JUN 10 2004

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

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Adequacy of Medicaid Payments to Albany County Nursing Home
(A-02-02-01020)

Attached is an advance copy of our final report on the adequacy of Medicaid payments to Albany County Nursing Home. 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 Albany County Nursing Home for audit because it received an immediate jeopardy rating from the State Department of Health in December 2001 as a result of a complaint investigation. An immediate jeopardy rating is the most unfavorable rating that a State can issue.

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

Total, or gross, Medicaid payments initially made to the nursing home were adequate to cover total operating costs. During the 3 years ended September 30, 2001, these payments totaled $132 million: $41 million in Medicaid per diem payments and $91 million in enhanced payments available under the upper payment limits. During the same period, the nursing home's total operating costs were about $70 million. Although these gross Medicaid payments were adequate, net payments were not sufficient. Because the State and the county required the nursing home to return about 90 percent of its upper-payment-limit funding, the nursing home was allowed to retain only about $50 million—$20 million less than its total operating costs. Thus, neither the Medicaid per diem rate alone nor the per diem rate plus the retained upper-payment-limit funds were sufficient to meet its 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 $20 million more than it expended for the nursing home's Medicaid residents without effectively contributing any

money, and the county was reimbursed 100 percent for its upper-payment-limit contribution. We are concerned that the Federal Government in effect provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments.

In addition, the nursing home did not retain enough Medicaid funding to fill all of its nursing positions. The nursing home was significantly understaffed considering the minimum number of nursing positions specified in its budget and recommended for similar-sized nursing homes by a consultant to the Centers for Medicare & Medicaid Services (CMS). This condition may have affected the quality of care provided to its residents.

We recommend that the State:

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

- allow the nursing home to retain sufficient funding, including upper-payment-limit funding as necessary, so that it can attract, hire, and retain sufficient nursing staff to provide an adequate level of care to its residents

In its comments on our draft report, the State did not agree with our recommendations. The State said that State regulations prohibited the recalculation of a Medicaid rate and that the State did not dictate to the county how upper-payment-limit funds should be distributed.

We do not agree with the State's comments. The State should submit a State plan amendment to CMS to calculate the nursing home's Medicaid rate on a more current base year and revise the State regulations as necessary. Also, the State's agreement with the counties 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.

Attachment

Office Of Inspector General
Office of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

JUN 17 2004

Report Number: A-02-02-01020

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

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of the Inspector General (OIG) final report entitled "Adequacy of Medicaid Payments to Albany County Nursing Home." 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 contained therein 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-02-02-01020 in all correspondence.

Sincerely,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

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
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ADEQUACY OF MEDICAID PAYMENTS TO ALBANY COUNTY NURSING HOME

JUNE 2004
A-02-02-01020

EXECUTIVE SUMMARY

BACKGROUND

Medicaid funding to non-State-owned public nursing facilities in New York State consists of the Medicaid 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 Albany County Nursing Home were adequate to cover its operating costs

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

SUMMARY OF FINDINGS

Adequacy of Medicaid Payments

Total, or gross, Medicaid payments to the nursing home were adequate to cover Medicaid-related costs, but net payments were not sufficient.

During the 3 years ended September 30, 2001, the nursing home's total operating costs were about $70 million. During the same period, gross Medicaid payments totaled $132 million: $41 million in per diem payments and $91 million in enhanced payments available under the upper-payment-limit regulations. However, the State and the county required the nursing home to return $82 million, or about 90 percent, of its upper-payment-limit funding back to them. Accordingly, the net Medicaid funding that the nursing home was allowed to retain was about $50 million—$20 million less than its total operating costs.

The State's upper-payment-limit funding approach benefited the State and the county more than the nursing home. The State received $20 million more than it expended for the nursing home's Medicaid residents without effectively contributing any money, and the county was reimbursed 100 percent for its upper-payment-limit contribution. We are concerned that the Federal Government in effect provided almost all of the nursing home'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 the nursing home 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 the nursing home 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, the nursing home was significantly understaffed compared with 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 conducted by the General Accounting Office (GAO) and Abt Associates also indicate that the ratio of nursing staff to nursing home residents affects quality of care.

RECOMMENDATIONS

We recommend that the State:

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

- allow the nursing home to retain sufficient funding, including upper-payment-limit funding as necessary, so that it can attract, hire, and retain sufficient nursing staff to provide an adequate level of care to its residents

STATE COMMENTS

In its comments on our draft report, the State did not agree with our recommendations. The State said that State regulations prohibited the recalculation of a Medicaid rate and that the State did not dictate to the county how upper-payment-limit funds should be distributed.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security 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 according to Part 86 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 pays 50 percent of the long-term-care per diem reimbursement, the State pays 40 percent, and the counties pay 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 maximum 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 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 or operated.

New York State allocates upper-payment-limit funds to nursing homes 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 increased from $631.1 million to $991.5 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 in order to participate in the Medicaid program. CMS contracts with States to conduct periodic certification surveys to ensure that these standards are met.

CMS's nursing home regulations define several categories of deficiencies that State survey agencies may find. Each deficiency is placed into 1 of 12 categories divided into 4 broad ratings 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.

Albany County Nursing Home

Albany County Nursing Home is a 420-bed public long-term-care facility owned and operated by the county. Approximately 87 percent of the total residents are Medicaid beneficiaries.

As a result of a complaint investigation by the Department of Health, the nursing home received an immediate jeopardy rating in December 2001 because of its lack of resident assessments for falls and accidents and its failure to assess, monitor, supervise, or implement effective means to prevent incidents and accidents. The deficiencies resulted in injuries to several residents. The survey team also cited the nursing home in February 2000 for medication administration errors that resulted in actual harm to residents. Surveys in January 1999 and May 2002 identified less severe deficiencies.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to ascertain whether:

- Medicaid payments to Albany County Nursing Home were adequate to cover its operating costs

- a link could be drawn between the quality of care that the nursing home 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, the nursing home received $131,963,261 in Medicaid funding, including per diem reimbursement for 24,772 claims totaling $40,800,856 ($20,400,396 Federal share) and upper-payment-limit funding of $91,162,405 ($45,581,203 Federal share).

We did not assess the nursing home's overall internal controls; we limited our review to gaining an understanding of those controls related to Medicaid funding and quality of care.

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 the nursing home
- toured the nursing home and interviewed nursing staff
- reviewed the nursing home'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 the nursing home prepared in response to State surveys
- analyzed the flow of funds from the Federal Government to the State and the nursing home
- 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

We performed fieldwork at the nursing home and conducted our audit in accordance with generally accepted government auditing standards.

We discussed our findings with county and nursing home 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 the nursing home, we requested and received oral comments from both parties and considered them in preparing our final report.

FINDINGS AND RECOMMENDATIONS

Although the nursing home received sufficient gross Medicaid funding to meet its operating costs, it was required to return a significant portion of its upper-payment-limit funding to the State and county. Neither the average Medicaid per diem rate nor the per diem rate plus the upper-payment-limit funds that the nursing home kept were sufficient to meet its operating costs. The nursing home 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 nearly all of the nursing home'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 Social Security 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 the nursing home's total costs. During the 3 years ended September 30, 2001, gross funding to the nursing home totaled $131,963,261, including $40,800,856 in Medicaid per diem payments and $91,162,405 in enhanced payments available under the upper-payment-limit regulations. During the same period, total operating costs were $71,675,730. Although the nursing home could not separate costs for Medicaid and non-Medicaid residents, its financial statements showed that costs for all residents averaged $170 per day whereas gross Medicaid-related revenue averaged $363 per day.

Although gross Medicaid payments were adequate to cover the nursing home's operating costs, retained net payments were not. The State and the county required the nursing home to return $82,046,164, or 90 percent, of its upper-payment-limit funding to the county and State treasuries. Accordingly, the nursing home retained only $49,917,097 in Medicaid funding ($40,800,856 in per diem and $9,116,241 in upper-payment-limit funding).

As noted in Table 1, the upper-payment-limit amount combined with the average Medicaid per diem rate of $132 would have created a daily surplus of $193 per resident. However, because the nursing home could retain only 10 percent of the upper-payment-limit funds, there was a daily shortfall of $16 per resident. Without the upper-payment-limit funds, the daily shortfall would have been $38.

Table 1: Medicaid Payments Versus Costs

	Per Diem Rate	Per Diem + 10% Upper Payment Limit	Per Diem + 100% Upper Payment Limit
Average Medicaid Payment	$131.95	$154.37	$362.95
Per Day Operating Costs	170.11	170.11	170.11
Difference	**$ (38.16)**	**$ (15.74)**	**$192.84**

Therefore, neither the Medicaid per diem rate alone nor the per diem rate plus the retained upper-payment-limit funds were sufficient to meet the nursing home's operating costs. For our 3-year audit period, the deficit for the per diem rate alone was $13,814,910 and the total Medicaid operating deficit was $5,668,906.[1]

This deficit occurred for several reasons:

- The per diem rate alone was insufficient to meet the nursing home's operating costs because the State based the rate on 1983 costs.

- Section 222, Chapter 474 of the New York State Laws of 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.

- The State's upper-payment-limit funding approach benefited the State and the county more than the nursing home and allowed the State to avoid contributing its matching share of Medicaid funding.

We are most concerned that, through intergovernmental transfers of funds, the Federal Government in effect provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments. The State contributed nothing to the nursing home's upper-payment-limit funding. The county also contributed nothing because its contributions were reimbursed 100 percent. At the same time, the Federal Government contributed $45,581,203 in upper-payment-limit funding—more than the total upper-payment-limit funds that the home retained. See Appendix B for an illustration of these transactions.

As summarized in Table 2, the Federal Government contributed approximately $66 million of the combined per diem and upper-payment-limit funds and the county contributed approximately $4 million. The State was able to make a profit of more than

[1] The total Medicaid operating deficit was computed by multiplying the average per day deficit by the total Medicaid patient days per year.

$20 million. The nursing home retained only about $50 million of the $132 million it initially received.

Table 2: Nursing Home Medicaid Funding (in millions)

	Funding Source			Nursing Home Funds	
	Federal	**State**	**County**	**Received**	**Retained**
Per Diem Contribution	$20.40	$16.32	$ 4.08	$ 40.80	$40.80
Upper-Payment-Limit Contribution	45.58	0.00	45.58	91.16	0.00
Upper-Payment-Limit Reimbursement	0.00	(36.46)	(45.58)	0.00	9.12
Total	**$65.98**	**$(20.14)**	**$ 4.08**	**$131.96**	**$49.92**

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

LINK BETWEEN QUALITY OF CARE AND FUNDING

According 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, New York Code of Rules and Regulations, Title 10, § 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 the nursing home for audit because it received an immediate jeopardy rating from the State Department of Health in December 2001 as a result of a complaint investigation. This rating, the most unfavorable that a State can issue, reflected a pattern of deficiencies that constituted actual harm to patients and required immediate correction.

The net Medicaid funds that the nursing home was allowed to retain and the quality of care provided to its residents may be related. Staffing appears to be the clearest link. Because the nursing home 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, the nursing home was significantly understaffed considering the minimum number of positions specified in its budget and recommended for similar-sized nursing homes by Abt Associates, a research and consulting firm. Studies by GAO and Abt Associates also indicate a relationship between staffing levels and quality of care at nursing homes.

Nursing Staff Shortages

As illustrated in Table 3, on December 15, 2001 (during the State review that resulted in an immediate jeopardy rating), the nursing home was staffed with 153 nursing positions while its own analysis called for 243 positions.[2] We reviewed several other days in 2001 and found a similar staffing shortage. To compensate for the low staffing levels, the nursing home implemented mandatory overtime for nursing staff and used temporary workers.

Table 3: Budgeted Versus Actual Nursing Staff

	Budgeted	Actual on 12/15/01	Shortfall
Registered Nurse	44	24	20
Licensed Practical Nurse	43	21	22
Certified Nurse Aide	156	108	48
Total	**243**	**153**	**90**

Recognizing the importance of recruiting and retaining nursing staff, the nursing home made enhanced efforts to recruit staff beginning in January 2002, after our audit period. Through these efforts, the nursing home hired 97 certified nurse aides and 26 licensed practical nurses between January and October 2002. The State's 2002 Special Worker Recruitment and Retention Law funded these additional staff.

Staffing and Quality of Care Studies

Recent studies indicate that the ratio of nursing staff to residents affects 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 titled "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 December 15, 2001, the nursing home did not meet these thresholds.

[2] The nursing home calculated the number of hours of care per patient per day to determine the number of budgeted staff positions.

Table 4: Recommended Versus Actual Nursing Staff

	Abt Associates Recommendation	Actual on 12/15/01	Shortfall
Registered Nurse	37	24	13
Licensed Practical Nurse	27	21	6
Certified Nurse Aide	137	108	29
Total	**201**	**153**	**48**

The nursing home 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:

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

- allow the nursing home to retain sufficient funding, including upper-payment-limit funding as necessary, so that it can attract, hire, and retain sufficient nursing staff to provide 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 response, are summarized below. The full text of the State's comments is included in Appendix C.

State Comments on Medicaid Rate Calculation

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 the nursing home'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 the nursing home's Medicaid rate on a more current base year and revise the State regulations as necessary.

State Comments on Distribution of Upper-Payment-Limit Funds

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

Office of Inspector General Response

We disagree 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 the nursing home for purposes of allocating upper-payment-limit funding.

State Comments on Upper-Payment-Limit Funding Mechanism

In our draft report, we recommended that the State reassess the fairness of its upper-payment-limit funding approach and contribute its matching share of all Medicaid funding paid to the nursing home. In reply, the State noted that the Federal Government had enacted regulations that would phase out the upper-payment-limit funds over a 5-year transition period beginning in State fiscal year 2002-2003. Therefore, the State maintained that our recommendation to reassess the current upper-payment-limit funding approach was a "moot point."

Office of Inspector General Response

In response to the State's comment, we have combined the recommendation regarding the fairness of upper-payment-limit funding with our central recommendation regarding the adequacy of funding for the nursing home. We appreciate that Federal regulations will substantially reduce the availability of upper-payment-limit funding during a transition period (although, contrary to the State's description, they will not entirely eliminate the use of such funding). Regardless of such rules, New York must maintain the safety and welfare of its nursing home residents. Our audit revealed that the sources of funding for the nursing facility were not adequate to meet its operating costs, a shortfall that may be especially significant given the immediate jeopardy rating earlier received by the facility.

APPENDICES

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 in order 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. According 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 nursing home regulations define several categories of deficiencies. Each deficiency is placed into 1 of 12 categories divided into 4 broad rating levels 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 categories, 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)

- 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." Deficiencies in this category 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 is considered to provide substandard quality of care.

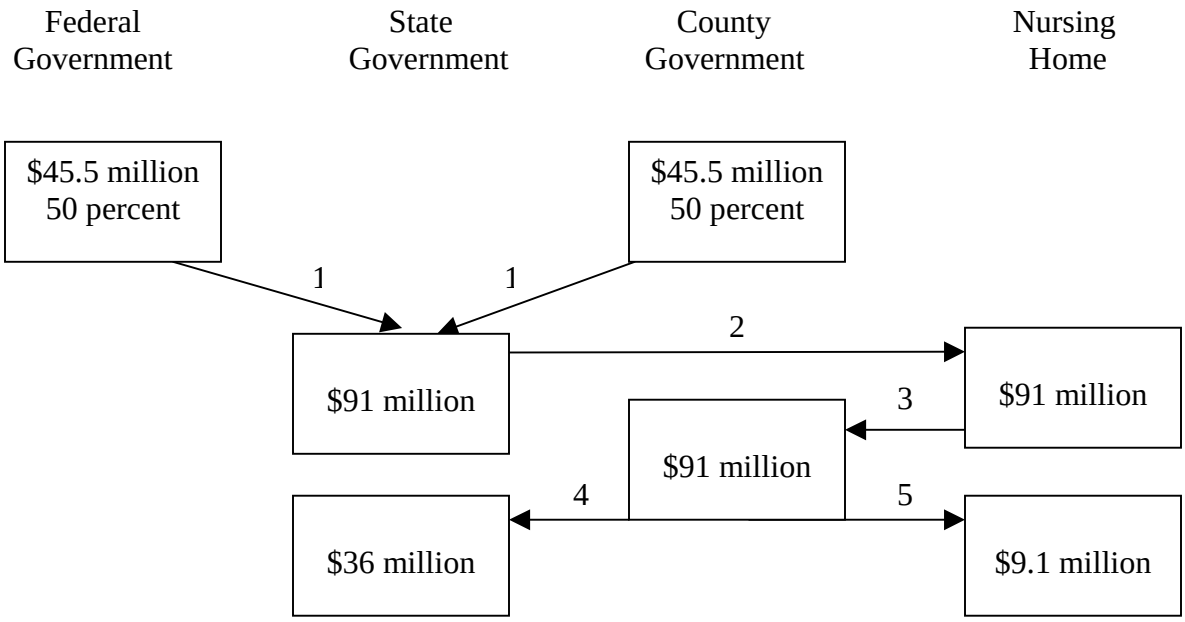
Scope and Severity

	Scope		
Severity	**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

The shaded area represents substandard quality of care.

APPENDIX B

INTERGOVERNMENTAL TRANSFERS
OF UPPER-PAYMENT-LIMIT FUNDING
Albany County Nursing Home
October 1, 1998 – September 30, 2001



1. Drawdowns by State from Federal Government and county to holding account.
2. State payment to nursing home operating bank account.
3. County transfer from nursing home operating account to county general fund.
4. State withdrawal from county general fund.
5. Amount designated through county budget for nursing home.

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

March 28, 2003

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-02-02-01020) entitled "Adequacy of Medicaid Payments to Albany County Nursing Home".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Department of Health
Comments on the
Department of Health and Human Services
Office of the Inspector General
Draft Audit Report A-02-02-01020
"Adequacy of Medicaid Payments to
Albany County Nursing Home"

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-02-02-01020 entitled "Adequacy of Medicaid Payments to Albany County Nursing Home (ACNH)".

Recommendation #1:

Recalculate ACNH's Medicaid per diem rate to more closely reflect the nursing home's operating costs.

Response #1:

The methodology for the calculation of Medicaid rates for nursing facilities has been approved by the Centers for Medicare and Medicaid through a State Plan Amendment. The base utilized to calculate the Medicaid rates for ACNH 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.

Exclusive of the Upper Payment Limit (UPL) payment, ACNH has a slightly lower Medicaid rate ($137.42) than the average Medicaid rate for Albany region nursing facilities ($140.47), but they also have a lower Case Mix Index (CMI) of 1.02, (which relates to the acuity level of the residents in the facility) than the average CMI for other nursing facilities in the County of 1.09. By including the net benefit of the 2001 UPL payment that ACNH has recorded on their financial statements, the Medicaid rate increases to $165.55, which is much higher than the average.

When examining the relationship of the Medicaid rate to the operating costs of the nursing home, it would be necessary to only look 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 should not be included in such a comparison.

ACNH reports a weighted average private pay rate of $195.97, which is less than the average weighted private pay rate of $201.57 for facilities in Albany County.

Recommendation #2:

Allow ACNH to retain a larger percentage of the UPL funding so that it can attract, hire and retain more nursing staff in order to provide better quality of care to its residents.

Response #2:

New York State does not dictate the financial relationship between the County and the County operated nursing facility. Any related transactions for UPL are between the County and New York State.

Calendar year 2000, inclusive of the recorded net value of the UPL payments in the nursing facility, showed ACNH had a total loss of $(419,055) or only 1.75% of the total revenue base. In 2001, inclusive of the recorded net value of the UPL payments in the nursing facility, ACNH had a total loss of $(359,652) or only 1.5% of the total revenue base. Financial data for 2002 is not available at this time.

A comparison of the 2001 Registered Nurse's (RN) Full Time Equivalents (FTE) per bed and 2001 total direct care FTEs per bed between ACNH and the RN FTEs per bed for the County on average reveals the following:

	RN FTEs per bed	Direct Care FTEs per bed
ACNH	.11	.65
Avgerage for all facilities in the County	.08	.58

As indicated, the staffing levels are higher than the average staffing levels of other facilities operating in Albany County, while the CMI for ACNH is lower than the average.

In 2002 New York passed a special worker recruitment and retention bill that will provide $475.5 million in funds to nursing facilities statewide to attract, hire and retain employees for the period 2002-2004. Included is $288 million for direct worker recruitment, of which ACNH will receive $977,600 over the three-year period.

In addition, to further supplement health recruitment and retention, there is statewide grant funding in the amount of $187.5 million over the same period. At this time, final grant awards have not been made, and it is unknown how much funding ACNH may receive.

Recommendation #3:

Reassess the fairness of the current UPL funding approach in NYS in terms of the partnership nature of the Medicaid program.

Response #3:

The federal government has enacted regulations that will phase out the UPL over a five-year period beginning in the State Fiscal Year (SFY) 2002/03. The new regulation will limit the total dollars to be paid through the UPL to the excess UPL calculated in the 1999/00 fiscal period, plus the actual UPL for non-state owned or operated facilities.

The phase out will be:

- 100% of the excess 1999/00 UPL plus actual UPL for non-state owned or operated public facilities in SFY 2001/02;
- 75% of the excess 1999/00 UPL plus actual UPL for non-state owned or operated public facilities in SFY 2002/03;
- 50% of the excess 1999/00 UPL plus actual UPL for non-state owned or operated public facilities in SFY 2003/04;
- 25% of the excess 1999/00 UPL plus actual UPL for non-state owned or operated public facilities in SFY 2004/05; and
- 0% of the excess 1999/00 UPL plus actual UPL for non-state owned or operated public facilities in SFY 2005/06.

Based on the phase out, the reassessment of the current UPL funding approach in New York State is a moot point.

Appendix F: Average Medicaid per Diem Reimbursement Rates by State

2001 The Guide to the Nursing Home Industry published annually by HCIA-Sachs and Arthur Andersen, LLP.

	Average 2000 per Diem Rates ($)
Alabama	108.53
Alaska	370.11/Combined
	233.80/Freestanding
Arizona	96.70
Arkansas	69.35
California	70.69/Level A (ICF)
	94.28/Level B (Freestanding)
Colorado	n/a
Connecticut	151.59
Delaware	124.85
District of Columbia	n/a
Florida	111.27
Georgia	88.50
Hawaii	158.80
Idaho	116.67/Freestanding
	138.24/Hospital-based
Illinois	87.05
Indiana	92.88
Iowa	113.57
Kansas	83.12
Kentucky	104.30
Louisiana	69.32
Maine	n/a
Maryland	n/a
Massachusetts	126.00
Michigan	110.00
Minnesota	111.13
Mississippi	87.42
Missouri	n/a
Montana	96.97
Nebraska	65.89

	Average 2000 per Diem Rates ($)
Nevada	102.54
New Hampshire	118.91
New Jersey	n/a
New Mexico	105.32/Low NF
	167.71/High NF
New York	171.60
North Carolina	118.27/SNF
	88.35/ICF
North Dakota	n/a
Ohio	121.34
Oklahoma	66.75/Basic NF
Oregon	93.52/Basic rate
	130.77/Basic + complex medical needs add-on
Pennsylvania	126.47
Rhode Island	114.00
South Carolina	91.90
South Dakota	n/a
Tennessee	91.18/Level I
	141.68/Level II
Texas	81.22
Utah	89.11
Vermont	113.19
Virginia	n/a
Washington	121.48
West Virginia	117.40/1-99 bed
	115.50/>99 beds
Wisconsin	111.23
Wyoming	96.76