DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 31 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 Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit (A-04-03-03023)

Attached is an advance copy of our final report on the adequacy of Tennessee's Medicaid payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit (Bordeaux). 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 Bordeaux for audit because it received an immediate jeopardy rating from the Tennessee Department of Health in March 2002 as a result of a complaint investigation. An immediate jeopardy rating is the most unfavorable rating that a nursing home can receive.

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

Total, or gross, Medicaid payments to Bordeaux were adequate to cover Medicaid-related costs, but net payments were not. During the 3 years ended June 30, 2002, Bordeaux's Medicaid operating costs were about $62.5 million. During the same period, gross Medicaid payments totaled $139.8 million—$35.3 million in per diem payments and $104.5 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 the county required Bordeaux to return $100.1 million (about 96 percent) of its upper-payment-limit funding. Accordingly, the net Medicaid funding that Bordeaux retained was about $39.7 million, which was $22.8 million less than its Medicaid operating costs.

As we have found in other States, Tennessee's upper-payment-limit funding approach benefited the State and the county more than Bordeaux. The State received $46.8 million more than it

expended for Bordeaux's Medicaid residents, and the county had a net gain of approximately $2 million.[1] We are concerned that the Federal Government provided all of Bordeaux's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

In addition, Bordeaux did not retain enough Medicaid funding to fill all of its nursing positions. This condition may have affected the quality of care provided to its residents. During our audit period, Bordeaux was significantly understaffed considering the minimum number of nursing positions specified in its budget 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.

We recommend that the State:

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

- allow Bordeaux 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 it did not require Bordeaux to return the funds to the county. The State also commented that its methodology for setting per diem rates was adequate, that the upper-payment-limit process enabled Bordeaux to receive more funds, and that Bordeaux's funding was more than adequate to cover its reasonable operating costs.

We do not agree with the State's comments. Even though the county, not the State, required Bordeaux to return the money, we believe that the State benefited the most from the transfer process. The State, by using a per diem rate-setting methodology that aggregated the beds of all nursing homes in Tennessee, did not provide Bordeaux with sufficient funds to meet its needs. Bordeaux did receive more in total funds under the upper-payment-limit funding process, but not enough to cover its operating costs and prevent staff shortages.

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 S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7800. Please refer to report number A-04-03-03023 in all correspondence.

Attachment

[1]Tennessee received $88.5 million in per diem and upper-payment-limit funds from the Federal Government. Tennessee made $39.7 million in Medicaid per diem payments to Bordeaux and paid a $2 million administrative fee to the county.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

APR - 4 2005

Report Number: A-04-03-03023

Mr. J. D. Hickey
Deputy Commissioner
Bureau of TennCare
Tennessee Department of Finance and Administration
729 Church Street
Nashville, Tennessee 37247-6501

Dear Mr. Hickey:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled *Adequacy of Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux 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-04-03-03023 in all correspondence.

Sincerely,

Lori S. Pilcher
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region IV
Department of Health and Human Services
61 Forsyth Street, SW., Room 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

ADEQUACY OF TENNESSEE'S MEDICAID PAYMENTS TO NASHVILLE METROPOLITAN BORDEAUX HOSPITAL, LONG-TERM-CARE UNIT

APRIL 2005
A-04-03-03023

Office of Inspector General

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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 Tennessee 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 Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit (Bordeaux) were adequate to cover its operating costs and

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

SUMMARY OF FINDINGS

Adequacy of Medicaid Payments

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

During the 3 years ended June 30, 2002, Bordeaux's Medicaid operating costs were about $62.5 million. During the same period, gross Medicaid payments totaled $139.8 million—$35.3 million in per diem payments and $104.5 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 the county required Bordeaux to return $100.1 million (about 96 percent) of its upper-payment-limit funding. Accordingly, the net Medicaid funding that Bordeaux was allowed to retain was about $39.7 million, which was $22.8 million less than its operating costs.

The State's upper-payment-limit funding approach benefited the State and the county more than Bordeaux. The State received $46.8 million more than it expended for Bordeaux's Medicaid residents, and the county was reimbursed a $2 million administrative fee for its participation in the funding process.[1] We are concerned that the Federal Government provided all of Bordeaux's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

[1]Tennessee received $88.5 million in per diem and upper-payment-limit funding from the Federal Government. Tennessee made $39.7 million in Medicaid per diem payments to Bordeaux and paid a $2 million administrative fee to the county.

Link Between Quality of Care and Funding

We selected Bordeaux for audit because it had received an immediate jeopardy rating from the State Department of Health as a result of a complaint investigation. An immediate jeopardy rating is the most unfavorable rating that can be issued.

The net Medicaid funding that Bordeaux retained was not adequate to fill all of its nursing positions. This condition may have affected the quality of care provided to its residents. During our audit period, Bordeaux was significantly understaffed considering the minimum number of positions specified in its budget 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.

RECOMMENDATIONS

We recommend that the State:

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

- allow Bordeaux 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 agree with our conclusions and recommendations. The State said that it did not require Bordeaux to return the funds to the county. The State also commented that its methodology for setting per diem rates was adequate, that the upper-payment-limit process enabled Bordeaux to receive more funds, and that Bordeaux's funding was more than adequate to cover reasonable operating costs. The State's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We do not agree with the State's comments. Even though the county, not the State, required Bordeaux to return the money, we believe that the State benefited the most from the transfer process. The State, by using a per diem rate-setting methodology that aggregated the beds of all nursing homes in Tennessee, did not provide Bordeaux sufficient funds to meet its needs. Bordeaux did receive more in total funds under the upper-payment-limit funding process, but not enough to cover its operating costs and prevent staff shortages.

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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 1994, Tennessee implemented a health care reform plan for its Medicaid program called TennCare. The Tennessee Department of Finance and Administration administers the TennCare program. The Medicaid per diem reimbursement rates paid to Medicaid-eligible long-term-care facilities are established by the Tennessee Comptroller of the Treasury pursuant to the rules of the Tennessee Department of Health, Chapter 1200-13-06-.13(2).

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 Tennessee'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 Tennessee, the Federal Government contributes approximately 63 percent of the long-term-care per diem reimbursement, and the State contributes the rest.

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.

Tennessee's allocation of upper-payment-limit funds to nursing homes is based on 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 $397.9 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 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.

Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit

Bordeaux is owned, operated, and funded by the metropolitan government of Nashville and Davidson County, TN. It is the second largest public nursing facility in Tennessee. Bordeaux is a long-term-care facility with 549 total licensed beds and 4 service units: intermediate care, skilled nursing facility, chronic disease hospital, and other onsite services. Between 2000 and 2002, about 94 percent of Bordeaux's residents were Medicaid recipients.

The Tennessee Department of Health surveys Bordeaux to determine if it complies with regulatory requirements, including Federal Medicare and Medicaid long-term-care regulations; State nursing facility, hospital, and laboratory regulations; and other State Department of Health and Human Services regulations.

As a result of a complaint investigation in March 2002 by the Tennessee Department of Health, Bordeaux was cited for 36 deficiencies involving failure to properly monitor its patients and initiate appropriate intervention. Lack of care and oversight caused some residents to suffer from decubitus wounds, which failed to heal and became life threatening. The deficiencies resulted in harm to patients and caused Bordeaux to receive an immediate jeopardy rating, the worst possible rating.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to ascertain whether:

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

Scope

Our audit covered the 3 years ended June 30, 2002. During that period, Bordeaux received $139.8 million in Medicaid funding, including per diem payments totaling $35.3 million ($22.3 million Federal share) and upper-payment-limit funding of $104.5 million ($66.2 million Federal share).

We did not assess Bordeaux's overall internal controls; we limited our review to gaining an understanding of those controls related to Medicaid funding and quality of care. We performed the majority of our fieldwork at Bordeaux in Nashville, TN.

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 Bordeaux;
- toured Bordeaux and interviewed nursing staff;
- reviewed Bordeaux's documentation, including medical records, remittance advices, corrective action plans, financial statements, Medicaid cost reports, and staffing assignments and patterns;
- reviewed Bordeaux's administrative costs to determine whether they were reasonable, allowable, and allocable;
- verified compliance with the corrective action plans that Bordeaux prepared in response to State surveys;
- analyzed the flow of funds from the Federal Government to the State and Bordeaux by tracing the payments included on the remittance advices to Bordeaux to the quarterly reports submitted by the State to CMS;

- verified the accuracy and completeness of State claims data by selecting 60 Medicaid claims and tracing the amount paid on remittance advices to computer data;

- calculated Medicaid operating costs by determining the percentage of Medicaid revenue compared with the total revenue and multipling that percentage by Bordeaux's total operating costs; and

- calculated the Medicaid operating deficit by subtracting the Medicaid portion of the operating costs from the total Medicaid per diem and retained upper-payment-limit revenue.

We discussed our findings with county and Bordeaux officials. We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Although Bordeaux received sufficient gross Medicaid funding to meet its Medicaid operating costs, it was required to return 96 percent of its upper-payment-limit funding to the county treasury. Neither the Medicaid per diem payments nor the per diem payments plus the retained upper-payment-limit funds were adequate to meet Bordeaux's Medicaid operating costs. Bordeaux was therefore unable to fill all of its nursing positions, which may have affected the quality of care provided to its residents. In addition, the Federal Government provided all of Bordeaux'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)(13)(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 Bordeaux's Medicaid operating costs, but retained payments were not. During the 3 years ended June 30, 2002, Medicaid operating costs were $62.5 million. During the same period, gross Medicaid funding totaled $139.8 million, including $35.3 million in per diem payments and $104.5 million in enhanced payments available under the upper-payment-limit regulations.

From the upper-payment-limit funding of $104.5 million, the county required Bordeaux to return $100.1 million (96 percent). Accordingly, Bordeaux retained only $39.7 million in Medicaid funding ($35.3 million in per diem funding and $4.4 million in upper-payment-limit funding). Thus, the per diem payments plus the retained upper-payment-limit funding were insufficient to meet Bordeaux's Medicaid operating costs. For our 3-year audit period, the total Medicaid operating deficit was $22.8 million.

On a daily basis, a similar funding shortage was evident. Bordeaux's cost reports showed an average daily cost of $136.47 per resident. As noted in Table 1, the average per diem payment

of $77.02 would have created a daily loss of $59.45 per resident. The average per diem payment plus the retained upper-payment-limit funding ($9.69) created a daily loss of $49.76 per resident. Had the county allowed Bordeaux to retain all of the upper-payment-limit funds, the daily Medicaid-related revenue would have exceeded costs by $168.69.

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	$77.02	$86.71	$305.16
Daily Cost per Resident	136.47	136.47	136.47
Difference	**$(59.45)**	**$(49.76)**	**$168.69**

Bordeaux's funding deficit occurred because:

- The per diem payments alone were insufficient to meet Bordeaux's operating costs.
- The county required Bordeaux to return 96 percent of the upper-payment-limit funding according to the terms of a June 2000 contract between the State and the county.

We are most concerned that, through intergovernmental transfers of funds, the Federal Government provided all of Bordeaux's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

As summarized in Table 2, the Federal Government contributed $88.5 million in combined per diem and upper-payment-limit funds. The State and the county made some initial payments to Bordeaux, but Bordeaux later returned all of these payments plus a portion of the Federal contribution. After various intergovernmental transfers, Bordeaux retained only $39.72 million of the Federal contribution. The State kept $46.78 million, and the county kept $2 million. In other words, the State and the county made a combined "profit" of $48.78 million from the Federal contribution. See Appendix B for an illustration of these intergovernmental transfers.

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

	Funding Source			Bordeaux's Retained Funds
	Federal	State	County	
Per Diem and Upper-Payment-Limit Contributions	$88.50	$16.59	$100.07	$35.28
Upper-Payment-Limit Transfer/ Reimbursement	0.00	(63.37)	(102.07)	4.44
Net Impact	**$88.50**	**$(46.78)**	**$(2.00)**	**$39.72**

In essence, through upper-payment-limit transactions, the financial burden of caring for Medicaid patients at Bordeaux was shifted 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. Further, the rules of the Tennessee Department of Health, Chapter 1200-8-6-.06 require facilities to ensure that each resident receives treatment, medication, diet, and other health services in accordance with individual care plans.

We selected Bordeaux for audit because it had received an immediate jeopardy rating from the State Department of Health as a result of a complaint investigation. This rating, the most unfavorable that a State can issue, represented deficiencies that constituted actual harm to patients and required immediate correction.

The net Medicaid funds that Bordeaux was allowed to retain and the quality of care provided to its residents may be related. Staffing appears to be the clearest link. Because Bordeaux did not retain enough funding to cover operating costs, it had difficulty in hiring needed staff and offering more competitive salaries. During our audit period, Bordeaux was significantly understaffed considering the minimum number of positions specified in its budget 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.

Nursing Staff Shortages

As illustrated in Table 3, Bordeaux's staffing level on September 6, 2001, was short by 44 employees when compared with the number of budgeted positions. We found similar staffing shortages on other days in 2001. To compensate for the low staffing levels, Bordeaux implemented mandatory overtime for nursing staff and used temporary workers.

Table 3: Budgeted Versus Actual Nursing Staff

	Budgeted	Actual on 9/6/01	Shortage
Registered Nurses	9	9	0
Licensed Practical Nurses	65	49	16
Certified Nurse Aides	124	96	28
Total	**198**	**154**	**44**

Recognizing the importance of recruiting and retaining nursing staff, Bordeaux surveyed nursing salaries in the Nashville area and determined that its starting salaries for licensed practical nurses (LPNs) were not competitive. After completing the salary survey in September 2002, Bordeaux raised LPN salaries, including entry-level salaries, by an average of $4,000 per year. To fund this increase, the county gave Bordeaux additional monies from the county's general fund. By raising the salaries, Bordeaux was able to attract LPNs to fill vacant positions. Bordeaux's reliance on temporary nursing services decreased significantly, from nearly 60 nurses per month when the immediate jeopardy rating was issued to about 20 per month after the salary increase.

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, on September 6, 2001, Bordeaux did not meet the recommended thresholds.

Table 4: Recommended Versus Actual Nursing Staff

	Abt Associates Recommendation	Actual on 9/6/01	Shortage
Registered Nurses	41	9	32
Licensed Practical Nurses	30	49	(19)
Certified Nurse Aides	153	96	57
Total	**224**	**154**	**70**

Bordeaux could have increased its staffing levels if the per diem rate had more closely reflected its operating costs or if it had been allowed to keep more of its designated upper-payment-limit funding.

RECOMMENDATIONS

We recommend that the State:

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

- allow Bordeaux 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

The State's comments on our draft report, as well as our responses, are summarized below. The full text of the State's comments is included as Appendix C.

Retention of Upper-Payment-Limit Funds

State Comments

The State said that it did not require Bordeaux to refund any part of the upper-payment-limit funds. According to the State, the owner of Bordeaux, the county government, apparently did require Bordeaux to transfer part of the money paid by TennCare to the county treasury.

Office of Inspector General Response

Even though the county, not the State, required Bordeaux to return the transferred funds, the State benefited greatly from this process. The transfer process resulted from a June 2000 meeting that the State held with officials from six Tennessee counties, including Davidson County. After this meeting, the State and the county negotiated a contract. To fulfill the contract's requirements, the county transferred $100.1 million to the State. The State then transferred the same amount to Bordeaux. Subsequently, Bordeaux sent the same amount back to the county. This enabled the State to use the $100.1 million to receive an additional $63.4 million in Federal funding.

Per Diem Rate Calculations

State Comments

The State said that its method of setting per diem rates had proven to be adequate for other nursing homes and should have been adequate to sustain a nursing home that was operated efficiently and economically in compliance with the State plan.

Office of Inspector General Response

The State's methodology, which was based on the aggregate costs of providing care to nursing home patients, did not consider the needs of individual nursing homes. Rather, the State used the aggregate number of beds in the State's nursing facilities to determine the per diem rate. Bordeaux's average operating costs for our audit period were $136.47 per day, and the average per diem rate was $86.71 per day. The per diem Bordeaux received under this methodology was insufficient to provide Bordeaux with enough funds to meet its needs. Consequently, Bordeaux experienced staffing shortages and was found by State inspectors to have placed patients in immediate jeopardy.

Upper-Payment-Limit Funding Process

State Comments

The State said that Bordeaux received more in total funds through the upper-payment-limit funding process than it otherwise would have received.

Office of Inspector General Response

Although Bordeaux received more in total funds under the upper-payment-limit funding process than it otherwise would have received, this process enabled the State to obtain $63.4 million in additional Federal funds. Even with the additional funds that it was allowed to retain, Bordeaux still did not have sufficient funds to cover its operating costs and improve its quality of care.

Adequacy of Medicaid Payments

State Comments

According to the State, payments to Bordeaux would have been more than adequate to cover reasonable operational costs had the owner, Davidson County, not diverted some of the funding for other purposes.

Office of Inspector General Response

As shown in Table 1, the average daily Medicaid payment ($86.71) was far less than the average daily cost ($136.47) incurred by Bordeaux in caring for Medicaid patients. Although we did not perform a comprehensive audit of Bordeaux's financial records, we reviewed operating expenses for the 3-year period ended June 30, 2002, and found that the costs were reasonable. Furthermore, the State offered no evidence that Bordeaux had incurred unreasonable operating costs.

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

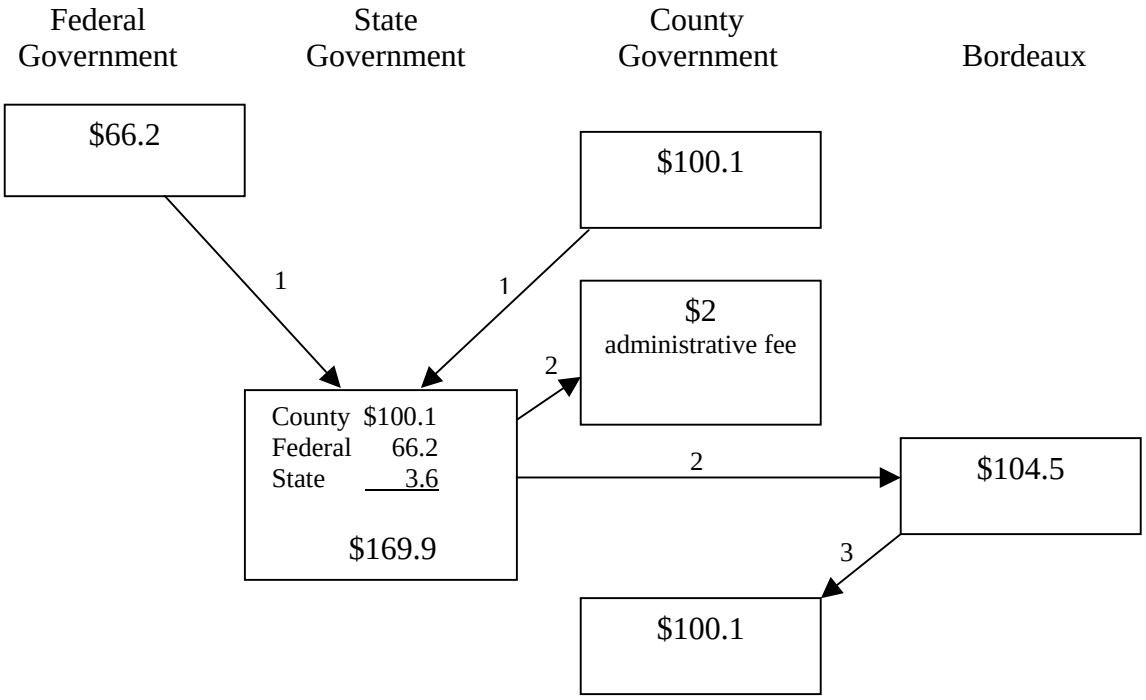
below, any nursing home with deficiencies in categories F, H, I, J, K, or L (in the shaded area) is considered to provide substandard quality of care.

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

APPENDIX B

INTERGOVERNMENTAL TRANSFERS
OF UPPER-PAYMENT-LIMIT FUNDING
Nashville Metropolitan Bordeaux Hospital
July 1, 1999 – June 30, 2002
(in millions)



1. The Federal Government made upper-payment-limit payments of $66.2 million to the State, and the county government made an intergovernmental transfer of $100.1 million to the State.

2. The State paid a $2 million administrative fee to the county and made upper-payment-limit payments of $104.5 million to Bordeaux.

3. Bordeaux returned $100.1 million (96 percent) of the upper-payment-limit funding to the county.

Note: Bordeaux retained $4.4 million of the upper-payment-limit funding.

STATE OF TENNESSEE
BUREAU of TENNCARE
729 Church Street
NASHVILLE, TENNESSEE 37247-6501

September 3, 2004

Charles J. Curtis
Regional Inspector General
Office of Audit, Region IV
61 Forsyth Street, S. W., Suite 3T41
Atlanta, GA 30303

RE: A-04-03-0323

Dear Mr. Curtis:

Thank you for allowing us the extra time to analyze the draft report and provide comments.

After reviewing the report, we offer the following comments:

1. OIG has concluded that the State and County required the nursing home to return 96% of the UPL to County and State treasuries.

   We do not concur. The State calculated the amount to be paid to the facility and paid that amount. The State did not require the nursing home to refund any part of the money paid to it back to the State. However, the owner of the nursing home, Davidson County government, apparently did require the nursing home to transfer part of the money paid by TennCare to the county treasury. This is an action taken by the owner of the home (county government), not by the State.

2. OIG has concluded that neither the Medicaid per diem rate alone nor the per diem rate plus the retained 4% UPL funds were sufficient to meet the facilities operating costs.

   The Medicaid per diem rates for each nursing home are established on a facility-by-facility basis based on the aggregate costs of providing care to its nursing home patients. A maximum payment amount (ceiling) is established at the lower of the 65th percentile of beds or facilities. Each facility is then paid its cost not to exceed the maximum payment amount, except that public facilities may receive more than the ceiling amount. This method of rate setting has proven adequate for other nursing homes in the program and in fact it covers the full operating costs for up to 65% of all nursing facilities. While the financial situation of the facility is troubling to the OIG, the county is the owner of the facility and is responsible for operation of its nursing home. The State has provided adequate funding to sustain a nursing home that is operated efficiently and economically in compliance with our state plan.

3. OIG has concluded that the UPL arrangement benefited the State more than the facility and allowed the state to avoid contributing its matching share of Medicaid funding.

   We do not concur. The nursing home received more in total funds through the use UPL than it would have received without the use of UPL. The actions by the county, not the State, determined the funding level of the nursing home. The State is an unintended benefactor of the actions taken by the County. All applicable requirements of payment of UPL amounts have been met. The UPL arrangement should not be considered flawed simply because the State was an unintended benefactor of the county's actions.

4. OIG has recommended the State pay a sufficient amount to cover their operating costs and that the facility be allowed to retain sufficient funding from UPL.

   As was stated in issue # 2 above, the facility was paid an amount more than adequate to cover reasonable operational costs but was subsequently impacted when the owner diverted some of the funding for other purposes. Paying the facility a higher per diem will not solve the problem if the owner continues to redirect the funds for that facility. The State does not control how much of the funding sent to the nursing home is allowed to remain at the nursing home. However, the State will attempt to influence the quality of care at the facility with its on-site inspection process and assessment of civil money penalties, when necessary.

I appreciate an opportunity to comment on the draft report. If you wish to discuss any of our comments, please feel free to contact me at the letterhead address or by telephone at (615) 741-0213.

Sincerely,

J D Hickey /kw

J. D. Hickey
Deputy Commissioner

JDH/sgh

ACKNOWLEDGMENTS

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

Richard C. Edris, *Audit Manager*
Marie Hoover, *Senior Auditor*
Hollie Sear, *Auditor in Charge*
Betty Mason, *Auditor*
Kozette Todd, *Referencer*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.