providers in neighboring states without NF rate equalization.
- Over the past several years, the COVID-19 pandemic has introduced a new set of pressures on NFs to meet service needs, although NFs received additional Federal and State funds to help offset these costs.
- Finally, on October 1, 2025, the Federal government will discontinue support to all states using its current acuity-based reimbursement system, including Minnesota. To continue NF payments based on people's acuity or service needs, states will need to transition to a different reimbursement system with Federal support (known as PDPM) or determine their own system.

DHS contracted with Myers and Stauffer, LC to analyze publicly available and other information for Minnesota and its surrounding states to fulfill this legislative request. DHS selected this contractor due its national experience working with NF reimbursement systems, and its pre-existing engagement with DHS to assess methods for transitioning to a new acuity-based reimbursement system (PDPM Rate Study). The PDPM Rate Study helped inform the analyses below.

Methods

To address the legislative request, contractor staff analyzed NF payment information in various ways. To assess how well facility costs are covered in Minnesota, they did the following:

- **Environmental scan.** They conducted an environmental scan (eScan) of seven bordering states' publicly available documents on state websites and Medicaid state plan filings and contacted internal Contractor employees who are subject matter experts working directly with the selected NF reimbursement systems.
- **All-payer cost coverage analysis.** There is no standardized, public information source of Medicaid-specific cost coverage for NFs. To compare facility cost and revenue coverage in Minnesota to other states, the contractor used information for all payers as reported on the Medicare 2540-10 cost report. (This publicly available cost report database is essentially as-filed provider information, and as such, is unaudited.)
- **Medicaid-specific cost coverage analysis.** The contractor compared allowable costs from as-filed Minnesota Medicaid cost reports in reporting year 2023 (yet to undergo full audit procedures) against projected rate information provided by State personnel for the same period.

To assess how facilities are paid, they did the following:

- **Funding-source analysis.** The contractor collected data from State staff to review sources of funding for Minnesota Medicaid NF rates and payments made to NFs. These included a full listing of calendar year (CY) 2023 Medicaid payments to NFs as well as a listing of surcharges NFs paid from cost reports for reporting year 2023.
- **Related-party analysis.** Neither the quantity of related-party transactions nor the name of the related party is currently collected by the Minnesota Medicaid cost report. To assess related-party transactions, the contractor instead used as-filed information on the quantity of related-party transaction adjustments and the underlying reasoning for these adjustments from Worksheet A-8-1 of the 2540-10 Medicare cost report.

Key findings

The contractor determined the following key findings from their analyses:

- **Environmental scan**. The eScan located information on seven of Minnesota's eight bordering states in Region V (Illinois, Indiana, Iowa, North Dakota, Ohio, South Dakota, and Wisconsin), as well as limited information about Michigan. The eScan provides context for how rates are determined in these states and finds a variety of state-specific factors and a diversity of rate-setting methods influencing average rates. The statewide average reimbursement rates for these states (effective during 2024) ranged from $243.13 to $586.38. The Minnesota average rate of $373.32 ranks second compared to these states.
- **All-payer cost coverage analysis.** The contractor used the Medicare 2540-10 cost report database to estimate total NF cost coverage, by dividing allowable allocated NF revenues by allowable allocated NF costs. A 100% value indicates allowable allocated cost has been fully covered by allowable allocated revenues. Values above 100% indicate revenues above cost, and below 100% indicates cost above revenues. They excluded hospital-based facilities due to known data limitations, as well as one outlier (Indiana) due to unique management and ownership arrangements. For the period 2019 through 2023, Minnesota's five-year average cost coverage (96.69%) is very comparable to comparison states (97.51%).
- **Medicaid-specific cost coverage analysis.** As Medicaid is the payer of last resort, it is generally expected that Medicaid-specific cost coverage would fall below cost coverage inclusive of Medicare and other commercial payers. The contractor's analysis supports this expectation, finding average Medicaid allowable cost coverage in Minnesota in 2023 (93.9%) lower than comparable total payer cost coverage for the past five years (96.69%, described above). As the application of audit procedures on submitted cost reports has typically resulted in costs being reduced by approximately 1.7% (the average change due to adjustments from 2017-2022 cost report periods), the estimated average cost coverage for Minnesota NF providers is 94% to 95%.
- **Funding-source analysis.** The contractor determined that total payments for Medicaid nursing facility services were approximately $1.3 billion in 2023. Of this, patient responsibilities covered 10.93% of Medicaid payments, while federal funds covered 49.54%, county funds covered 0.94%, and state funds covered 38.59%. Base Medicaid payments made up the large majority (about 92%) while private room

fees, surcharges, enhanced rates for short stays and paid leave payments determined the remainder (about 8%).

- **Related-party analysis.** When comparing available related party information for Minnesota against nationwide aggregate facility information, a different than expected pattern emerges. On average, Minnesota NFs consistently add cost via A-8-1 adjustments, while the majority of facilities nationwide remove cost from the NF system via A-8-1 adjustments. While not necessarily incorrect in nature, this treatment is outside of the standard reporting seen nationwide. For the 2023 year-ended Medicare 2540-10 cost reports, the five largest Minnesota facility aggregate adjustments and total cost additions to the NF system were management fees – administrative and general ($13.3 million), admin accounting ($8.6m), corporate IT services ($6.1m), home office pass-through ($4.7m) and home office – administrative ($1.9m).

IV. Recommendations

DHS acknowledges Myers and Stauffer for their expertise, flexibility, and collaborative approach on the Nursing Facility Rate Study and the related PDPM Rate Study. The focus of the Nursing Facility Rate Study was to assess Minnesota Medicaid NF rates, revenues, and the ability of revenues to cover cost (cost coverage). The contractor emphasizes that the Medicaid rate is not expected to produce 100% cost coverage, as Medicaid is the payer of last resort. However, after incorporating data from a multitude of sources, the contractor found that Minnesota's Medicaid NF rates and cost coverage are competitive with the requested states.

The estimated average Minnesota Medicaid NF rate of $373.32 is greater than all but one of the states in the comparison group. Between 2019 and 2023, all-payer cost coverage averaged 96.69 percent for Minnesota nursing facilities, while the cost coverage average for comparison states was 97.51 percent. During that five-year period there were years where Minnesota's cost coverage exceeded the average from the comparison states and others where it fell below the comparison states. The findings suggest that Minnesota Medicaid NF rates are in line with comparable state averages, and in some cases, offer more comprehensive coverage of NF costs. This competitive environment balances the needs of both providers and people needing care, which should help to promote NF access.

Their study concludes with four recommendations. DHS agrees with each:

- **Recommendation 1:** An adjustment to Medicaid nursing facility rates strictly for competitive alignment with other state Medicaid programs is not deemed necessary or recommended at this time.
- **Recommendation 2:** The State continues to move towards implementation of a Patient-Driven Payment Model (PDPM)-based resident classification system, as recommended in its separately contracted PDPM Rate Study, in order to preserve its acuity-based payment strategy and promote the continued care of Medicaid recipients with comparably higher levels of need.
- **Recommendation 3:** The State makes no other adjustment to its NF reimbursement methodology at this time other than continuing to move toward implementing a PDPM-based resident classification system for rate setting purposes. It would likely be difficult to fully evaluate the impact of transitioning to PDPM if other changes to the reimbursement system were implemented concurrently.
- **Recommendation 4:** The State include additional Medicaid reporting requirements to capture related-party information. By doing so, the State can help ensure residents have access to quality care, facilities are encouraged to operate efficiently, and the State can manage its Medicaid budget effectively.

V. Appendix

Nursing Facility Rate Study

January 14, 2025

Prepared for:

Minnesota Department of Human Services

Prepared by:

Myers and Stauffer, LC

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Executive Summary

The Minnesota Department of Human Services (DHS or State) retained Myers and Stauffer LC (Myers and Stauffer) to assess rates, revenues, and revenue sufficiency to cover cost (cost coverage) as it pertains to nursing facilities (NFs) in Minnesota, border states, and those states included in the Center for Medicare & Medicaid Services (CMS) Region V. The intent of this engagement is to analyze the operating environment of the Minnesota Medicaid NF reimbursement system and comparable state NF reimbursement systems to provide the State with information and analysis regarding the sufficiency of Medicaid reimbursement to cover NF operating cost.

At the request of the Minnesota Legislature, and in agreement with DHS, Myers and Stauffer performed the following analyses:

- *An assessment of other states which includes:*
  - *A review and listing of NF rates for all bordering states and states included in Centers for Medicare & Medicaid Services (CMS) Region V.*
  - *The average reimbursement rate per resident day and the information included in each state's specific reimbursement methodology.*
- *A review of the total net income and operating margin for Minnesota NFs and comparable states as noted above.*
  - *A Determination if Minnesota NFs can sufficiently cover operating expense.*
- *Acquisition of Minnesota facility-level data necessary to report on all Medicaid payments, including, but not limited to:*
  - *Base payments*
  - *Supplemental rate add-ons*
  - *Rate components*
  - *Source of nonfederal share of spending for Medicaid payments*
  - *Transactions from related party organizations*

Through the work performed in this engagement, it became evident that Minnesota Medicaid NF rates are competitive when compared to the investigated states in terms of average rate, average cost coverage, and general reimbursement methodology. Additionally, the most currently available data indicates that Minnesota NFs are rebounding from COVID-19-related challenges and that the transition from a Resource Utilization Group (RUG)-based system to a Patient Driven Payment Model (PDPM)-

based system may increase current Medicaid reimbursement and provide additional incentives to NF providers.

Based on the analyses completed, Myers and Stauffer presents the following conclusion and recommendations for consideration.

- *They concluded that an adjustment to Medicaid nursing facility rates strictly for competitive alignment with other state Medicaid programs is not deemed necessary or recommended at this time.*
- *They recommend the State continue to move forward with the implementation of a PDPM based resident classification system in order to preserve its acuity-based payment strategy and promote the continued care of Medicaid recipients with comparably higher levels of need.*
- *They do not recommend any other adjustment to the Minnesota reimbursement methodology at this time other than the PDPM-based resident classification system for rate setting purposes. It would likely be difficult to fully evaluate the impact of transitioning to PDPM if other changes to the reimbursement system were implemented concurrently.*
- *They recommend that the State include additional reporting requirements to capture related-party information. By doing so, the State can help ensure residents have access to quality care, facilities are encouraged to operate efficiently, and the State can manage its Medicaid budget effectively.*

Background

The state of Minnesota currently utilizes a resident-specific billing RUG-IV 48 system plus two state-specific case mix groups for establishing NF payment rates for Medicaid. This system also impacts private pay residents as Minnesota statutes prohibit NFs from charging private pay residents a rate for similar services in semi-private rooms that exceed the rate established for Medicaid recipients.

In May of 2023, the Minnesota Legislature authorized DHS to investigate and report NF information in the state and within comparable states. This authorization was presented under the following statutory language in its entirety:

132.28 Sec. 41. NURSING FACILITY RATE STUDY.

(a) The commissioner of human services shall contract with an independent organization with subject matter expertise in nursing facility accounting to conduct a study of nursing facility rates that includes:

(1) a review of nursing facility rates of all states bordering Minnesota and the states included in the Centers for Medicare and Medicaid Services Region V;

(2) the data necessary to determine the total net income and the operating margin of a nursing facility;

(3) the data necessary to determine whether a nursing facility can generate sufficient revenue to cover the nursing facility's operating expenses;

(4) the average reimbursement rate per resident day in each state and the data used to compute that rate;

(5) facility-level data on all types of Medicaid payments to NFs, including but not limited to:

(i) supplemental rate add-ons;
(ii) rate components;
(iii) data on the sources of the nonfederal share of spending necessary to determine the net Medicaid payment at the facility level; and
(iv) disclosure of transactions from a related party; and

(6) any other information determined necessary by the commissioner to complete the study

(b) Upon request, a nursing facility must provide information to the commissioner pertaining to the nursing facility's financial operations.

(c) By January 1, 2025, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services

policy and finance recommending adjustments to the nursing facility rate methodology under Minnesota Statutes, chapter 256R, based on the results of the study in paragraph (a). The commissioner shall consult with the Office of the Legislative Auditor Financial Audit Division and Program Evaluation Division on study design methods.

Due to this legislative request, DHS contracted with Myers and Stauffer to perform an analysis of the requested comparable states to compile publicly available information to meet the needs of the legislative request. Myers and Stauffer was well positioned to undertake this rate study due to their extensive experience working with nursing facility reimbursement systems and pre-existing engagement with the Department to assess methods for determining resident acuity for Medicaid payments to Minnesota nursing facilities (PDPM Rate Study). Implementing a PDPM-based reimbursement system is one of the recommendations of the PDPM Rate Study. The results of the current analysis and data compilation are presented in the following sections, but it should be noted that this analysis is also informed by the PDPM Rate Study.

Assessment of Other States

Myers and Stauffer conducted an environmental scan (eScan) of selected states' publicly available documents on state websites and Medicaid state plan filings, while also contacting internal Myers and Stauffer employees who are with subject matter experts working directly with the selected NF reimbursement systems. The states selected for the eScan in conjunction with DHS were all bordering states and states included in CMS Region V: Illinois, Indiana, Iowa, Michigan, North Dakota, Ohio, South Dakota, and Wisconsin. The major topics and areas of research focus include the average reimbursement rate per resident day for each state, and the various components and reimbursement methodologies employed by each state.

Table 1 includes the statewide average reimbursement rate per resident day, the maximum reimbursement rate per resident day, and the minimum reimbursement rate per resident day for each of the selected states for the most recently available time period. The statewide average reimbursement rates for the selected states ranged from $243.13 to $586.38. The Minnesota average rate of $373.32 ranks second compared to these states. However, there are a few considerations and notable items for the information presented in *Table 1*.

- *Myers and Stauffer was not able to locate publicly available reimbursement rates for the state of Michigan. Michigan has been excluded from this portion of the assessment of other states.*
- *North Dakota's publicly available rate information reflects only the low and high rates for each facility out of the range of rates corresponding to the 48 case mix classifications. The published low and high rates for each facility were used to determine the statewide average rate.*
- *Both Indiana and Illinois have significant supplemental payment programs which are not reflected in the Medicaid reimbursement rates displayed below.*
- *South Dakota's publicly available rates include material amounts of Tribal facilities which may have an impact on the values presented below.*
- *The rate statistics included in Table 1 below were determined from base rate information. However, it should be noted that each state's reimbursement system may include provisions that could impact these statistics. For example, Minnesota applies the lowest case mix index to late assessments and applies a case mix index of 1.0 for short stays in participating NFs.*

Table 1: Average Reimbursement Rate per Resident Day

Average Reimbursement Rate per Resident Day

State	Rate Effective Date	Minimum Rate	Maximum Rate	Average Rate
North Dakota	1/1/2024	$216.02	$1,105.11	$586.38
Minnesota	**1/1/2024**	**$236.54**	**$940.23**	**$373.32**
Wisconsin	10/1/2023	$233.65	$494.46	$351.20
Indiana	7/1/2024	$205.69	$459.49	$305.42
Iowa	7/1/2024	$162.52	$381.19	$282.11
South Dakota	7/1/2024	$178.62	$371.87	$278.17
Ohio	7/1/2024	$135.87	$354.53	$271.77
Illinois	7/1/2024	$120.16	$505.01	$243.13

In addition to compiling the average reimbursement rate per resident for the selected states, Myers and Stauffer also researched the various components and reimbursement methodologies employed by each state. The components and methodologies covered in the eScan include:

- *Whether the reimbursement system is facility- or resident-specific.*
- *Rate setting methodologies (price, cost, or hybrid).*
    - *Price-based rate setting methodologies utilize prices set on a statewide basis, such as a statewide median.*
    - *Cost-based rate setting methodologies utilize provider-specific costs and typically include State-established reasonable cost limits. Limits may be set as a percentage of median or cost percentile.*
    - *Hybrid rate setting methodologies use both price-based and cost-based methodologies, depending on the rate component.*
- *A high-level overview of the various rate components for each state, such as direct care, indirect care, administrative and operating, capital, ancillary, provider tax, and potential rate add-ons.*
- *Details surrounding acuity-related adjustments and the case mix grouper utilized.*
- *Other rate setting specifics, such as the frequency of incorporating new cost report data, the application of inflationary indices, and the differentiation of peer groups.*

Table 2 includes the key results from the eScan of the rate setting components and methodologies. The primary focus of the information presented relates to the high-level rate setting mechanics that each state employs and does not attempt to provide a full, in-depth explanation for each state's reimbursement system. The rate setting methodology applies to the direct care, indirect care, and administrative rate components, unless otherwise specified. Capital components have been excluded for purposes of this report due to their general complexity.

Table 2: Rate Setting Methodologies by State

Rate Setting Methodologies by State

State	Facility or Resident Specific Billing	Case Mix Grouper	Rate Setting Methodology	Rebase Cadence
Minnesota	Resident	RUG-IV	Hybrid	Annually
Illinois	Facility	PDPM	Direct Care – Price Support – Cost	Upon Legislative Approval
Indiana	Facility	RUG-IV	Price	Annually
Iowa	Facility	RUG-III	Cost	Every Second Year
Michigan	Facility	None Found	Cost	Annually
North Dakota	Resident	RUG-IV	Price	Annually
Ohio	Facility	RUG-IV	Hybrid	Once Every Five State Fiscal Years
South Dakota	Resident	PDPM	Cost	Annually
Wisconsin	Resident	PDPM	Price	Annually

As direct care typically makes up the largest portion of a NF's reimbursement rate, each state's direct care component is explained in more detail below.

- ***Minnesota –*** *Direct care costs include wages and fringe benefits of nurses, certified nursing assistants (CNAs), and other health care staff, as well as training and medical supplies related to the provision of care. Only the direct care rate component is adjusted for acuity.*
- ***Illinois*** *- The nursing and direct care component covers costs associated with direct care, nursing, and other group care-related health and treatment services. The rate includes payment for*

assisting residents in meeting basic functional and special health needs and for rehabilitative and restorative nursing care. Only the nursing and direct care component is adjusted for acuity.

- ***Indiana -*** *Direct care costs include salaries, wages, and employee benefits of nursing staff, as well as technology and medical supplies related to direct patient care services. Only the direct care component of the rate is adjusted for acuity.*
- ***Iowa -*** *Direct care costs include salaries and benefits of registered nurses (RNs), licensed practical nurses (LPNs), CNAs, rehabilitation nurses, and contracted nursing services. Only the direct care component of the rate is adjusted for acuity.*
- ***Michigan -*** *Variable cost component consists of two subcomponents: base cost and support cost. Base costs are generally defined as those costs which cover activities associated with direct patient care. Base cost component is recalculated annually to reflect the more current costs of both the resource needs of patients and the business expenses associated with nursing care. Michigan does not appear to include an acuity component in reimbursement.*
- ***North Dakota –*** *Direct care costs include salaries, wages, employee benefits, and training costs for speech, occupational, and physical therapists, as well as non-capitalized therapy equipment and supplies. Direct care costs also include salaries, wages, employee benefits, and training costs for Director of Nursing, nursing supervisors, in-service nursing trainers, RNs, LPNs, quality assurance personnel, CNAs, others providing assistance with activities of daily living and care-related services, and ward clerks, as well as medical supplies, non-capitalized equipment, routine hair care, and non-capitalized wheelchairs. Only the direct cost category is adjusted for acuity.*
- ***Ohio –*** *Direct care costs include salaries, wages, employee benefits, and training costs for RNs, LPNs, nurse aides, direct care staff, administrative nursing staff, medical directors, respiratory therapists, purchased nursing services, quality assurance, consulting and management fees related to direct care, allocated direct care home office costs, habilitation staff, medical supplies, physical therapists, occupational therapists, speech therapists, and standard wheelchairs. Only the direct care costs are adjusted for acuity.*
- ***South Dakota –*** *Direct care costs include allowable costs directly related to the care of the resident, such as salary cost for RNs, LPNs, nurse aides, nursing supplies, and therapies. Only the direct care rate is acuity adjusted.*
- ***Wisconsin -*** *Direct care nursing services cost include wages, benefits, and purchased service expenses for RNs, nurse practitioners, LPNs, qualified intellectual disabilities personnel, CNAs, feeding assistants, nurse aide training and nurse aide training supplies. The direct care nursing component is adjusted for acuity (PDPM Nursing Component). Direct care other supplies and services include expenses for ward clerks, non-billable physician time, non-billable lab, radiology, pharmacy, physical therapy/occupational therapy/speech therapy, dental, psychiatric and respiratory services, active treatment, volunteer coordinators, social services, recreational,*

religious services, and supplies. The direct care other supplies and services component is adjusted for acuity (PDPM Non-therapy Ancillary Component).

A detailed summation of the research conducted in peer states may be requested from the state.

Evaluation of Reimbursement Sufficiency

The determination of the sufficiency of NF revenues to cover operating cost (cost coverage) is a complex issue, with multiple avenues of funding, allowable cost, and reporting methods depending on the payer source and state regulations specific to each NF reimbursement system. To review this sufficiency on a nationwide basis, the best publicly available source of information is the Medicare 2540-10 cost report database stored in the Healthcare Cost Report Information System operated by CMS. This database includes all Medicare cost reports filed with CMS and is considered the best source of publicly available information for NF cost and revenues. The cost report database was created for federal reporting and Medicare reimbursement purposes, and as such, does not require completion of all information necessary to determine state- and facility-specific Medicaid cost. Due to the lack of availability of this information, a Medicaid-specific cost coverage cannot be accurately obtained from this database. The best available information for comparing revenue sufficiency between states at a national level is with total facility cost and revenue coverage for all payers as reported on the Medicare 2540-10 cost report. Please note the information contained within the publicly available Medicare 2540-10 cost report database is essentially as-filed provider information, and as such, is unaudited. The Medicare Administrative Contractors (MACs) in charge of payment and reporting oversight only perform limited review of cost report filings for payment purposes, leaving the majority of cost and payment information without review oversight. The MAC for the state of Minnesota is National Government Services, Inc. Multiple MACs cover the other states located in CMS Region V and are included in this rate study.

All-Payer Cost Coverage

From the Medicare 2540-10 cost report database, Myers and Stauffer was able to extract the following data points for all NFs which file cost reports with CMS:

- *Worksheet B Part I, Column 18, Lines 30 & 31 – Skilled Nursing Facility Cost*
- *Worksheet G-2 Columns 1, Lines 1 & 2 – Skilled Nursing Facility Revenues*
- *Worksheet B Part I, Column 18, Lines 40-59.xx – Ancillary Costs*
- *Worksheet G-2 Columns 1 & 2, Line 6 – Ancillary Revenues*
- *Worksheet G-3 Column 1, Line 1 – Total Facility Revenue*
- *Worksheet G-3 Column 1, Line 2 – Total Facility Contractual Adjustments*

Utilizing these data points, an allocation of ancillary cost to skilled NF operations was calculated before comparing total facility revenue and total facility skilled nursing cost. An example of the revenue (prior to removal of contractual allowances) and cost allocations are shown below:

Total Allocated Revenue:

$$\left(\frac{Nursing\ Routine\ Revenue}{(Total\ Revenue - Ancillary\ Revenue)} \times Ancillary\ Revenue\right) + Nursing\ Routine\ Revenue$$

Total Allocated Cost:

$$\left(\frac{Nursing\ Routine\ Cost}{(Total\ Cost - Ancillary\ Cost)} \times Ancillary\ Cost\right) + Nursing\ Routine\ Cost$$

In this analysis, allowable allocated NF revenues are divided by allowable allocated NF costs, with a 100% value indicating that allowable allocated cost has been fully covered by allowable allocated revenues. Values above 100% indicate revenues in excess of cost, and below 100% indicates cost in excess of revenues. *Table 3* shows the results of this analysis covering cost reports from 2019 through 2023 for Minnesota, the requested comparable states, and nationwide totals. Note that this analysis excludes hospital-based facilities due to the additional complexity of their cost reporting data and the use of the Medicare 2552-10 cost report. This analysis is limited to provider-reported information, and would not capture provider misreporting of patient revenues, supplemental payments, or any related costs.

Table 3: 2540-10 Cost Report Total Cost Coverage

Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage

Average Cost Coverage	2019	2020	2021	2022	2023	5 Year Average
Minnesota	**102.84%**	**97.44%**	**95.01%**	**91.64%**	**96.49%**	**96.69%**
National	104.45%	100.62%	98.53%	98.99%	101.18%	100.75%
Comparable State Average	102.91%	100.16%	96.82%	96.68%	100.49%	99.41%
Wisconsin	91.85%	91.65%	89.43%	89.44%	96.07%	91.69%
North Dakota	101.09%	100.99%	97.07%	97.12%	99.68%	99.19%
South Dakota	99.74%	99.04%	95.08%	98.08%	98.40%	98.07%
Iowa	103.56%	101.37%	97.01%	93.14%	99.73%	98.96%
Illinois	103.31%	99.42%	95.85%	95.37%	96.72%	98.14%

Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage

Average Cost Coverage	2019	2020	2021	2022	2023	5 Year Average
Indiana	115.00%	114.48%	112.50%	114.29%	117.05%	114.66%
Michigan	107.43%	100.23%	96.01%	97.61%	101.43%	100.54%
Ohio	101.37%	96.80%	93.42%	93.47%	98.80%	96.77%

As illustrated in *Table 3* above, the average cost coverage between 2019 and 2023 for all payer sources in Minnesota NFs falls below national and comparable state averages. However, there are some extenuating factors that should be considered with this analysis. The impacts of the COVID-19 pandemic had a notable effect on cost coverage averages nationwide, with a downward trend during the 2021 and 2022 periods. When reviewing comparable states, Indiana is an outlier in this instance as the NF reimbursement system in Indiana includes sizable supplemental payments due to the unique structuring of private-public partnerships in the management and ownership of the majority of NFs in the state. To provide a better understanding of total payer cost coverage without this outlier, *Table 4* showcases the results of comparable states excluding Indiana.

Table 4: 2540-10 Cost Report Total Cost Coverage – Excluding Indiana in Comparable States

Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage – Excluding Indiana

Average Cost Coverage	2019	2020	2021	2022	2023	5 Year Average
Minnesota	**102.84%**	**97.44%**	**95.01%**	**91.64%**	**96.49%**	**96.69%**
National	104.45%	100.62%	98.53%	98.99%	101.18%	100.75%
Comparable State Average – Excluding Indiana	101.40%	98.37%	94.86%	94.48%	98.42%	97.51%

With the removal of Indiana's influence, Minnesota NF total facility cost coverage appears more in line with comparable state averages for 2019 - 2021, while falling below comparable states post 2021. With this adjustment, the five-year average for Minnesota is very comparable to the average for the comparison states.

Because the prior information relates to all potential payer sources, it includes factors beyond State Medicaid control and could distort an understanding of the Minnesota Medicaid-specific environment if

taken alone and without context. There is not a publicly available Medicaid-only cost database to query, and the investigation into Medicaid revenue sufficiency for the purposes of this report will be limited to Myers and Stauffer calculations involving Minnesota-specific data and reports presented by the congressional Medicaid and CHIP Payment and Access Commission (MACPAC) reports on nationwide Medicaid cost coverage (which is unable to be duplicated due to the inclusion of non-public information).

Medicaid Cost Coverage

A database of the as-filed Minnesota Medicaid cost reports for the year ended 2023 (yet to undergo full audit procedures) were compared against projected rate information provided by State personnel for the same time period. The provided projected rates are based on rates as set for state rate year 2023 (January 1, 2023 through December 31, 2023) using Medicaid cost report information obtained from the year ended 2021 cost reports. The benefit of this approach is that while the contractor is only able to review information for Minnesota NFs, the allowable cost contained in the database is Medicaid allowable cost only and can be directly compared to the Medicaid projected rates and revenues for the same time period.

Table 5 shows the maximum, minimum, simple average, and standard day-weighted average Medicaid cost coverage for Minnesota NFs. *Table 6* showcases the percent of Minnesota NFs that fall into a specific range of cost coverages. This information is presented both with and without the inclusion of capital cost and the capital component of the Medicaid rate. The reason behind this presentation is that capital expense as reported in both Medicare and Medicaid cost reports has the potential to be both co-mingled with related-party information and potentially show higher than fair value rents due to the presence of sales to real estate investment trusts and subsequent rental agreements. In some cases, these agreements may result in higher than standard rents due to purchase/lease-back arrangements and other operating decisions. Due to the nature in which capital costs are paid at the federal and state level, direct capital cost, in their totality, are typically not part of review procedures and may not reflect the full impact of allowable cost rules. Similar to the prior Medicare 2540-10 cost coverage analyses, a 100% value indicates that allowable allocated cost has been fully covered by allowable allocated revenues. Values above 100% indicate revenues in excess of cost, and below 100% indicates cost in excess of revenues. A full listing of all facilities and their allowable cost/revenues and cost coverage is available upon request to the State.

Table 5: Estimated 2023 Cost Report Year vs Rate Year Medicaid Cost Coverages

Estimated 2023 Cost Report Year vs Rate Year Medicaid Cost Coverages

	Allowable Cost Per Day*	Projected Rate Per Day*	Cost Coverage*	Allowable Cost Per Day W/O Capital*	Projected Rate Per Day W/O Capital*	Cost Coverage W/O Capital*
Maximum	$1,428.44	$586.90	**151.8%**	$1,368.57	$579.10	**165.1%**
Minimum	$157.66	$184.47	**30.1%**	$151.20	$172.60	**30.3%**
Simple Average for All Facilities	$380.10	$342.15	**92.5%**	$352.62	$320.01	**93.0%**
Standard Day Weighted Average for All Facilities	$375.26	$342.59	**93.2%**	$346.91	$319.64	**93.9%**

**Note: All averages above are independently calculated.*

Table 6: Estimated 2023 Cost Report Year vs Rate Year Medicaid Cost Coverages - Bands

Estimated 2023 Cost Report Year vs Rate Year Medicaid Cost Coverages - Bands

Cost Coverage Range	Percent of Facilities	Percent of Facilities W/O Capital
Greater than 110%	7.2%	7.2%
100%-109%	20.9%	20.0%
90%-99%	30.7%	33.1%
80%-89%	24.8%	26.6%
70%-79%	12.5%	10.4%
60%-69%	3.3%	2.1%
Less than 60%	0.6%	0.6%

As noted in *Table 5* above, Medicaid allowable cost coverage (93.9%) is lower than comparable total payer cost coverages from the prior 2540-10 analysis displayed in *Table 3* and *Table 4 (96.69%)*. As Medicaid is the payer of last resort, it is generally expected that Medicaid-specific cost coverage would fall below cost coverage inclusive of Medicare and other commercial payers.

Of the 335 providers with useable information, the majority fall within a Medicaid cost coverage band greater than 90%. When removing capital costs and revenues from considerations, the percentage of providers increases slightly. Please note, that cost figures presented above are developed prior to the application of audit and review procedures. The application of these audit and review procedures on the submitted cost reports has typically resulted in costs being reduced by approximately 1.7% (the average change due to adjustments from 2017-2022 cost report periods). With these considerations, the contractor would expect the estimated average cost coverage for Minnesota NF providers to rest between 94% and 95%.

MACPAC, in a report dated January 2023 indicated that, based on 2019 Medicare 2540-10 cost report information and non-public upper payment limit information, the average nationwide Medicaid NF cost coverage ratio was 84%. For the time period covered under the MACPAC report, Minnesota NFs showed a cost coverage ratio of 96%, which aligns closely with the 93%-95% estimation from the Medicaid cost report analysis prepared above. *Table 7* shows a breakdown of nationwide averages and comparable states' averages as contained within the MACPAC report.

Table 7: MACPAC Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage – 2019 Data Sets

MACPAC Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage – 2019 Data Sets

	MN	Nation	WI	ND	SD	IA	IL	IN	MI	OH
Medicaid Cost Coverage	**96%**	84%	75%	94%	60%	90%	90%	88%	81%	86%

In addition to providing statewide average cost coverage data, the MACPAC report also includes facility level cost coverage information by cost coverage bands, i.e. facilities with less than 60% cost coverage, facilities with 60-69% cost coverage, etc. *Table* 8 showcases the percentage of facilities that fall within specific cost coverage bands as contained within the MACPAC report.

Table 8: MACPAC Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage Bands – 2019 Data Sets

MACPAC Yearly Medicare 2540-10 Total Cost Report Average Cost Coverage Bands – 2019 Data Sets

	Less than 60%	60-69%	70-79%	80-89%	90-99%	100-109%	Greater than 110%
Minnesota	0.0%	0.8%	2.7%	22.9%	40.8%	24.0%	8.8%
National	5.4%	9.8%	19.2%	25.2%	22.0%	11.6%	6.8%
Wisconsin	20.1%	19.7%	19.0%	18.7%	9.9%	6.1%	6.5%
North Dakota	0.0%	0.0%	2.4%	26.2%	50.0%	19.0%	2.4%
South Dakota	43.5%	34.8%	17.4%	4.3%	0.0%	0.0%	0.0%
Iowa	1.3%	3.9%	14.2%	30.0%	32.3%	14.7%	3.6%
Illinois	7.1%	10.5%	18.7%	23.1%	17.7%	8.5%	14.4%
Indiana	1.2%	91%	16.3%	25.0%	26.0%	13.0%	9.4%
Michigan	5.1%	12.3%	28.3%	29.3%	20.3%	4.1%	0.5%
Ohio	3.9%	7.9%	19.2%	32.0%	23.4%	9.1%	4.5%

While the methodology behind the MAPAC report is neither exactly the same as the analysis into Minnesota-specific data performed for this report, nor is it reproducible by non-federal entities, the distribution and aggregate cost coverage does broadly align with the results of the Myers and Stauffer

analysis. From this determination, the contractor can conclude that Minnesota is competitive when compared nationwide and other similar states in the realm of Medicaid-specific cost coverage. This is not to discount any individual lack of coverage for specific facilities, but in the aggregate, Minnesota has the highest Medicaid cost coverage from the MACPAC report per the comparable states. Additionally, the shift to PDPM for the assessment-based reimbursement system now in consideration has the potential to add material additional funding to the Minnesota Medicaid system without a corresponding increase in cost borne by NFs.

Sources of Funding and Related-Party Data

Funding Sources

In conjunction with the collection of data related to daily reimbursement rates, data was also collected to review, in the aggregate, the sources of funding for the Minnesota Medicaid NF rates and the payments made to NFs. A full listing of calendar year (CY) 2023 Medicaid payments to NFs was obtained from the State, as well as a listing of surcharges nursing facilities paid from cost reports for the cost report year ended 2023. This information was reviewed to determine the specific sources of funding for NFs.

Funding for Medicaid nursing facility services comes from a combination of sources including, patient contributions, federal funds, and state funds. For CY 2023 total payments for Medicaid nursing facility services came to $1,287,931,492. Facilities reported patient responsibility collections of $140,756,388 during that period. This left a net Medicaid program responsibility of $1,147,175,104. This amount was split between federal and state funds based on a blended CY 2023 FMAP rate of 55.62% or $638,058,793, and a non-federal share of 44.38% or $509,116,311. There are county funds that are specifically used as part of the non-federal share of nursing facility payments. While the State tracks these funds on a state fiscal year basis, according to data provided by the Department, Myers and Stauffer estimates that county funds contributed $12,165,948 to nursing facility payments in CY 2023. This left $496,950,363 to be covered by state funds. Considering all fundings sources, patient responsibilities covered 10.93% of the Medicaid nursing facility payments, while federal funds covered 49.54%, county funds covered 0.94%, and state funds covered 38.59%.

Table 9: Estimated CY 2023 Medicaid Funding Sources

Estimated CY 2023 Medicaid Funding Sources

		Total Dollar Value	Percentage
Total Payments for Medicaid NF Services		**$1,287,931,492**	**100.00%**
Patient Responsibility		$140,756,388	10.93%
Medicaid Program Payments to Nursing Facilities		$1,147,175,104	89.07%
Federal Share (based on blended CY 2023 FMAP rates)	**55.62%**	$638,058,793	49.54%
Non-Federal Share (based on blended CY 2023 FMAP rates)	**44.38%**	$509,116,311	39.53%

Estimated CY 2023 Medicaid Funding Sources

		Total Dollar Value	Percentage
County Intergovernmental Transfer Used for State Share		$12,165,948	0.94%
State General Funds Used for State Share		$496,950,363	38.59%

It is important to note that there are multiple sources of revenue that contribute to the state's funds that are available to use as the state share of Medicaid payments. In Minnesota, the state assesses a surcharge on nursing facility beds that generated $65,839,772 in CY 2023. While these funds are not specifically earmarked for nursing facility payments, they are a significant source of revenue for the State.

Just as funding sources used to cover nursing facility payments come from multiple sources, the payments made to nursing facilities are also divided across multiple categories. Of the approximately $1.3 billion paid for Minnesota Medicaid nursing facility services, 92.26% or $1,188,225,703 was for base Medicaid payments. A small share of payments, 0.43% or $5,555,682 was made for enhanced rates. Private room rate payments contributed 4.70% or $60,551,955. Paid leave rate payments accounted for 0.03% or $412,002. Surcharge payment rates accounted for the remaining 2.58% or $33,186,149. *Table 10* summarizes the breakdown of Minnesota Medicaid nursing facility services.

Table 10: Estimated CY 2023 Payments Made to Medicaid NFs

Estimated CY 2023 Payments to Medicaid NFs

	Total Dollar Value	Percentage of Total Payment
Total Payments to Facilities	**$1,287,931,492**	**100.00%**
Base Medicaid Payment	$1,188,225,703	92.26%
Enhanced Rate	$5,555,682	0.43%
Private Room Rate	$60,551,955	4.70%
Paid Leave Rate	$412,002	0.03%
Surcharge Payment Rate	$33,186,149	2.58%

Related-Party Analysis

Published information available to review related-party transactions is limited in both the Minnesota Medicaid cost report data sets and the published Medicare 2540-10 cost report database. From discussions with the State, neither the quantity of related-party transactions nor the name of the related party are captured in the current version of the Minnesota Medicaid cost report database. While the names of related parties are not readily identifiable from the Medicare 2540-10 cost report database, the quantity of related-party transaction adjustments and the underlying reasoning for these adjustments are included in Worksheet A-8-1 of the 2540-10 Medicare cost report.

Worksheet A-8-1 is designed to capture either the inclusion of related-party expenses not present on the individual facility working trial balance (WTB), or to adjust any related-party expense included in the WTB report transactions at the underlying cost borne by the related-party entities. The reporting of this information is governed by the Provider Reimbursement Manual, CMS Publication 15-1, Chapter 10, and it is considered necessary to report related-party transactions at the cost of the related party. For example, if Facility A purchases $30 of medical supplies from a related party, but the medical supplies only cost the related party $20, a negative $(10) adjustment would be reported on Worksheet A-8-1 for medical supplies to write down the expense to the actual cost incurred by the related party. When reviewing adjustments nationwide, the average NF reports an aggregate negative amount in this worksheet, consistent with the intent to write down related-party transactions to actual cost incurred by the related party.

When reviewing Minnesota aggregate facility information against nationwide aggregate facility information, a different than expected pattern emerges. As shown below in *Table 11*, Minnesota facilities consistently *add* cost in the aggregate to the NF system via A-8-1 adjustments, while the majority of facilities nationwide *remove* cost from the NF system via A-8-1 adjustments.

Table 11: Yearly A-8-1 Medicare 2540-10 Cost Report Averages

Yearly A-8-1 Medicare 2540-10 Cost Report Averages

	2021 National Data	2021 Minnesota Data	2022 National Data	2022 Minnesota Data	2023 National Data	2023 Minnesota Data
Maximum Facility Adjustment	$3,760,742	**$8,865,082**	$3,798,834	**$5,743,646**	$4,550,704	**$6,270,080**
Minimum Facility Adjustment	$(2,885,881)	**$(511,639)**	$(2,742,033)	**$(494,942)**	$(2,870,990)	**$(1,036,030)**
Average Facility Adjustment	$(54,316)	**$159,655**	$(43,797)	**$149,079**	$(60,053)	**$161,169**
Minnesota Rank of Average Adjustment	-	**4**	-	**4**	-	**6**

Across the three years of reviewed data, Minnesota ranks in between the 4th and 6th place of all states for the positive value of A-8-1 adjustments. As A-8-1 adjustments are typically used to remove related-party profit and recognize related transactions at underlying cost, the aggregate positive nature of the Minnesota facility adjustments are outside expected results at first glance. Additional information was extracted from the A-8-1 worksheets for the 2023 year-ended Medicare 2540-10 cost reports. The following descriptions for the five largest Minnesota facility aggregate adjustments were noted, alongside their total cost additions to the NF system:

- *MGMT FEE - A&G RELATED: $13,300,092*
- *ADMIN. ACCOUNTING: $8,641,233*
- *CORP IT SERVICES: $6,123,064*
- *HOME OFFICE PASS: $4,688,822*
- *HOME OFFICE – ADMINISTRATIVE: $1,923,599*

The noted explanations suggest that rather than reporting home office and related-party management fees on the NF WTB and then removing expense in excess of related-party cost (as is generally seen in other nationwide cost report information), NFs in Minnesota, in the aggregate, might not include this expense on their individual facility cost reports WTB. Instead, these expenses may be reported as positive adjustments to the cost report filing pulling in the additional expense into the NF system. While not necessarily incorrect in nature, this treatment is outside of the standard reporting seen nationwide.

It was noted that the total aggregate impact of capital-related (property, plant, and equipment) adjustments in Minnesota was an addition of $840,271 in cost to the NF system, rather than a negative aggregate amount to write down rent paid in excess of related-party cost. While not necessarily incorrect in nature, given the changing environment of NF capital expenditures and the emergence of real estate investment trusts that house NF assets and charge rents to facilities, additional investigation may be warranted to confirm proper treatment of these expenses.

Please note, this information has not been audited, and that additional investigation into the reported amounts and explanations may uncover additional relevant information which cannot be gleaned from publicly available sources.

Due to the lack of related-party information included in the Minnesota Medicaid cost report, Medicare 2540-10 cost repot database, and the lack of opacity in the information that is currently available, Myers and Stauffer recommends that Minnesota consider adjusting the Medicaid cost report to include additional reporting areas for related-party information and require the completion and submission of audited financial statements annually with the cost report.

Conclusion and Recommendations

The focus of this study was to assess Minnesota Medicaid nursing facility rates, revenues, and the sufficiency of revenues to cover cost (cost coverage). The analysis of Medicaid NF rates and Medicaid cost coverage in Minnesota reveals a competitive landscape. The estimated average Minnesota Medicaid nursing facility rate of $373.32 is greater than all but one of the states in the comparison group. Between 2019 and 2023, cost coverage averaged 96.69 percent for Minnesota nursing facilities, while the cost coverage average for comparison states was 97.51 percent. During that five-year period there were years where Minnesota's cost coverage exceeded the average from the comparison states and others where it fell below the comparison states. The findings suggest that Minnesota Medicaid NF rates are in line with comparable state averages, and in some cases, offer more comprehensive coverage of NF costs. This competitive environment benefits both facilities and residents and should serve to promote access to care for NF residents.

It is important to note that the Medicaid rate is not expected to produce 100% cost coverage, as Medicaid is the payer of last resort. Medicaid reimbursement begins when all other resources have been exhausted, and therefore Medicaid is a marginal payer that does not cover some of the costs that facilities incur to exist such as advertising for occupancy.

Recommendation 1

An Adjustment to Medicaid nursing facility rates strictly for competitive alignment with other state Medicaid programs is not deemed necessary or recommended at this time.

The contractor's review also found that Minnesota uses many of the same reimbursement system practices as other states. Minnesota pays nursing facilities an acuity-adjusted rate determined by data derived from the RUG IV classification system, as do most of the comparison states. Like most of the comparison states, Minnesota is moving towards using PDPM to replace the RUG IV system given that CMS will stop supporting the data necessary for RUG-IV systems in 2025. Two of the comparison states have already implemented PDPM reimbursement systems. Minnesota also allows for annual rate rebasing as do most of the comparison states. Some states rebase less frequently, e.g. every two years or every five years, but the majority of the comparison states rebase annually. In general, Myers and Stauffer did not find any deficiencies in the Minnesota reimbursement methodology other than continuing to move toward implementing a PDPM case mix system.

Recommendation 2

Myers and Stauffer recommends the State continue to move towards implementation of a PDPM based resident classification system, as recommended in PDPM Rate Study, in order to preserve its acuity-based payment strategy and promote the continued care of Medicaid recipients with comparably higher levels of need.

Recommendation 3

Myers and Stauffer does not recommend any other adjustment to the Minnesota reimbursement methodology at this time other than continuing to move toward implementing a PDPM-based resident classification system for rate setting purposes. It would likely be difficult to fully evaluate the impact of transitioning to PDPM if other changes to the reimbursement system were implemented concurrently.

As Minnesota continues to navigate the complexities of long-term care, it is essential to maintain a competitive and sustainable NF rate structure, and to ensure that proper attestation procedures are performed on provider-submitted costs. One of the great challenges to today's Medicaid reimbursement systems is cost transparency. Many facilities utilize related-party entities to provide required services. This can mask the true cost of these services. Collecting additional related-party information with the Medicaid cost report should help ensure the integrity and transparency of the cost data.

Recommendation 4

The contractor recommends that the State include additional reporting requirements to capture related-party information. By doing so, the State can help ensure residents have access to quality care, facilities are encouraged to operate efficiently, and the State can manage its Medicaid budget effectively.