DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 12 2005

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

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

**SUBJECT:** Adequacy of New York State's Medicaid Payments to A. Holly Patterson Extended Care Facility (A-02-03-01004)

Attached is an advance copy of our final report on the adequacy of New York State's Medicaid payments to A. Holly Patterson Extended Care Facility (Patterson). 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 Patterson for audit because it received an immediate jeopardy rating from the State Department of Health in October 2000. An immediate jeopardy rating is the most unfavorable rating that a State can issue.

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

Total, or gross, Medicaid payments to Patterson were adequate to cover Medicaid-related costs, but net payments were not. During the 3 years ended September 30, 2001, Patterson's Medicaid operating costs were about $190 million. During the same period, gross Medicaid payments totaled $348 million—$145 million in per diem payments and $203 million in enhanced payments available under the upper-payment-limit regulations. However, the State established per diem rates that were lower than actual costs, and the State and the county required Patterson to return $183 million (about 90 percent) of its upper-payment-limit funding. Accordingly, the net Medicaid funding that Patterson was allowed to retain was only $165 million, which was $25 million less than its Medicaid operating costs.

As we have found in other States, New York's upper-payment-limit funding approach benefited the State and the county more than the nursing home. The State received $23 million more than it expended for Patterson's Medicaid residents, and the county was reimbursed 100 percent for its upper-payment-limit contribution. We are concerned that the Federal Government provided

almost all of Patterson's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

The Medicaid funding that Patterson 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, Patterson 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 and Abt Associates indicated that the ratio of nursing staff to residents could affect quality of care. Further, Patterson officials believed that they could improve quality of care if they had more funds to hire additional nursing and specialized staff, provide more training, and improve security and resident safety.

We recommend that the State:

- consider revising Patterson's Medicaid per diem rate to more closely reflect operating costs and

- allow Patterson 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 agree with our conclusions and recommendations. The State said that its regulations prohibited the recalculation of a Medicaid rate and that it did not dictate to the county how upper-payment-limit funds should be distributed.

We are not persuaded by the State's comments. The State should submit a State plan amendment to CMS to calculate Patterson's Medicaid rate on a more current base year and revise the State regulations as necessary. Also, the State's agreement with each county allowed nursing homes to retain only 10 percent of their upper-payment-limit funds and thus dictated the county's distribution of those funds.

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 Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-03-01004 in all correspondence.

Attachment

Office of Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

APR 14 2005

Report Number: A-02-03-01004

Antonia C. Novello, M.D.
Commissioner
State of New York Department of Health
Corning Tower, Empire State Plaza
14th Floor, Room 1408
Albany, New York 12237

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Adequacy of New York State's Medicaid Payments to A. Holly Patterson Extended Care Facility." A copy of this report will be forwarded to the 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.

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Please refer to report number A-02-03-01004 in all correspondence.

Sincerely,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures

**Direct Reply to HHS Action Official:**

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
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**Department of Health and Human Services**

**OFFICE OF INSPECTOR GENERAL**

# ADEQUACY OF NEW YORK STATE'S MEDICAID PAYMENTS TO A. HOLLY PATTERSON EXTENDED CARE FACILITY


**APRIL 2005**
**A-02-03-01004**

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**http://oig.hhs.gov**

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## 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 New York State consists of the per diem rate and upper-payment-limit funds. The facility-specific per diem reimbursement rate covers basic care and many 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 A. Holly Patterson Extended Care Facility (Patterson) were adequate to cover its operating costs and

- a link could be drawn between the quality of care that Patterson provided to its residents and the amount of Medicaid funding received.

## SUMMARY OF FINDINGS

### Adequacy of Medicaid Payments

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

During the 3 years ended September 30, 2001, Patterson's Medicaid operating costs were about $190 million. During the same period, gross Medicaid payments totaled $348 million—$145 million in per diem payments and $203 million in enhanced payments available under the upper-payment-limit regulations. However, the State established per diem rates that were lower than actual costs, and the State and the county required Patterson to return $183 million (about 90 percent) of its upper-payment-limit funding. Accordingly, the net Medicaid funding that Patterson was allowed to retain was only about $165 million, which was $25 million less than its Medicaid operating costs.

The State's upper-payment-limit funding approach benefited the State and the county more than Patterson. The State received $23 million more than it expended for Patterson's Medicaid residents, and the county was reimbursed 100 percent for its upper-payment-limit contribution. We are concerned that the Federal Government provided almost all of Patterson's Medicaid funding, 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 Patterson for audit because it received an immediate jeopardy rating from the State Department of Health in October 2000. An immediate jeopardy rating is the most unfavorable rating that can be issued.

The net Medicaid funding that Patterson 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, Patterson 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, Patterson officials believed that they could improve quality of care if they had more funds to hire additional supervisors as well as nursing and specialized staff, provide additional training, and improve facility security and resident safety.

## RECOMMENDATIONS

We recommend that the State:

- consider revising Patterson's Medicaid per diem rate to more closely reflect operating costs and

- allow Patterson 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 disagreed with our conclusions and recommendations. The State said that its regulations prohibited the recalculation of a Medicaid rate and that it did not dictate to the county how upper-payment-limit funds should be distributed.

## OFFICE OF INSPECTOR GENERAL RESPONSE

We are not persuaded by the State's comments. The State should submit a State plan amendment to CMS to calculate Patterson's Medicaid rate on a more current base year and revise the State regulations as necessary. Also, the State's agreement with each county allowed nursing homes to retain only 10 percent of their upper-payment-limit funds and thus dictated the county's distribution of those funds.

## TABLE OF CONTENTS

**Page**

**INTRODUCTION** .....1

BACKGROUND .....1
Medicaid Program .....1
State Surveys .....2
A. Holly Patterson Extended Care Facility .....2

OBJECTIVES, SCOPE, AND METHODOLOGY .....2
Objectives .....2
Scope .....3
Methodology .....3

**FINDINGS AND RECOMMENDATIONS** .....4

ADEQUACY OF MEDICAID PAYMENTS …… .....4

LINK BETWEEN QUALITY OF CARE AND FUNDING.....6
Nursing Staff Shortages.....7
Staffing and Quality-of-Care Studies.....7
Nurses and Other Specialized Staff, Training, and Security Improvements .....8

RECOMMENDATIONS .....8

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....9
Medicaid Rate Calculation.....9
Lower Case Mix Index.....9
Medicare Versus Medicaid Reimbursement Rates.....10
Distribution of Upper-Payment-Limit Funds.....10
Patterson Staffing Levels.....11

**APPENDIXES**

A – CMS SURVEY PROCEDURES
B – INTERGOVERNMENTAL TRANSFERS OF UPPER-PAYMENT-LIMIT FUNDING
C – STATE COMMENTS

# INTRODUCTION

## BACKGROUND

### Medicaid Program

Title XIX of the Social Security Act (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 New York State, the Department of Health administers the Medicaid program. The Department of Health's Bureau of Long Term Care Reimbursement calculates nursing home reimbursement rates pursuant to part 86-2 of Title 10 of the New York Code of Rules and Regulations.

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

#### Per Diem Rate

Under New York's State plan, all nursing homes receive a facility-specific per diem reimbursement that covers basic care and many ancillary services for Medicaid-eligible residents. In New York State, the Federal Government contributes 50 percent of the long-term-care per diem reimbursement, the State contributes 40 percent, and the counties contribute 10 percent.

#### 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 most 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 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.

New York State allocates upper-payment-limit funds to nursing homes according to the ratio of a particular nursing home's Medicaid patient days to the total Medicaid patient days of all nursing homes in the State. During our 3-year audit period, the State upper-payment-limit funding totaled $2.66 billion.

### 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 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.

### A. Holly Patterson Extended Care Facility

During the audit period, Patterson was an 889-bed, public long-term-care facility operated by Nassau County. The geriatric unit had a capacity of 859 beds, and the AIDS and ventilation units each had a capacity of 20 beds. The Medicaid per diem rate was significantly greater for the AIDS and ventilation unit residents because the cost of their care was higher than the cost of care for geriatric unit residents. Approximately 91 percent of the residents were Medicaid beneficiaries.

On October 2, 2000, Patterson received an immediate jeopardy rating from the Department of Health for a pattern of deficiencies observed between September 25 and September 29, 2000. Those deficiencies constituted actual harm to residents, including the death of one resident, and required significant corrections.

Patterson had similar, although less severe, deficiencies in its September 1999 and October 2001 surveys.

## OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

Our objectives were to ascertain whether:

- Medicaid payments to Patterson were adequate to cover its operating costs and

- a link could be drawn between the quality of care that Patterson provided to its residents and the amount of Medicaid funding received.

**Scope**

Our audit covered the 3 years ended September 30, 2001. During that period, Patterson received $347.6 million in Medicaid funding, including per diem payments totaling $144.73 million ($72.36 million Federal share) and upper-payment-limit funding of $202.87 million ($101.4 million Federal share).

We did not assess Patterson'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 the majority of our fieldwork at Patterson in Uniondale, NY.

**Methodology**

To accomplish our objectives, we:

- reviewed Federal and State laws and regulations and several nurse staffing and quality-of-care studies;

- interviewed officials from CMS, the State, the county, and Patterson;

- toured Patterson and interviewed nursing staff;

- reviewed Patterson's documentation, including medical records, remittance advices, corrective action plans, financial statements, Medicaid cost reports, and staffing assignments and patterns;

- verified compliance with the corrective action plans that Patterson prepared in response to State surveys;

- analyzed the flow of funds from the Federal Government to the State and Patterson;

- verified the accuracy and completeness of State claims data by selecting 50 Medicaid claims and tracing the amount paid on remittance advices to our computer data;

- reviewed administrative costs to determine whether they were reasonable, allowable, and allocable;

- 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.

We discussed our findings with county and Patterson officials. The officials agreed with our amounts for Medicaid per diem rates and average per day operating costs and with the flow of upper-payment-limit funds. Although we directed no recommendations to the county or Patterson, we requested and received oral comments from both parties and considered them in preparing our final report.

## FINDINGS AND RECOMMENDATIONS

Although Patterson received sufficient gross Medicaid funding to meet its Medicaid operating costs, it was required to return 90 percent of its upper-payment-limit funding to the State and the county. Neither the Medicaid per diem payments nor the per diem payments plus the retained upper-payment-limit funds were adequate to meet Patterson's Medicaid operating costs. That funding shortage may have affected the quality of care provided to its residents. In addition, the Federal Government provided nearly all of Patterson's Medicaid funding, 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 Patterson's Medicaid operating costs, but retained payments were not. During the 3 years ended September 30, 2001, Medicaid operating costs were $190 million. During the same period, gross Medicaid funding totaled $347.6 million, including $144.7 million in per diem payments and $202.9 million in enhanced payments available under the upper-payment-limit regulations.

From the upper-payment-limit funding of $202.9 million, the State and the county required Patterson to return $182.6 million (about 90 percent). Ultimately, Patterson was allowed to retain only $165 million in Medicaid funding ($144.7 million in per diem funding and $20.3 million in upper-payment-limit funding). Thus, the per diem payments plus the retained upper-payment-limit funding were insufficient to meet Patterson's Medicaid operating costs. For our 3-year audit period, the total Medicaid operating deficit was $24.7 million.[1]

On a daily basis, a similar funding shortage was evident. As noted in Table 1, the average per diem payment would have created a daily loss in all three of Patterson's units. The average per diem payment plus the retained upper-payment-limit funding ($24.32) created a daily loss in two of the three units. Had Patterson been allowed to retain all of the upper-

[1]We computed the total Medicaid operating deficit by multiplying the average daily deficit by the total Medicaid patient days per year.

payment-limit funds, the daily Medicaid-related revenue would have created daily surpluses in all three units.

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

| | Per Diem Rate | Per Diem + Retained Upper Payment Limit | Per Diem + 100% Upper Payment Limit |
|---|---|---|---|
| **Geriatric Unit:** | | | |
| Daily Medicaid Payment | $180.25 | $204.57 | $423.44 |
| Daily Cost per Resident | 236.19 | 236.19 | 236.19 |
| **Difference** | **$(55.94)** | **$(31.62)** | **$187.25** |
| **AIDS Unit:** | | | |
| Daily Medicaid Payment | $431.00 | $455.32 | $674.19 |
| Daily Cost per Resident | 435.29 | 435.29 | 435.29 |
| **Difference** | **$(4.29)** | **$20.03** | **$238.90** |
| **Ventilation Unit:** | | | |
| Daily Medicaid Payment | $519.32 | $543.64 | $762.51 |
| Daily Cost per Resident | 602.45 | 602.45 | 602.45 |
| **Difference** | **$(83.13)** | **$(58.81)** | **$160.06** |

Patterson's funding deficit occurred because:

- The per diem payments alone were insufficient to meet Patterson's operating costs. The State based the per diem rate on 1983 costs. Although the rate was updated annually for inflation, the rate did not reflect Patterson's current operating costs.

- NY Public Health Law, section 2808 (1996) required counties to return 40 percent of their nursing homes' upper-payment-limit funding to the State. In addition, as reaffirmed in a letter from the State each year, an agreement between the State and the counties allowed public nursing homes to retain only 10 percent of their upper-payment-limit funds; the county retained the remaining 50 percent.

We are most concerned that, through intergovernmental transfers of funds, the Federal Government provided almost all of Patterson's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments. Neither the State nor the county contributed to Patterson's upper-payment-limit funding. At the same time, the Federal Government contributed $101.4 million in upper-payment-limit funding—more than the total upper-payment-limit funds that Patterson retained. See Appendix B for an illustration of these transactions.

As summarized in Table 2, the Federal Government contributed approximately $174 million in combined per diem and upper-payment-limit funds, and the county contributed approximately $14 million. The State was able to make a profit of more than $23 million. Patterson retained only about $165 million of the $348 million it initially received.

**Table 2: Patterson's Funding Sources for Medicaid Patients (in millions)**

| | Funding Source | | | Patterson Funds | |
|---|---|---|---|---|---|
| | **Federal** | **State** | **County** | **Received** | **Retained** |
| Per Diem Contribution | $72.36 | $57.89 | $14.47 | $144.72 | $144.72 |
| Upper-Payment-Limit Contribution | 101.44 | 0.00 | 101.44 | 202.88 | 0.00 |
| **Total Contribution** | $173.80 | $57.98 | $115.91 | $347.60 | $144.72 |
| Upper-Payment-Limit Transfer/Reimbursement | 0.00 | (81.15) | (101.44) | 0.00 | 20.29 |
| **Net Impact** | **$173.80** | **$(23.26)** | **$14.47** | **$347.60** | **$165.01** |

In essence, through upper-payment-limit transactions, the financial burden of caring for Medicaid patients at Patterson 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. Further, New York Code of Rules and Regulations, Title 10, section 415.13 requires facilities to ensure that each resident receives treatments, medications, diets, and other health services in accordance with individual care plans.

We selected Patterson for audit because it received an immediate jeopardy rating in October 2000. This rating, 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 Patterson's Medicaid funding shortage. During our audit period, Patterson 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, Patterson officials believed that they could improve quality of care if they had more funds.

Although the Medicaid funding that Patterson retained was not adequate to cover its Medicaid operating costs, Patterson used cash reserves (as working capital) from the issuance of bonds to cover its losses and keep the facility open.

**Nursing Staff Shortages**

As illustrated in Table 3, Patterson's staffing level in September 2000 was short by 99 employees when compared with the number of budgeted positions. We found similar staffing shortages in other months.

**Table 3: Budgeted Versus Actual Nursing Staff**

| | Budgeted | Actual in September 2000 | Shortage |
|---|---|---|---|
| Registered Nurses | 88 | 78 | 10 |
| Licensed Practical Nurses | 122 | 108 | 14 |
| Certified Nurse Aides | 403 | 328 | 75 |
| **Total** | **613** | **514** | **99** |

Patterson's staffing was based on a prior-year census and assumed a relatively stable resident population.[2] Patterson officials believed that additional nursing staff would improve the quality of care provided to its residents by reducing the nurse-to-resident ratios and providing more personalized service.

**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 nurse 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, Patterson did not meet the recommended thresholds on September 26, 2000, during the survey that resulted in an immediate jeopardy rating. We reviewed several other days and found that staffing shortages generally decreased from 2000 through 2001 because

[2]Patterson determined its staffing budget by calculating the number of daily hours of direct patient care needed per patient. The budgeted nursing staff positions for 2000 were based on the number of residents as of December 1999.

Patterson's resident population declined. However, during this period, staffing levels still fell short of Abt Associates recommendations.

**Table 4: Recommended Versus Actual Nursing Staff**

| | Abt Associates Recommendation | Actual (9/26/00) | Shortage |
|---|---|---|---|
| Registered Nurses | 77 | 63 | 14 |
| Licensed Practical Nurses | 57 | 81 | (24) |
| Certified Nurse Aides | 288 | 228 | 60 |
| **Total** | **422** | **372** | **50** |

**Nurses and Other Specialized Staff, Training, and Security Improvements**

According to Patterson officials, the home could improve quality of care if it had more funds to hire additional staff, provide more training, and improve facility security and resident safety. For example, the officials said they would like to hire more nurses and other specialized staff, including therapists, to enhance skilled care. With fewer therapists, nurses must take time away from their normal duties to provide occupational and physical therapy to the residents. In addition, Patterson had only one inservice educational specialist for more than 700 employees. Therefore, according to Patterson officials, additional trainers were needed to work with the staff, and additional supervisors could provide much needed one-on-one training.

Patterson officials also indicated that the lack of adequate funding had caused security and resident safety problems, as indicated in the State's 2001 survey. The officials noted that, contrary to physician orders, patients sometimes left the facility without authorization. Patterson officials said that additional funding would:

- permit the hiring and retention of additional security personnel to be posted at all exits and to conduct patrols throughout the entire facility,

- allow for the installation of computer systems to better identify residents having the right to exit the building safely and to prohibit exit of those who do not, and

- allow for greater education in the areas of emergency management and extended nursing home security training.

**RECOMMENDATIONS**

We recommend that the State:

- consider revising Patterson's Medicaid per diem rate to more closely reflect operating costs and

- allow Patterson 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 written comments on our draft report, the State did not agree with our conclusions and recommendations. The State's comments, as well as our responses, are summarized below. The full text of the State's comments is included as Appendix C.

### Medicaid Rate Calculation

#### State Comments

The State said that through a State plan amendment, CMS had approved its method for calculating Medicaid rates for nursing homes and that the 1983 cost report was the base used to calculate Patterson's rates. According to the State, its regulations prohibit recalculating the Medicaid rate using a new base year without a complete change in ownership, the appointment of a receiver, a complete replacement of the building, or a major construction/renovation to conform to current codes.

#### Office of Inspector General Response

The State should submit a State plan amendment to CMS to calculate Patterson's Medicaid rate on a more current base year and revise the State regulations as necessary.

### Lower Case Mix Index

#### State Comments

The State commented that, without upper-payment-limit funds, Patterson's Medicaid rate was slightly lower than the average rate in the area but that Patterson had a lower case mix index. The State also noted that the net benefit of the calendar year 2002 upper-payment-limit funds that Patterson recorded on its financial statements resulted in a Medicaid rate that was higher than the average in Nassau County.

#### Office of Inspector General Response

Although Patterson's funding was higher than the county average, its funding was still well below Patterson's average operating costs per day. For our 3-year audit period, the Medicaid operating deficit, with the 10-percent retained upper-payment-limit funds, totaled approximately $25 million. We computed the total Medicaid operating deficit by multiplying the average daily shortfall by the total number of Medicaid patient days for each year in our audit period.

## Medicare Versus Medicaid Reimbursement Rates

### State Comments

The State commented that our computation of Patterson's operating costs should have included only those costs associated with Medicaid residents because costs for Medicare residents were higher.

### Office of Inspector General Response

We agree that ideally Patterson's operating costs should include only those costs associated with Medicaid residents. However, we were unable to separate operating costs by resident type (e.g., Medicare, Medicaid, or private pay) because Patterson did not separately categorize its operating expenses by resident type in its internal accounting records or financial statements. Therefore, we used total operating expenses to calculate the cost per day for each resident.

We acknowledge that the average daily operating cost of the facility, as used in our report, may differ slightly from the average daily operating cost of caring for only Medicaid patients. However, we believe that any difference would be minimal. The Medicaid population at Patterson was approximately 91 percent of the total resident population, whereas the Medicare population was about 5 percent during our 3-year audit period. Consequently, the vast majority of the expenses were for Medicaid residents. We believe that the percentage of Medicare residents was so low that any difference in costs would have a minimal effect on our calculation of costs per day.

## Distribution of Upper-Payment-Limit Funds

### State Comments

The State said that it did not dictate the financial relationship between the county and Patterson; upper-payment-limit funding transactions were between the county and the State.

### Office of Inspector General Response

We do not agree with the State's description of its role in allocating upper-payment-limit funding. In 1995, the counties reached an agreement with the State that allowed nursing homes to retain only 10 percent of their upper-payment-limit funds. This process is reaffirmed each year in a letter from the State to each county. Therefore, the State dictates the financial relationship between the county and Patterson for the purposes of allocating upper-payment-limit funding.

**Patterson Staffing Levels**

**State Comments**

In its comments on our second recommendation, the State noted that Patterson's staffing levels were equal to or higher than those of other facilities in Nassau County.

**Office of Inspector General Response**

During our audit period, Patterson's nurse staffing levels did not meet the levels recommended by Abt Associates or the levels budgeted by Patterson officials. The number of budgeted positions was based on Patterson's calculation of the number of hours of patient care needed per day. We believe that Patterson was in the best position to determine its required nursing staff needs.

# 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

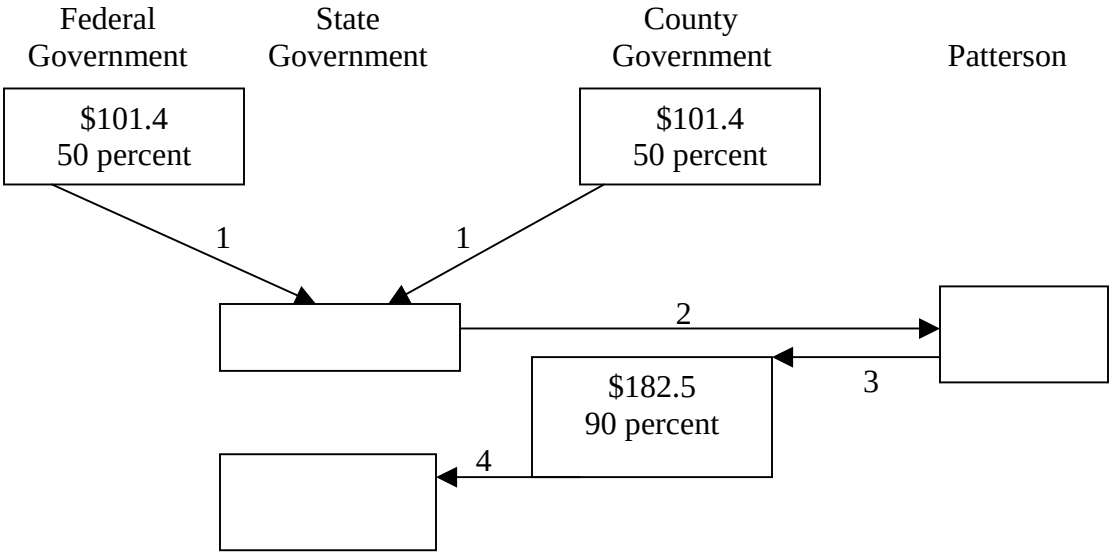
the chart below, any nursing home with deficiencies in categories F, H, I, J, K, or L (in the shaded area) is considered to provide substandard quality of care.

**Scope and Severity**

| Severity | Scope | | |
|---|---|---|---|
| | **Isolated** | **Pattern** | **Widespread** |
| Immediate Jeopardy | | | |
| Actual Harm | G | | |
| Potential for More Than Minimal Harm | D | E | |
| Potential for Minimal Harm | A | B | C |

**APPENDIX B**

**INTERGOVERNMENTAL TRANSFERS OF UPPER-PAYMENT-LIMIT FUNDING**
**A. Holly Patterson Extended Care Facility**
**October 1, 1998 – September 30, 2001**
(in millions)




1. The State withdrew $101.4 million each from the Federal Government and county holding accounts.

2. The State transferred $202.8 million to Patterson's operating bank account.

3. The county transferred $182.5 million from Patterson's operating account to the county general fund.

4. The State withdrew $81.1 million from the county general fund.

Note: Patterson retained $20.3 million of upper-payment-limit funding.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*

September 8, 2004

Timothy J. Horgan
Regional Inspector General for
Audit Services
DHHS OIG Office of Audit Services
26 Federal Plaza
Room 3900A
New York, New York 10278

Dear Mr. Horgan:

Enclosed are the Department of Health's comments on the DHHS - OIG's Draft Audit (A-02-03-01004) entitled "Adequacy of Medicaid Payments to A. Holly Patterson Extended Care Facility."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Cox
Ms. Gill
Mr. Griffin
Mr. Higgitt
Mr. Howe
Ms. Kuhmerker
Mr. Meister
Ms. Pettinato
Mr. Osten
Mr. Reed
Mr. Servis
Mr. Seward
Mr. Van Guysling
Mr. Van Slyke
Ms. Wickens

# Department of Health
# Comments on the
# Department of Health and Human Services
# Office of Inspector General
# Draft Audit Report
# A-02-03-01004 Entitled
# "Adequacy of Medicaid Payments to
# A. Holly Patterson Extended Care Facility"

The following are the Department of Health's (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-03-01004) entitled "Adequacy of Medicaid Payments to A. Holly Patterson Extended Care Facility"

**Recommendation #1:**

Seek the necessary authority to calculate the nursing home's Medicaid per diem rate to more closely reflect operating costs.

**Response #1:**

The methodology for the calculation of Medicaid rates for nursing facilities was approved by the Centers for Medicare and Medicaid Services through a State Plan Amendment. In keeping with that federally approved methodology, the base utilized to calculate the Medicaid rates for A. Holly Patterson is the 1983 cost report. **Currently, the regulations prohibit recalculation of a Medicaid rate utilizing a new base year unless there has been a** complete change in ownership, the appointment of a receiver, a complete replacement of the nursing facility building or major construction/renovation to conform to current codes.

Over a number of years several proposals, both regulatory and legislative, have been made to update the base year and reimbursement methodology for nursing facilities. However, these have not been enacted into law or regulation. Absent statutory/regulatory change, the Department is required to use the methodology currently in law and State Plan Amendment.

The following presents a comparison of A. Holly Patterson to the average of other Nassau County nursing facilities:

- Exclusive of the Upper Payment Limit (UPL) payment, A. Holly Patterson has a slightly lower Medicaid rate ($196.87) than the average Medicaid rate for Nassau County nursing facilities ($210.55), but they also have a lower case mix index (CMI) of 1.12 (which relates to the acuity level of the residents in the facility), than the average CMI for other nursing facilities of 1.24. By including the net benefit of the 2002 UPL payment that A. Holly Patterson recorded on their financial

statements, the Medicaid rate increases to $222.02, which is higher than the average.

- A. Holly Patterson reports a weighted average private pay rate of $222.02, which is substantially less than the average weighted private pay rate of $309.54 for facilities in Nassau County. Such private pay rates are established by the facility, and are not subject to regulation by New York State.

When examining the relationship of the Medicaid rate to the operating costs of the nursing home, it is necessary to look only at the operating costs associated with Medicaid residents rather than the overall operating costs of the facility. Medicare residents have a much higher cost of care, and correspondingly, Medicare reimburses a higher rate and should not be included in such a comparison. The cost report does not break out just Medicaid costs so this comparison cannot be made.

It should also be noted that New York spends $6.5 billion on Medicaid nursing home care – more than California and Pennsylvania combined, which are the next two highest spending states. In addition, New York's per recipient costs are $31,000, which is significantly greater than the national average of $23,259. The State's per recipient costs also greatly exceed those of other states including California ($20,015) and Florida ($17,683), and states in the Northeast such as Massachusetts ($20,171) and New Jersey ($30, 569).

**Recommendation #2:**

Allow the nursing home to retain adequate funding, including upper payment limit funding as necessary, so that it can hire additional staff, provide more training, and improve its security and resident safety.

**Response #2:**

**The State law does not dictate the financial relationship between the County and the County operated nursing facility.** The financial relationship between the County and its nursing home is locally established by the locally elected county government.

For 2002, inclusive of the recorded net value of the UPL payments in the nursing facility, A. Holly Patterson reported a total loss of $4,229,326 or 5.8% of the total revenue base. In 2003, they reported a total loss of $8,007,891 or 15.3% of the total revenue base.

A comparison of the Registered Nurses (RN) Full Time Equivalent (FTE) per bed and total direct care FTEs per bed between A. Holly Patterson and the total per bed FTEs for Nassau County in 2002 on average reveals the following:

| | RN FTEs per bed | Direct Care FTEs per bed |
|---|---|---|
| A. Holly Paterson | 0.06 | 0.56 |
| Average for all facilities in County | 0.06 | 0.53 |

As indicated, the staffing levels are at or higher than the average staffing levels of other facilities operating in Nassau County, while the CMI for A. Holly Patterson is well below the average (1.12 vs. 1.24). Staffing levels have not been identified in any Statement of Deficiencies issued by the Department during the time covered by the audit, or since, as a cause of quality of care problems for which the facility was cited. In most cases in which this facility was cited for noncompliance with federal regulations, the deficient practice identified was caused by the lack of facility policies and procedures to guide staff in appropriate processes, or the failure of staff to follow either facility policy or the professional standards of practice.

New York State passed a special worker recruitment and retention bill that will provide $475.5 million in funds to nursing facilities to attract, hire, retain and train employees for the period 2002-2004. A. Holly Patterson will receive $3,300,315 over the three-year period for these purposes.