



MAR - 4 2005

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Acting Inspector General

SUBJECT: Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit (A-10-04-00001)

Attached is an advance copy of our final report on the adequacy of Washington State's Medicaid payments to Newport Community Hospital, Long-Term-Care Unit (Newport). We will issue this report to the State within 5 business days. This report is part of our multistate review of the adequacy of Medicaid payments to public nursing facilities and is an effort to examine, at the provider level, the impact of enhanced payments subject to the upper payment limit. Our prior work at the State level found that public facilities had returned millions of dollars of enhanced Medicaid payments to State governments through intergovernmental transfers.

We selected Newport for audit because it had received numerous immediate jeopardy and actual harm ratings from the State Department of Social and Health Services. Those ratings are the most unfavorable ones that can be issued.

Our objectives were to ascertain whether (1) Medicaid payments to Newport were adequate to cover its operating costs and (2) a link could be drawn between the quality of care that Newport provided to its residents and the amount of Medicaid funding received.

Total, or gross, Medicaid payments to Newport were adequate to cover Medicaid-related costs, but net payments were not. During the 3 years ended December 31, 2002, Newport's Medicaid operating costs were about \$6.42 million. During the same period, gross Medicaid payments totaled \$46.39 million—\$5.16 million in per diem payments and \$41.23 million in enhanced payments available under the upper-payment-limit regulations. However, the State established per diem rates that were significantly lower than actual costs and required Newport to return \$38.93 million (about 94 percent) of its upper-payment-limit funding. In addition, the State directed Newport to pay \$1.33 million (about 3 percent) of its upper-payment-limit funding to other health organizations. Accordingly, the net Medicaid funding that the State allowed Newport to retain was about \$6.13 million, which was \$290,000 less than its Medicaid operating costs.

As we have found in other States, Washington's upper-payment-limit funding approach benefited the State more than the nursing home. The State received \$16.47 million more than it expended

for Newport's Medicaid residents. The health organizations received \$1.33 million but provided no services to Newport. We are concerned that the Federal Government provided all of Newport's Medicaid funding, with the exception of private payments by Newport residents. This situation is contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

The Medicaid funding that Newport retained was not adequate to cover its daily Medicaid operating costs. This condition may have affected the quality of care provided to its residents. During our audit period, Newport was understaffed considering the number of positions needed as identified by management and recommended for similar-sized nursing homes by Abt Associates, a consultant to the Centers for Medicare & Medicaid Services. Recent studies by the Government Accountability Office and Abt Associates indicated that the ratio of nursing staff to residents could affect quality of care. Further, Newport officials believed that they could improve quality of care if they had more funds to hire additional staff, provide more training, improve the facility, and purchase safety equipment.

We recommend that the State:

- consider revising Newport's Medicaid per diem rate to more closely reflect operating costs and
- allow Newport to retain sufficient funding, including upper-payment-limit funding as necessary, to cover the costs of providing an adequate level of care to its residents.

In its comments on our draft report, the State did not concur with our conclusions and recommendations. The State said that we misunderstood the Medicaid nursing facility payment system (per diem rate) and mischaracterized upper-payment-limit funding. The State also said that our conclusions concerning the link between quality of care and funding were not well founded.

We disagree with the State's comments. The State has the flexibility and authority under Title XIX of the Social Security Act to increase Medicaid funding to Newport by revising the Medicaid per diem rate and/or allowing Newport to retain more upper-payment-limit funding. Also, we believe that deficiencies in quality of care may have resulted from the Medicaid funding shortage. Statements by Newport officials support our position.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360. Please refer to report number A-10-04-0001 in all correspondence.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

MAR - 8 2005

Report Number: A-10-04-00001

Mr. Doug Porter
Assistant Secretary
Medical Assistance Administration
Department of Social and Health Services
623 Eighth Avenue SE.
Olympia, Washington 98504

Dear Mr. Porter:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-10-04-00001 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand".

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

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Direct Reply to HHS Action Official:

Mr. Roy J. Ruff
Regional Administrator
Centers for Medicare & Medicaid Services, Region X
Department of Health and Human Services
2201 Sixth Avenue, MS-40, Room 911
Seattle, Washington 98121

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ADEQUACY OF
WASHINGTON STATE'S
MEDICAID PAYMENTS TO
NEWPORT COMMUNITY HOSPITAL,
LONG-TERM-CARE UNIT**



**MARCH 2005
A-10-04-00001**

Office of Inspector General

<http://oig.hhs.gov>

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Medicaid funding to non-State-owned public nursing facilities in Washington State consists of the per diem rate and upper-payment-limit funds. The facility-specific per diem reimbursement rate covers direct care and ancillary services for Medicaid-eligible residents. Upper-payment-limit funds are enhanced payments in addition to the per diem payments.

OBJECTIVES

Our objectives were to ascertain whether:

- Medicaid payments to Newport Community Hospital, Long-Term-Care Unit (Newport) were adequate to cover its operating costs and
- a link could be drawn between the quality of care that Newport provided to its residents and the amount of Medicaid funding received.

SUMMARY OF FINDINGS

Adequacy of Medicaid Payments

Total, or gross, Medicaid payments to Newport were adequate to cover Medicaid-related costs, but net payments were not.

During the 3 years ended December 31, 2002, Newport's Medicaid operating costs were about \$6.42 million. During the same period, gross Medicaid payments totaled \$46.39 million—\$5.16 million in per diem payments and \$41.23 million in enhanced payments available under the upper-payment-limit regulations. However, the State established per diem rates that were significantly lower than actual costs and required Newport to return \$38.93 million (about 94 percent) of its upper-payment-limit funding. In addition, the State directed Newport to pay \$1.33 million (about 3 percent) of its upper-payment-limit funding to other health organizations. Accordingly, the net Medicaid funding that the State allowed Newport to retain was about \$6.13 million, which was \$290,000 less than its operating costs.

The State's upper-payment-limit funding approach benefited the State and other health organizations more than the nursing home. The State received \$16.47 million more than it expended for Newport's Medicaid residents. The health organizations received \$1.33 million but provided no services to Newport. We are concerned that the Federal Government provided all of Newport's Medicaid funding, with the exception of private payments by Newport residents. This situation is contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

Link Between Quality of Care and Funding

We selected Newport for audit because it had received numerous immediate jeopardy and actual harm ratings from the State Department of Social and Health Services during the 3-year period ended December 31, 2002. Those ratings are the most unfavorable ones that can be issued.

The net Medicaid funding that Newport retained was not adequate to cover its daily Medicaid operating costs. This condition may have affected the quality of care provided to its residents. During our audit period, Newport was understaffed considering the number of positions needed as identified by management and recommended for similar-sized nursing homes by Abt Associates, a consultant to the Centers for Medicare & Medicaid Services (CMS). Recent studies by the Government Accountability Office (GAO) and Abt Associates indicated that the ratio of nursing staff to residents could affect quality of care. Further, Newport officials believed that they could improve quality of care if they had more funds to hire additional staff, provide more training, improve the facility, and purchase safety equipment.

RECOMMENDATIONS

We recommend that the State:

- consider revising Newport's per diem rate to more closely reflect operating costs and
- allow Newport to retain sufficient funding, including upper-payment-limit funding as necessary, to cover the costs of providing an adequate level of care to its residents.

STATE COMMENTS

In its comments on our draft report, the State did not concur with our conclusions and recommendations. The State said that we misunderstood the Medicaid nursing facility payment system (per diem rate) and mischaracterized the Proportionate Share program (upper-payment-limit funding). The State also said that our conclusions concerning the link between quality of care and funding were not well founded. The State's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We disagree with the State's comments. The State has the flexibility and authority under Title XIX of the Social Security Act (the Act) to increase Medicaid funding to Newport by revising the Medicaid per diem rate and/or allowing Newport to retain more upper-payment-limit funding. Also, we believe that deficiencies in quality of care may have resulted from the Medicaid funding shortage. Statements by Newport officials support our position.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State administers its Medicaid program in accordance with a State plan approved by CMS. Title XIX provides for Federal matching payments to States for services covered under an approved State plan. Although States have considerable flexibility in plan design and program operation, they must comply with broad Federal requirements.

In Washington State, the Department of Social and Health Services administers the Medicaid program. The Department's Office of Rates Management calculates nursing home reimbursement rates pursuant to Chapter 388-96 of the Washington Administrative Code, Chapter 74.46 of the Revised Code of Washington, and pertinent Medicaid State plan amendments.

The Federal and State Governments jointly fund the State's Medicaid program. Funding to public nursing facilities consists of the per diem rate and upper-payment-limit funds.

Per Diem Rate

Under Washington's State plan, all nursing homes receive a facility-specific per diem reimbursement that covers basic care and ancillary services for Medicaid-eligible residents. In Washington, the Federal Government contributes slightly more than 50 percent of the per diem reimbursement rate, and the State contributes the rest. The State requires some Medicaid residents to pay a portion of the per diem rate, reducing Federal and State shares accordingly.

Upper-Payment-Limit Funds

Subject to Federal upper-payment-limit regulations, States are permitted to provide enhanced payments to providers, such as nursing facilities, in addition to per diem payments. The upper payment limit is an estimate of the amount that would be paid to a category of Medicaid providers on a statewide basis under Medicare payment principles. Regulations in effect during the first half of our audit period placed an upper limit on aggregate payments to State-operated facilities and on aggregate payments to all facilities.

Effective March 13, 2001, revised regulations limited the amount of available enhanced Medicaid funds over a 5-year transition period and established separate upper payment limits for three types of nursing facilities: those owned or operated by a State, those owned or operated by a locality (or other non-State governmental entity), and those that are privately owned and operated.

Washington allocates upper-payment-limit funds in proportion to the number of Medicaid days of care provided by each non-State government nursing home. During our 3-year audit period, the State upper-payment-limit funding totaled \$382 million.

State Surveys

The Omnibus Budget Reconciliation Act of 1987, Public Law 100-203 (Title IV, subtitle C), implemented in 1990, requires that nursing homes meet Federal standards to participate in the Medicaid program. CMS contracts with States to conduct periodic certification surveys to ensure that these standards are met.

CMS's "State Operations Manual" defines several categories of deficiencies that State survey agencies may find. Each deficiency is placed in 1 of 12 groups depending on the extent of resident harm and the number of residents affected. The most unfavorable rating, immediate jeopardy, applies to the most serious deficiencies that endanger the health and safety of residents. CMS also uses a fifth designation referred to as "substandard quality of care," which automatically applies to an immediate jeopardy rating. Deficiencies in this category involve resident behavior and facility practices, quality of life, and quality of care. See Appendix A for more information regarding the survey and rating process.

Newport Community Hospital, Long-Term-Care Unit

During the audit period, Newport was a 50-bed, public long-term-care facility owned and operated by Newport Community Hospital. Approximately 85 percent of the residents were Medicaid beneficiaries.

As a result of surveys by the Department of Social and Health Services, Newport received ratings indicating varying levels of deficiencies from 2000 through 2003. In January 2003, Newport received immediate jeopardy ratings in three related areas. The ratings resulted from its failure to (1) ensure that each resident was free from verbal, sexual, physical, and mental abuse and from corporal punishment and involuntary seclusion; (2) report all alleged violations involving mistreatment, neglect, or abuse; and (3) develop and implement written policies and procedures that prohibited mistreatment, neglect, and abuse of its residents. The deficiencies resulted in injuries to several residents from August through November 2002.

During 2002, three complaint investigations found that Newport had failed to (1) implement safety interventions, (2) assess and monitor residents with injuries of unknown origin, (3) provide the necessary assistance when moving a resident within the facility, and (4) ensure that each resident received adequate supervision and assistance devices. The deficiencies resulted in actual harm to several residents. Two of those residents were taken to the emergency room.

The 2001 survey found less severe deficiencies. In 2000, Newport received an actual harm rating for its failure to ensure treatment and preventive measures for two residents with pressure sores. As a result of a complaint investigation, it also received another actual

harm rating for not providing adequate supervision and assistance devices when moving a resident within the facility.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to ascertain whether:

- Medicaid payments to Newport were adequate to cover its operating costs and
- a link could be drawn between the quality of care that Newport provided to its residents and the amount of Medicaid funding received.

Scope

Our audit covered the 3 years ended December 31, 2002. During that period, Newport received \$46.39 million in Medicaid funding, including per diem payments totaling \$5.16 million (\$2.20 million Federal share) and upper-payment-limit funding of \$41.23 million (\$20.89 million Federal share).

We did not assess Newport's overall internal controls; we limited our review to gaining an understanding of those controls related to Medicaid funding and quality of care. We conducted our fieldwork at the Department of Social and Health Services in Lacey and Olympia, WA, and at Newport in Newport, WA.

Methodology

To accomplish our objectives, we:

- reviewed Federal and State laws and regulations and two nurse staffing and quality-of-care studies;
- interviewed officials from CMS, the State, and Newport;
- toured Newport and interviewed nursing staff;
- reviewed Newport's documentation, including medical records, remittance advices, corrective action plans, and staffing assignments and patterns;
- reviewed the Medicaid cost reports submitted annually to the State;
- reviewed Newport's audited financial statements for which the independent auditors rendered an unqualified opinion;

- verified compliance with the corrective action plans that Newport prepared in response to State surveys;
- analyzed the flow of funds from the Federal Government to the State and Newport;
- verified the accuracy and completeness of State claims data by selecting 40 Medicaid claims and tracing the amount paid on remittance advices to our computer data;
- verified the accuracy and completeness of a selected sample of direct and indirect costs reported by Newport;
- calculated Medicaid operating costs by multiplying the average cost per patient day by the total number of Medicaid patient days; and
- calculated the Medicaid operating deficit by multiplying the average daily loss by the total number of Medicaid patient days.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Although Newport received sufficient gross Medicaid funding to meet its Medicaid operating costs, it was required to return 97 percent of its upper-payment-limit funding to the State and other health organizations. Neither the Medicaid per diem payments nor the per diem payments plus the retained upper-payment-limit funds were adequate to meet Newport's Medicaid operating costs. That funding shortage may have affected the quality of care provided to its residents. In addition, the Federal Government provided all of Newport's Medicaid funding, with the exception of private payments by Newport residents. This situation is contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

ADEQUACY OF MEDICAID PAYMENTS

Section 1902(a)(30)(A) of the Act requires that Medicaid payments for care and services under an approved State plan be consistent with efficiency, economy, and quality of care. Authority for specific upper payment limits is set forth in 42 CFR § 447.272.

Gross Medicaid payments were adequate to cover Newport's Medicaid operating costs, but retained payments were not. During the 3 years ended December 31, 2002, Medicaid operating costs were \$6.42 million. During the same period, gross Medicaid funding totaled \$46.39 million, including \$5.16 million in per diem payments and \$41.23 million in enhanced payments available under the upper-payment-limit regulations.

From the upper-payment-limit funding of \$41.23 million, the State required Newport to return \$38.93 million (about 94 percent) and to pay \$1.33 million (about 3 percent) to other health organizations. Overall, the State allowed Newport to retain \$6.13 million in Medicaid funding (\$5.16 million in per diem funding and \$970,000 in upper-payment-limit funding). Thus, the per diem payments plus the retained upper-payment-limit funding were insufficient to meet Newport’s Medicaid operating costs. For our 3-year audit period, the total Medicaid operating deficit was \$290,000.

On a daily basis, a similar funding shortage was evident. Newport’s cost reports showed an average daily cost of \$169.61 per resident. As noted in Table 1, the average per diem payment of \$136.36 would have created a daily loss of \$33.25 per resident. The average per diem payment plus the retained upper-payment-limit funding (\$25.60) created a daily loss of \$7.65 per resident. Had the State allowed Newport to retain all of the upper-payment-limit funds, the daily Medicaid-related revenue would have exceeded costs by \$1,056.37.

**Table 1: Medicaid Payments Versus Costs
(average daily)**

	Per Diem Rate	Per Diem + Retained Upper Payment Limit	Per Diem + 100% Upper Payment Limit
Daily Medicaid Payment	\$136.36	\$161.96	\$1,225.98
Daily Cost per Resident	\$169.61	\$169.61	\$169.61
Difference	\$(33.25)	\$(7.65)	\$1,056.37

Newport’s funding deficit occurred because:

- The per diem payments alone were insufficient to meet Newport’s operating costs.
- Newport had a contractual commitment¹ to return at least 82 percent of the upper-payment-limit funding to the State treasurer. In addition, the State directed Newport to pay a total of \$1.33 million to three health organizations: the Association of Washington Public Hospital Districts, Washington Health Foundation, and Washington State Hospital Association.

We are most concerned that, through intergovernmental transfers of funds, the Federal Government provided all of Newport’s Medicaid funding, with the exception of private payments by Newport residents. This situation is contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments. We are also concerned that the three health organizations expended no money for Newport’s residents but received

¹Newport voluntarily signed a contract with the State to participate in the upper-payment-limit funding program.

\$1.33 million in Federal funds. See Appendix B for an illustration of these intergovernmental transfers.

As summarized in Table 2, the Federal Government contributed \$23.09 million in combined per diem and upper-payment-limit funds, the State contributed \$22.46 million, and Newport residents contributed \$840,000. However, Newport returned \$38.93 million to the State, resulting in a profit to the State of \$16.47 million. Also, Newport paid the three health organizations \$1.33 million but received no services in return. Newport retained only \$6.13 million of the \$46.39 million it initially received.

**Table 2: Newport Funding Sources for Medicaid Patients
(in millions)**

	Funding Source				Newport Funds	
	Federal	State	Health Organizations	Residents	Received	Retained
Per Diem Contribution	\$2.20	\$2.12	\$0.00	\$0.84	\$5.16	\$5.16
Upper-Payment-Limit Contribution	<u>20.89</u>	<u>20.34</u>	<u>0.00</u>	<u>0.00</u>	<u>41.23</u>	<u>0.00</u>
Total Contribution	\$23.09	\$22.46	\$0.00	\$0.84	\$46.39	\$5.16
Upper-Payment-Limit Transfer/Distribution	<u>0.00</u>	<u>(38.93)</u>	<u>(1.33)</u>	<u>0.00</u>	<u>0.00</u>	<u>0.97</u>
Net Impact	\$23.09	\$(16.47)	\$(1.33)	\$0.84	\$46.39	\$6.13

In essence, through upper-payment-limit transactions, the financial burden of caring for Medicaid patients at Newport was shifted almost entirely to the Federal Government.

LINK BETWEEN QUALITY OF CARE AND FUNDING

Pursuant to 42 CFR § 483.30, facilities must have sufficient nursing staff to provide nursing and related services that attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Staffing is considered sufficient if licensed nurses and other nursing personnel provide nursing care to all residents on a 24-hour basis in accordance with resident care plans. Also, pursuant to 42 CFR § 483.70, facilities must have sufficient space and equipment to enable staff to provide residents with needed services as identified in their plans of care.

We selected Newport for audit because it received numerous immediate jeopardy and actual harm ratings during our review period. Those ratings, the most unfavorable that a State can issue, represented deficiencies that constituted actual harm to patients and required immediate correction.

The deficiencies in quality of care may have resulted from Newport’s Medicaid funding shortage. During our audit period, Newport was understaffed considering the number of positions needed as identified by management and recommended by Abt Associates. Recent studies by GAO and Abt Associates indicated that the ratio of nursing staff to residents could affect quality of care. Further, Newport officials believed that they could improve quality of care if they had more funds.

Although the Medicaid funding that Newport retained was not adequate to cover its Medicaid operating costs, Newport’s management recognized the importance of having a nursing home in a rural community and used funds from bonds, tax revenue, and donations to cover their losses and keep the facility open. Newport also corrected the quality-of-care deficiencies cited by the State.

Nursing Staff Shortages

According to a Newport official, the staffing level in June 2001 was short by three employees when compared with the number of positions needed to maintain quality of care. (See Table 3.) We found similar staffing shortages in other months.

Table 3: Needed Versus Actual Nursing Staff

	Newport’s Need	Actual in June 2001	Shortage
Number of Licensed Staff	6	5	1
Number of Certified Nurse Aides	<u>16</u>	<u>14</u>	<u>2</u>
Total	22	19	3

Our interviews with the staff revealed that they were stretched thin during mealtimes, night shifts, and unscheduled absences. Furthermore, they stated that the current staffing level might not be sufficient to provide necessary care and services in fire or other emergency or disaster situations.

Staffing and Quality-of-Care Studies

Recent studies indicate that the ratio of nursing staff to residents could affect quality of care.

A GAO study (GAO-02-431R, “Nursing Home Expenditures and Quality”) showed that in two States, nursing homes that provided more nursing hours per resident day, especially nurses’ aide hours, were less likely than homes providing fewer nursing hours to have repeated, serious, or potentially life-threatening quality problems, as measured by deficiencies detected during State surveys.

In addition, Abt Associates, under contract with CMS, issued a study in December 2001 entitled “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.” This study noted that quality improves with incremental increases in staffing up to certain

recommended thresholds based on a nursing home’s average resident population. As illustrated in Table 4, in June 2001, Newport did not meet the recommended thresholds.

Table 4: Recommended Versus Actual Nursing Staff

	Abt Associates Recommendation	Actual in June 2001	Shortage
Number of Licensed Staff	8	5	3
Number of Certified Nurse Aides	<u>16</u>	<u>14</u>	<u>2</u>
Total	24	19	5

Training, Facility Improvements, and Safety Equipment

Newport officials believed that the home could improve quality of care if it had more funds to hire additional staff, provide more training, improve its facility, and purchase safety equipment.

According to the officials, the current training program met minimum State requirements, but employees would like to have more hands-on and inservice training to reinforce their skills and learn new patient care techniques. Regarding facility improvements, officials would like to reduce the number of residents per room by adding more rooms, and they would like to have a bathroom in each room. Officials would also like to make improvements in fall alarms, call lights, and other safety equipment.

RECOMMENDATIONS

We recommend that the State:

- consider revising Newport’s per diem rate to more closely reflect operating costs and
- allow Newport to retain sufficient funding, including upper-payment-limit funding as necessary, to cover the costs of providing an adequate level of care to its residents.

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, the State did not concur with our conclusions and recommendations. The State said that we misunderstood the Medicaid nursing facility payment system (per diem rate) and mischaracterized the Proportionate Share program (upper-payment-limit funding). The State also said that our conclusions concerning the link between quality of care and funding were not well founded.

We summarized and addressed the State’s comments below and included the comments, except the enclosures, in their entirety as Appendix C. The enclosures to the State’s

comments are available upon request. Where appropriate, we revised the report to reflect the State's comments.

State Comments on the Per Diem Rate

The State said that we misunderstood how the Medicaid payment system operated. It stated that Newport's Medicaid per diem rate was in compliance with appropriate State regulations and the approved Medicaid State plan. According to the State, the payment rate was based on the median cost for all nursing homes, and Newport's reported costs exceeded the median cost limits.

Office of Inspector General Response

We disagree that we misunderstood the Medicaid per diem rate. Because the State defined any costs above the median cost limits as unallowable, payments to Newport were 20 percent lower than its operating costs. We believe that the State has the flexibility and authority under Title XIX of the Act to change the payment system and calculate a per diem rate that more closely reflects Newport's operating costs.

State Comments on the Upper-Payment-Limit Funding Program

The State said that we mischaracterized the upper-payment-limit funding program by giving the impression that the State coercively imposed the program upon public nursing homes. The State noted that if a public nursing home chose to participate in the program, the home voluntarily signed a contract that was consistent with State law and the Medicaid State plan. According to the State, it also directed a small portion of Newport's payments to health organizations through a verbal agreement. The State said that this agreement was completely voluntary and had since been discontinued.

Furthermore, the State said that our conclusions and concerns about intergovernmental transfers were both extraneous and unfounded. According to the State, our views on intergovernmental transfers, the underlying equities of the upper-payment-limit funding arrangement, and the shifting of Medicaid costs to the Federal Government were unrelated to the audit objectives.

Office of Inspector General Response

We did not mischaracterize the upper-payment-limit funding program. Although we acknowledge that Newport voluntarily participated in the program, Title XIX of the Act provided the State the flexibility and authority to specify the funding amounts. During the 3-year audit period, the State allowed Newport to retain only \$970,000 of the \$41.23 million in upper-payment-limit funds. During the same period, Newport had a \$290,000 Medicaid operating deficit and may have needed additional Medicaid funds to improve its quality of care.

We disagree with the State's comments on intergovernmental transfers. To ascertain whether Medicaid payments to Newport were adequate to cover its operating costs, it was necessary to understand the upper-payment-limit funding program and the related intergovernmental transfers. Our review showed that the State received \$16.47 million more than it expended for Newport's Medicaid residents and that the Federal Government provided all of Newport's Medicaid funding, with the exception of private payments by Newport residents.

State Comments on the Link Between Quality of Care and Funding

The State said that our conclusions concerning the link between quality of care and funding were not well founded. The State particularly disagreed with the conclusion that Newport was understaffed based on a study by Abt Associates. The State asserted that management practices were frequently the deciding factors in producing positive resident outcomes and that good management practices were generally not sensitive to funding levels.

Office of Inspector General Response

Our conclusions were not based only on the Abt Associates study. Newport had deficiencies in quality of care during the audit period. While we acknowledge that additional funding may not guarantee an improved facility, Newport officials believed that the nursing home could improve quality of care if it had more funds to hire additional staff, provide more training, improve its facility, and purchase safety equipment. Newport's need for additional staff to maintain and improve quality of care is supported by GAO and Abt Associates studies. We continue to believe that an increase in nursing staff, together with other improvements, could have led to improved quality of care for Newport's Medicaid beneficiaries.

OTHER MATTER

We identified errors in the State's calculations of upper-payment-limit funding that resulted in overpayments. The State agreed that it had made some errors and recalculated the upper-payment-limit funding. After we referred the issues to CMS, CMS requested that the State make an adjustment of \$8.86 million (\$4.49 million Federal share).

APPENDIXES

CMS SURVEY PROCEDURES

The Omnibus Budget Reconciliation Act of 1987, implemented in 1990, introduced a standard certification survey process for determining whether nursing homes meet Federal requirements. Nursing homes must meet Federal standards to participate in the Medicaid program. CMS contracts with State governments to conduct periodic surveys to ensure that these standards are met. CMS's June 1995 "State Operations Manual" outlines procedures and protocols for surveys that measure nursing home compliance with Federal requirements.

Surveys assess the quality of services, the accuracy of resident care plans, the observance of residents' rights, and the adequacy of residents' safety. Pursuant to Federal regulations, State agencies must survey each nursing home no later than 15 months after the end of the previous survey. Surveys must be unannounced and conducted by a multidisciplinary team of professionals, at least one of whom must be a registered nurse. After the survey, the State agency determines whether the nursing home is in substantial compliance with Federal requirements.

CMS requires that surveyors interview a certain number of nursing home residents and family members. In addition, surveyors must review the total care environment for a sample of residents to determine if the home's care has enabled residents to reach or maintain their highest practicable physical, mental, and psychosocial well-being. These reviews include an examination of the rooms, bedding, care equipment, and drug therapy that residents receive.

CMS's "State Operations Manual" defines several categories of deficiencies. Each deficiency is placed in 1 of 12 groups depending on the extent of resident harm (severity) and the number of residents adversely affected (scope). The scope of deficiencies may be classified as (1) isolated, affecting a limited number of residents; (2) pattern, affecting more than a limited number of residents; and (3) widespread, affecting all or almost all residents. The four severity levels are:

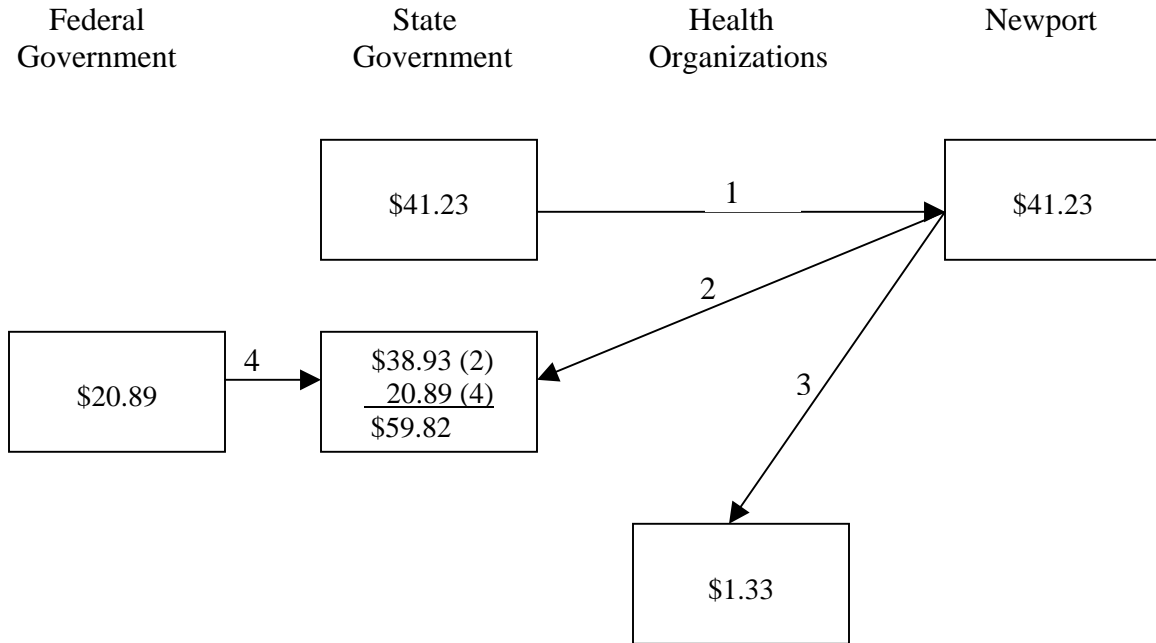
- substantial compliance—deficiencies that have only minimal potential for harm (categories A, B, and C);
- potential for more than minimal harm—deficiencies for which no actual harm has occurred, but with potential for more than minimal harm (categories D, E, and F);
- actual harm—deficiencies that cause actual harm to residents but do not immediately jeopardize their health or safety (categories G, H, and I); and
- immediate jeopardy—deficiencies that immediately jeopardize the health and safety of residents (categories J, K, and L).

CMS uses a fifth designation, “substandard quality of care,” for deficiencies that affect resident behavior and facility practices, quality of life, and quality of care. As illustrated in the chart below, any nursing home with deficiencies in categories F, H, I, J, K, or L (in the shaded area) is considered to provide substandard quality of care.

Scope and Severity

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate Jeopardy	J	K	L
Actual Harm	G	H	I
Potential for More Than Minimal Harm	D	E	F
Potential for Minimal Harm	A	B	C

**INTERGOVERNMENTAL TRANSFERS
OF UPPER-PAYMENT-LIMIT FUNDING
Newport Community Hospital, Long-Term-Care Unit
January 1, 2000 – December 31, 2002
(in millions)**



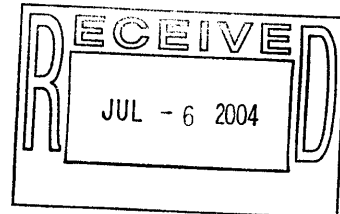
1. The State made upper-payment-limit payments of \$41.23 million to Newport.
2. Newport transferred \$38.93 million back to the State as required.
3. Newport made contractual payments of \$1.33 million to the Association of Washington Public Hospital Districts, Washington Health Foundation, and Washington State Hospital Association.
4. The Federal Government reimbursed the State for its share of the upper-payment-limit funding, which was \$20.89 million.

Note: Newport retained \$970,000 of upper-payment-limit funding.



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia WA 98504-5000

July 1, 2004



Lori A. Ahlstrand
Regional Inspector General for Audit Services
Region IX, Office of Audit Services
50 United Nations Plaza
San Francisco, California 94102

Re: Draft Report Number A-10-04-00001, "Adequacy of Medicaid
Payments to Newport Community Hospital, Long-Term Care Unit"

Dear Ms. Ahlstrand:

Thank you for sending us the above-referenced draft report. After reviewing the draft, we have the following comments and suggestions:

1. The report fundamentally mischaracterizes the Proportionate Share program and payments under it.

If one read this report without bringing to it prior knowledge of the Proportionate Share program (ProShare), one would be left with the impression that the ProShare program was unilaterally and coercively imposed upon Public Hospital Districts by the state. For example, these passages appear on page i, in the first paragraph of the Summary of Findings in the Executive Summary:

- "...the State...required Newport to return \$38.93 million,..."
- "...the State directed Newport to pay \$1.33 million,..."
- "...the State allowed Newport to retain...about \$6.13 million."

In fact, ProShare was a completely voluntary program in which Public Hospital Districts (PHD) were free to participate or not, as they saw fit. If a PHD chose to participate in ProShare, it signed a contract, termed an "Interlocal Agreement," with the state. The contract – consistent with both state law and Washington's State Plan on Medicaid – specified what percentage of the supplemental payments the PHD would return to the state. A separate agreement among the PHDs, their industry associations, and the state – never put into writing and since discontinued – provided that the state would direct a small portion of the PHD payments to the associations. A PHD's participation in both the written Interlocal Agreement and the verbal agreement with the associations was completely voluntary.



Office of Inspector General note: The State's response consisted of a letter and enclosures. The letter contained the State's comments on the draft report. The enclosures included documents related to the upper-payment-limit funding program. Due to the volume and lack of relevance of the enclosures, we included only the State's letter in this appendix.

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Only once – on page 5 – does the report refer to a “contractual commitment” on the part of the Newport PHD, and that reference does not make clear the existence of the Interlocal Agreement signed between DSHS and the Newport PHD.

The report does not include the Interlocal Agreement, the state law authorizing the ProShare program, or the portion of the Washington State Plan describing and authorizing the program. To correct these oversights and to set the record straight, we are enclosing complete copies of the specimen Interlocal Agreement; c. 392, Laws 1999 (see Sec. 2 (15)); and Section XVII of Attachment 4.19-D, Part I of the Washington State Plan under Title XIX of the Social Security Act.

2. The report misunderstands Washington's Medicaid nursing facility payment system.

The report recognizes that the controlling statute is Ch. 74.46 RCW, the Washington nursing facility Medicaid payment system. However, the report does not seem to understand how that system operates. What other conclusion can be drawn from this statement, appearing on page 5 of the draft?

- “The per diem rate alone was insufficient to meet the nursing home's operating costs because the State established a per diem rate that was significantly lower than actual costs.”

The goal of Washington's payment system is stated in RCW 74.46.190 (2):

All documented costs which are ordinary, necessary, related to care of medical care recipients, and not expressly unallowable under this chapter or department rule, are to be allowable....

The Newport PHD's Medicaid nursing facility rate was established in compliance with Ch. 74.46 RCW and the related regulation, Ch. 388-96 WAC. The statute and the regulation are both included in Washington's State Plan on Medicaid, which is filed with and approved by the Centers for Medicare and Medicaid Services.

Reported costs often differ from costs that are allowable for payment under Washington's Medicaid nursing facility payment system. For example, inherent in our system are payment lids based on the median cost for all nursing homes. In the case of Newport, the reported costs exceeded these median cost limits. Washington did pay Newport for all of its allowable Medicaid costs. We disagree with any recommendation that would require us to pay for nonallowable costs.

3. The report cites an inappropriate regulation.¹

On page 6, the draft cites Ch. 388-97 WAC as the source of regulatory standards for resident care and services at the Newport PHD nursing facility. This is an error.

¹ Office of Inspector General note: This comment no longer applies to this report because the issue referred to by the State has been deleted.

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DSHS licenses nursing homes under Ch. 18.51 RCW, and has adopted regulations for them at Ch. 388-97 WAC. However, hospitals are exempted from Ch. 18.51 RCW. Instead, hospitals – including their long-term care units – are licensed by the Washington Department of Health under Ch. 70.41 RCW. The Residential Care Services Division within DSHS' Aging and Disability Services Administration performs surveys at hospital long-term care units, but those are done under federal requirements for Medicare and Medicaid. The standards and enforcement mechanisms of Ch. 388-97 are not applicable to hospital long-term care units.

4. The report's conclusions concerning the link between quality of care and funding are not well founded.

The report asserts that the long-term care unit could improve the quality of care if it had more funds to hire additional staff, provide more training, make improvements to its facility, and purchase necessary safety equipment. More particularly, the report states that during the audit period Newport was understaffed. This conclusion was based on a comparison between the number of staff that Newport identified as necessary and the "number of positions needed to maintain quality of care" based on an excerpt from a report done by Abt Associates under contract to CMS, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," Phase II Final Report, December 2001.

The Abt report itself concluded that nurse-to-resident staffing ratios are only one aspect of adequate staffing. In addition to staffing ratios, many factors impact the quality of care, e.g.: wages/benefits, training, supervision, career ladders, scheduling, and a host of staff organizational considerations. All of these were outside the scope of the Abt study.

In Washington State's experience with quality of care oversight and regulation in nursing homes, nursing home management practices are frequently the deciding factors in producing positive resident outcomes. Good management practices are generally not sensitive to the level of funding.

5. The report's conclusions and concerns about intergovernmental transfers are both extraneous and unfounded.

By its own terms, the audit's two objectives were to ascertain whether:

- Medicaid payments to Newport were adequate to cover its Medicaid operating costs, and
- a link could be drawn between the quality of care that Newport provided to its residents and the amount of Medicaid funding received.

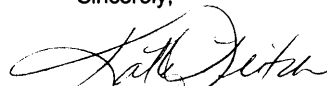
Notwithstanding these clear, limited objectives, the report includes the auditors' views on the use and appropriateness of intergovernmental transfers; the underlying equities of the ProShare arrangement among the PHDs, the state health associations, and the

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state; and the alleged "shifting" of Medicaid costs to the federal government. The report generally mischaracterizes the ProShare program as a unilateral imposition upon PHDs by the state, designed to circumvent the joint federal/state funding design of Medicaid.

As noted previously, the ProShare program was set up under Washington State statute. It was specifically made part of Washington's State Plan for Medicaid, and therefore approved by CMS. The participation of PHDs in the program was completely voluntary, and was subject to a written agreement between each PHD and the state. While a small amount of money was directed to several state health associations, this was done on the basis of a voluntary agreement between the PHDs, the associations, and the state. The ProShare program was voluntary, above-board, and consistent with legal requirements as they existed and were administered at the time. We strenuously object to the report's suggestions to the contrary.

Sincerely,



Kathy Leitch, Assistant Secretary
Aging and Disability Services Administration

Enclosures

cc: Doug Porter

ACKNOWLEDGMENTS

This report was prepared under the direction of Lori Ahlstrand, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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