



Office of Audit Services, Region III
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June 9, 2004

Report Number: A-03-03-00211

Mr. Michael Stauffer
Deputy Secretary for Administration
Department of Public Welfare
Health & Welfare Building, Room 234
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Stauffer:

Enclosed are two copies of our final report entitled "Medicaid Denial of Payment Remedy for Sanctioned Nursing Homes in the Commonwealth of Pennsylvania." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS Action official named below. 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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If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Bernard Siegel, Audit Manager, at (215) 861-4484, or through e-mail at bernard.siegel@oig.hhs.gov. To facilitate identification, please refer to report number A-03-03-00211 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a horizontal line extending to the right.

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID DENIAL OF PAYMENT
REMEDY FOR
SANCTIONED NURSING HOMES
IN THE COMMONWEALTH OF
PENNSYLVANIA**



**JUNE 2004
A-03-03-00211**

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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

In a 1986 study conducted at the request of Congress, the Institute of Medicine found that residents of nursing homes were being abused, neglected, and given inadequate care. As part of the Omnibus Budget Reconciliation Act of 1987, Congress passed the Nursing Home Reform Act that established quality standards for nursing homes nationwide, established resident rights, and defined the State survey and certification process to enforce those standards. It also required that nursing homes that participated in the Medicaid and Medicare programs comply with the requirements for standards of care as prescribed by Federal laws.

The Department of Health and Human Services and the States implemented the requirements that are contained in Title XIX, section 1919, of the Social Security Act. To monitor whether nursing homes meet the Nursing Home Reform Act requirements, the law established a certification process that requires States to conduct unannounced surveys, including resident interviews, at irregular intervals at least once every 15 months. The law also requires that the average statewide interval between consecutive standard surveys should be no greater than 12 months.

We initiated this audit to determine whether the Commonwealth of Pennsylvania (the State) was enforcing the Federal standards. The “denial of payment sanction” enforcement process was the primary focus of this review.

OBJECTIVES

The objectives of our audit were to determine whether State controls were adequate to:

1. prevent improper Medicaid payments to nursing homes under the denial of payment sanction, and
2. ensure that the mandatory denial of payment sanction was applied in nursing homes that were not in compliance with Federal requirements.

This review included the denial of payment sanctions that should have been in effect during the period from October 1, 1999 to September 30, 2001. In addition, we reviewed selected data for all nursing homes surveyed by the State during 1999 to 2003, which the Centers for Medicare & Medicaid Services (CMS) maintained in its “Online Survey, Certification, and Reporting” (OSCAR) database.

FINDING - State Controls Over Denial of Payment Sanctions for Nursing Homes

State controls were not adequate to prevent improper Medicaid payment to nursing homes that were under a denial of payment sanction. Title XIX, section 1919, of the Social Security Act and 42 CFR § 488 require that the State establish adequate controls over the mandatory denial of payment sanction. Of the 73 nursing homes that were sanctioned during our audit period, 13 received unallowable Medicaid payments for new admission residents because the State Medicaid agency had not implemented pre-payment edits or post-payment reviews during the period of our review to ensure that only allowable services were paid to nursing homes. As a result, the State Medicaid agency made Medicaid payments totaling \$75,342 to the 13 nursing homes for residents who were admitted during the sanction periods, of which \$40,553 represented the Federal share of the payment. One of the nursing homes recognized that some of the payments it received were unallowable and returned \$2,758 to the State prior to our review. The balance, totaling \$72,584 (Federal share totaling \$39,074) was not identified by the nursing homes as unallowable until the time of our review.

FINDING - Mandatory Denial of Payment Sanctions for Substandard Quality of Care

A review of CMS's OSCAR database indicated that 101 of the 653 Medicaid certified nursing homes surveyed by the State received a deficiency with a scope and severity code that required a denial of payment sanction that were not identified on the CMS and State lists of sanctioned nursing homes. The denial of payment sanction was warranted because those nursing homes had not reached substantial compliance within 3 months of having the deficiency identified by the State survey agency. As a result, the State could have made Medicaid payments to those nursing homes for new admissions during those sanction periods because they had not identified them as requiring a mandatory denial of payment sanction.

RECOMMENDATIONS

We recommend that the State Medicaid Agency:

1. refund \$39,074 to CMS for the Federal share of the unallowable Medicaid payments,
2. implement pre-payment edits, in addition to the newly established post-payment reviews, to ensure that Medicaid payments are not paid to nursing homes that are under a denial of payment sanction, and
3. establish procedures to identify nursing homes that should receive a denial of payment sanction.

AUDITEE COMMENTS – CMS

CMS Region III office suggested changes in the wording of three statements in the report. Those changes were implemented where appropriate throughout the report. CMS will implement a new tracking system that will identify those nursing homes that require follow-up actions by the State or the CMS regional office to ensure that payments are withheld for nursing homes that received sanctions. A copy of the response is shown in Appendix B.

AUDITEE COMMENTS – COMMONWEALTH OF PENNSYLVANIA

The Department of Public Welfare generally agreed with the findings and recommendations contained in the report. It stated that: a) two denial of payment sanctions (Bans of Admission) were cancelled, b) \$60,532 of the reported \$76,274 unallowable Medicaid payments had already been recovered, and c) the Department's new claims processing and management information system (PROMISe™) has edits and new functions in place to prevent nursing facilities from billing when Bans on Admission are imposed.

Based on the documentation provided by the Commonwealth, we revised the report to show that \$75,342 was identified as unallowable Medicaid payments. Of that total:

- \$2,758 was collected prior to the audit
- \$43,577 was collected during the audit
- \$26,431 is awaiting collection
- \$2,576 is still disputed by the Commonwealth

A copy of the significant portion of the Commonwealth's response is shown in Appendix C. We did not include the additional 100 pages of documentation that supported the amounts recovered from the nursing homes for each recipient stay questioned.

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INTRODUCTION

BACKGROUND

Nursing Home Reform Act Requirements

In a 1986 study conducted at the request of Congress, the Institute of Medicine found that residents of nursing homes were being abused, neglected, and given inadequate care. As part of the Omnibus Budget Reconciliation Act of 1987, Congress passed the Nursing Home Reform Act that established quality standards for nursing homes nationwide, established resident rights, and defined the State survey and certification process to enforce the standards. It also required that nursing homes that participated in the Medicaid and Medicare programs, comply with the requirements for standards of care as prescribed by Federal laws.

Ten years after the passage of the Nursing Home Reform Act, a series of studies and Senate hearings called attention to serious threats to residents' well being. Those studies identified weaknesses in the Federal and State survey and enforcement processes. States and CMS must certify that nursing homes are in substantial compliance with the requirements of the Nursing Home Reform Act in order to receive Medicaid and Medicare payments for long-term care of residents. The Department of Health and Human Services and the States implemented the requirements of the Nursing Home Reform Act that are contained in Title XIX, section 1919, of the Social Security Act.

To monitor whether nursing homes continue to meet the requirements of the Nursing Home Reform Act, the law established a certification process that requires States to conduct unannounced surveys, including resident interviews, at irregular intervals at least once every 15 months. The law also requires that the average statewide interval between consecutive standard surveys should be no greater than 12 months. Those surveys generally focus on residents' rights, quality of care, quality of life, and services provided to residents. Nursing homes are in "substantial compliance" when identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Deficiencies result from either noncompliance with established requirements or substandard quality of care in the nursing home.

Nursing homes that are not in substantial compliance with the Federal standards of care may have one or more enforcement remedies (sanctions) imposed on them. The severity of the sanction depends on whether the deficiency constitutes either: (1) immediate jeopardy to resident health or safety; (2) actual harm that is not immediate jeopardy; (3) a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm; or (4) a pattern of or an isolated potential for more than minimal harm that is not immediate jeopardy, with no actual harm. The State and CMS may impose the "denial of payment sanction for all new or existing Medicaid or Medicare residents," either alone or in combination with other sanctions when nursing homes are not in substantial compliance with the certification standards of care.

We initiated this audit to determine whether the Commonwealth of Pennsylvania (the State) was enforcing the Federal standards. The “denial of payment sanction” enforcement process was the primary focus of this review.

Enforcement of Denial of Payment Sanctions

The Federal regulation governing the enforcement for compliance of nursing homes is set forth in 42 CFR § 488, Subpart F. As noted above, the State imposes a sanction on a nursing home based on the seriousness of the deficiency – a measure of the scope and severity of the deficiency. Nursing homes that do not achieve substantial compliance are not eligible to participate in the Medicaid and Medicare programs. Before the State can lift an enforcement sanction, the State survey agency must certify that the nursing home is currently in substantial compliance.

When a nursing home is not in substantial compliance with one or more Federal requirements, the State may impose a denial of payment sanction. There are two types of denial of payment sanctions.

Denial of Payment for New Admissions. Under typical circumstances, if a nursing home is not in substantial compliance with Medicaid requirements, the State denies payments to nursing homes for Medicaid residents admitted after the sanction became effective. Payments for existing Medicaid residents continue. The denial of payment for new admissions can be either optional or mandatory based on the seriousness of the deficiency.

- The State or CMS may impose the “optional” denial of payment sanction for all new Medicaid admissions when a nursing home is not in substantial compliance with the Medicaid participation requirements.
- The State or CMS must impose a “mandatory” denial of payment sanction when a nursing home is not in substantial compliance 3 months after the last day of the survey identifying a deficiency, or when a nursing home has furnished substandard quality of care on the last three consecutive standard surveys.

CMS Publication 7, “State Operations Manual,” section 7506 (C) (2), requires that the State Medicaid agency must deny payment to the nursing home, and CMS must deny Federal financial participation to the State Medicaid agency for all new Medicaid admissions to the nursing home when a denial of payment sanction is determined. The “State Operations Manual” defines “substandard quality of care” as:

... one or more deficiencies related to participation requirements under 42 CFR 483.13, resident behavior and facility practices, 42 CFR 483.15, quality of life, or 42 CFR 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Denial of Payment for All Medicaid Residents. Under extreme circumstances, and only with the approval of the Secretary, Department of Health and Human Services, the State and CMS can deny payments to nursing homes for all Medicaid residents, regardless of their date of admission. In those instances, the State will not pay nursing homes for all residents who resided in the nursing home, from the effective date of the denial of payment sanction until the date that CMS verifies that the nursing home is in substantial compliance with Medicaid requirements. None of the denial of payment sanctions identified in our review was for all Medicaid residents.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to determine whether State controls were adequate to:

1. prevent improper Medicaid payments to nursing homes under the denial of payment sanction, and
2. ensure that the mandatory denial of payment sanction was applied in nursing homes that were not in compliance with Federal requirements.

Scope

Our review included denial of payment sanctions that should have been in effect in Pennsylvania during the 2-year period from October 1, 1999 to September 30, 2001. We obtained information from the CMS Region III regional office, the State Medicaid agency, and selected nursing homes. Some of the documentation reviewed included the following.

- State nursing home surveys
- CMS and State lists of sanctioned nursing homes
- Medicaid paid claims information
- Denial of payment letters issued by CMS and received by the State and provider
- Nursing home admission census reports
- Nursing home billing documentation
- Other financial and operational documentation, as appropriate

We reviewed the current OSCAR database to identify all standard surveys recorded for Pennsylvania nursing homes. We summarized all deficiencies identified during the State survey and certification process that included a deficiency that potentially warranted a denial of payment sanction for new admissions.

Our review was limited in scope and was not intended to be a full-scale internal control assessment of the State Medicaid agency operations. The objectives of our audit did require an understanding and assessment of the internal control structures related to the specific areas reviewed.

Methodology

Denial of Payment for Sanctioned Nursing Homes. To determine whether the State had sufficient controls to prevent improper Medicaid payments to nursing homes, we obtained a list of denial of payment sanction letters provided by the State and reconciled that information with the “Long-Term Care, Denial of Payment Report” provided by CMS.

To ensure that denial of payment sanctions were applied in nursing homes that were not in substantial compliance, we obtained a listing of the Medicaid paid claims from the Pennsylvania Medicaid Management Information System to determine whether the State made improper payments to sanctioned nursing homes during our audit period. Also, we reviewed documentation at the sanctioned nursing homes that received Medicaid payments to determine whether those payments were allowable or unallowable.

- Allowable Payments. Payments were considered appropriate and allowable if a Medicaid resident was admitted to the nursing home before a denial of payment sanction for new admissions was issued.
- Unallowable Payments. Payments were considered inappropriate and unallowable if a Medicaid resident was admitted on or after the date the denial of payment sanction was issued. When a denial of payment sanction was issued for all residents, the payment for all Medicaid residents was considered unallowable beginning on the date the denial of payment sanction was issued, regardless of when the resident was admitted to the nursing home.

Subsequently, when the State surveyed the nursing home and found it to be in substantial compliance, the denial of payment sanction was lifted, and payments for all Medicaid residents were allowable.

Deficient Nursing Homes Not Sanctioned. To identify potentially deficient nursing homes that were not sanctioned, we queried the OSCAR database to identify surveys that recorded deficiencies (known as F-tags) associated with the mandatory denial of payment for new Medicaid admissions. That list of potentially deficient nursing homes contained the four most recent standard surveys for each Pennsylvania nursing home entered by the State survey agency, including the deficiency, the date of survey and the date of compliance for each deficiency. Based on discussions with personnel from the CMS Region III office, although the OSCAR database included an “enforcement tracking system,” the information captured was found inadequate for tracking all of the enforcement actions, and an OSCAR “enforcement tracking system” report was never produced. The date of compliance and other data fields are not always accurate and reliable. Beginning in January 1999, CMS used a long-term care enforcement tracking system developed by CMS Region V for tracking nursing home enforcement actions (the Chicago system). In late 2004, CMS will be converting its long-term care enforcement tracking system to the ASPEN software as part of an upgrade and enhancement of that system. We performed the following analysis, although we could not make definitive conclusions without validation of each entry included in the initial analysis results.

We identified OSCAR data that met the mandatory denial of payment for new Medicaid admissions criteria. We identified all unique records that showed that:

- the nursing home was not in substantial compliance 3 months after the last day of the survey that identified the deficiency; and
- the result of the standard survey for the last four reported surveys.

We used the first list to determine whether all nursing homes that were not in substantial compliance within 3 months after the last day of the survey were included on our list of sanctioned nursing homes that CMS Region III personnel provided to us. We considered any deficiency with a scope and severity code of 'D' through 'L' to identify nursing homes that were not in substantial compliance. We used the second list to determine whether any nursing homes had three consecutive substandard quality of care surveys and whether the mandatory denial of payment remedy was enforced.

Our review was conducted in accordance with generally accepted government auditing standards. The work was performed at the CMS Region III regional office in Philadelphia, Pennsylvania, the Pennsylvania Department of Public Welfare in Harrisburg, Pennsylvania, and various nursing homes throughout Pennsylvania, from April 2003 through February 2004.

FINDINGS AND RECOMMENDATIONS

FINDING - State Controls Over Denial of Payment Sanctions for Nursing Homes

State controls were not adequate to prevent improper Medicaid payment to nursing homes that were under a denial of payment sanction. Title XIX, section 1919, of the Social Security Act and 42 CFR § 488 require that the State establish adequate controls over the mandatory denial of payment sanction. Of the 73 nursing homes that were sanctioned during our audit period, 13 received unallowable Medicaid payments for new admission residents because the State Medicaid agency had not implemented pre-payment edits or post-payment reviews during the period of our review to ensure that only allowable services were paid to nursing homes. As a result, the State Medicaid agency made Medicaid payments totaling \$75,342 to the 13 nursing homes for residents who were admitted during the sanction periods, of which \$40,553 represented the Federal share of the payment. One of the nursing homes recognized that one of the payments it received was unallowable and returned \$2,758 to the State prior to our review. The balance, totaling \$72,584 (Federal share totaling \$39,074) was not identified by the nursing homes as unallowable until the time of our review.

State Controls Over Medicaid Payments

State Medicaid agency personnel told us that they had not established controls to ensure that nursing homes that received denial of payment sanctions were not paid for new Medicaid residents during the sanction period. The State's only control was to maintain file copies of the denial of payment sanction letters that it issued. Based on our limited review, its files were not complete. The documentation maintained by CMS was more extensive and complete than the

documentation received from the State. The State had not established any controls to ensure that all denial of payment sanctions was identified and that sanctions were enforced to prevent improper Medicaid payments. The State informed us that beginning in October 2003, they were planning to perform post-payment reviews to prevent the payment for claims for new admissions during a denial of sanction period.

The State imposes sanctions in order to safeguard Medicaid residents in nursing homes. The denial of payment sanction is an enforcement remedy for nursing homes that were not in substantial compliance with one or more of the Federal requirements when surveyed by the State survey agency. The scope and severity of the deficiency requires imposition of the denial of payment remedies. Consequently, it is imperative that the State identifies sanctioned nursing homes and suspends Medicaid payments to those nursing homes in a timely manner when there is a risk to residents' health and safety.

Medicaid Payments for Optional Denial of Payment Sanctions

Our review of available documentation received from CMS showed that 73 nursing homes received a denial of payment sanction for new admissions during our audit period. Payments for Medicaid residents admitted to nursing homes before the denial of payment sanction was in effect were allowable; consequently, we had to determine whether some or all of Medicaid payments made to those 73 nursing homes was either allowable or unallowable.

The denial of payment status for a resident is determined by the admission date of the Medicaid resident. A new admission resident is defined in 42 CFR § 488.401 as:

. . . a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.

Based on available payment records provided by the State, we identified 51 nursing homes that had a potential for receiving unallowable payments during the sanction periods. We visited or contacted those 51 nursing homes, and reviewed admission records and billing histories to identify any new admission residents that were not eligible for Medicaid coverage during the sanction period. Many of those payments were allowable because the nursing homes had admitted the Medicaid residents before the denial of payment sanction was in effect.

Nevertheless, the State Medicaid agency paid \$75,342 (Federal portion totaling \$40,553) to 13 nursing homes for 32 new admission residents that resided at those homes for 639 sanction days. One nursing home recognized that a portion of the payment received was unallowable and returned \$2,758 (Federal portion totaling \$1,479) to the State. Appendix A contains a detailed list of those payments, including the dates of the sanction period, the number of residents, the denial of payment sanction days, and the unallowable payment amounts for each nursing home. At the time of our review, the 13 nursing homes still had not repaid \$72,584 (Federal portion totaling \$39,074) to the State. We calculated the Federal portion of the Medicaid payment using the Federal financial participation rate in effect at the time of the denial of payment sanction.

Although the State had properly sanctioned the nursing homes that were out of substantial compliance, the State controls were inadequate to prevent Medicaid payments to nursing homes that were under a denial of payment sanction.

FINDING - Mandatory Denial of Payment Sanctions

A review of CMS's OSCAR database indicated that 101 of the 653 Medicaid certified nursing homes surveyed by the State received a deficiency with a scope and severity code that required a denial of payment sanction that were not identified on the CMS and State lists of sanctioned nursing homes. The denial of payment sanction was warranted because those nursing homes had not reached substantial compliance within 3 months of having the deficiency identified by the State survey agency. As a result, the State could have made Medicaid payments to those nursing homes for new admissions during those sanction periods because they had not identified them as requiring a mandatory denial of payment sanction.

OSCAR Documentation

From our match between CMS's list of sanctioned nursing homes and the deficiencies identified in the OSCAR database, we identified nursing homes that had not achieved substantial compliance within 3 months of the original deficiency. Nursing homes that received a deficiency causing it to be out of compliance included any deficiency with a scope and severity code of 'D' through 'L'. We also determined whether a nursing home received three consecutive standard surveys with substandard quality of care deficiencies. The OSCAR data is a compilation of the results obtained during the State survey and certification process. According to CMS personnel, the information entered into the OSCAR database was not always validated and accurate, and neither CMS nor the State used the OSCAR system as an enforcement tracking system. Particularly, the date of compliance, which we used to determine the number of days the nursing home took to become compliant, was suspect as an accurate field. Instead, CMS used the Chicago system to track long-term care enforcement.

We used the OSCAR database to identify and review the 73 sanctioned nursing homes that are discussed in the finding titled "State Controls Over Denial of Payment Sanctions for Nursing Homes." Of the 201 denial of payment sanction periods contained in the OSCAR database for our review period, 54 periods were not in the Chicago system. We could not determine why there were differences between those databases without additional detailed audit work. Some of the nursing homes that were not included in the Chicago system could include mandatory sanctions for which CMS decided not to impose the sanction. Those records were not easily available for our review.

However, based on our analysis of the OSCAR data, 101 facilities should have been sanctioned because substantial compliance had not been achieved within 3 months. We did not identify any nursing homes that received three consecutive standard surveys of substandard quality of care deficiencies. From the information that was available in the OSCAR database and the documentation provided by CMS and the State, we did not determine whether the State made a

payment to those nursing homes that should have been sanctioned during the identified periods, and whether any payments were for new admissions.

State Controls Over Mandatory Denial of Payment Sanctions

Based on our preliminary review of the OSCAR database, the State did not have adequate controls to prevent Medicaid payment to nursing homes that should have been sanctioned. Sanctions are imposed to safeguard beneficiaries and the denial of payment is an enforcement remedy for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements. The scope and severity of the deficiency requires imposition of the denial of payment remedies. Although we could not quantify the total amount of the payments made by the State for new Medicaid admissions, the number of sanctions identified in the OSCAR database indicated the lack of controls imposed by the State to identify and monitor those nursing homes that received a deficiency during the last survey and certification process.

RECOMMENDATIONS

We recommend that the State Medicaid Agency:

1. refund \$39,074 to CMS for the Federal share of the unallowable Medicaid payments,
2. implement pre-payment edits, in addition to the newly established post-payment reviews, to ensure that Medicaid payments are not paid to nursing homes that are under a denial of payment sanction, and
3. establish procedures to identify nursing homes that should receive a denial of payment sanction.

AUDITEE COMMENTS AND OIG RESPONSE – CMS

CMS Region III office suggested changes in the wording of three statements in the report. Those changes were implemented where appropriate throughout the report. Also, in late 2004, CMS and the Commonwealth survey agencies will implement the ASPEN Enforcement Tracking Module that includes a standard report used to monitor the sanction process. That report will identify those nursing homes that require follow-up actions by the Commonwealth or the CMS regional office to prevent unallowable payments for nursing homes under sanction. A copy of the response is shown in Appendix B.

AUDITEE COMMENTS AND OIG RESPONSE – COMMONWEALTH OF PENNSYLVANIA

The Department of Public Welfare generally agreed with the findings and recommendations contained in the report. It stated that: a) two denial of payment sanctions (Bans of Admission) were cancelled, b) \$60,532 of the reported \$76,274 unallowable Medicaid payments had already been recovered, and c) the Department's new claims processing and management information system (PROMISe™) has edits and new functions in place to prevent nursing facilities from billing when denial of payment sanctions are imposed.

A copy of the significant portion of the Commonwealth's response is shown in Appendix C. We did not include the additional 100 pages of documentation that supported the amounts recovered from the nursing homes for each recipient stay questioned.

We agree that the denial of payment sanctions was canceled for two nursing home sanction periods identified in our draft report. Those amounts were removed from the report. However, we were unable to reconcile to the reported collection of \$60,532 that was identified in the Commonwealth's response. Consequently, we reviewed the documentation provided by the Commonwealth to support its findings and found the following.

- Unallowable Medicaid payments were reversed by the nursing homes and the Commonwealth recovered payments totaling \$46,336, which includes one payment, totaling \$2,758, recovered prior to the audit, and calculation adjustments totaling \$3,799. The adjustments represent differences between the original amounts in the draft report and the actual amounts collected.
- The Commonwealth agreed that additional unallowable Medicaid payments for seven nursing homes, totaling \$26,430, should be recovered.
- The Commonwealth indicated that it had not made payments, totaling \$2,576, and consequently those payments are not recoverable. However, we obtained documentation from the nursing homes that shows that those amounts were included on Commonwealth remittance advices showing that payment was made.

All unallowable amounts in the final report have been corrected to reflect the differences summarized above. Documentation supporting the payments for four claims still remaining in dispute will be provided to the Commonwealth for its review.

APPENDICES

MEDICAID UNALLOWABLE PAYMENTS

Nursing Home	Sanction Period		Resident Count	Sanction Days	Total Unallowable	Collected ¹	Pending Collection	In Question	Calculation Differences
	Start	End							
9	04/10/01	04/23/01	1	2	\$ 274.54	\$ -	\$ 274.54	\$ -	\$ -
11	08/03/00	10/05/00	7	202	21,157.10	15,722.28	2,858.64	2,576.18	(12.39)
15	11/18/00	12/12/00	1	15	1,725.30	1,725.30	-	-	-
19	05/25/01	05/31/01	1	2	226.46	226.46	-	-	-
20	02/07/01	03/11/01	2	23	6,720.09	6,720.09	-	-	3,868.09
21	07/20/01	10/10/01	1	3	394.41	394.41	-	-	-
23	12/20/00	01/31/01	2	32	3,200.03	3,200.03	-	-	(139.17)
32	02/04/00	04/06/00	6	142	15,183.01	15,183.01	-	-	82.42
34	07/18/01	09/03/01	3	66	8,181.29	405.75	7,775.54	-	-
36	06/29/00	08/21/00	1	15	2,076.90	-	2,076.90	-	-
38	06/12/00	07/23/00	2	43	5,046.24	-	5,046.24	-	-
40	09/01/00	10/24/00	4	71	8,398.55	-	8,398.55	-	-
12			31	616	\$ 72,583.92	\$ 43,577.33	\$ 26,430.41	\$ 2,576.18	\$ 3,798.95
Federal Financial Participation Amount					\$ 39,074.07	\$ 23,432.54	\$ 14,260.18	\$ 1,381.35	\$ 2,035.73

MEDICAID UNALLOWABLE PAYMENTS - REPAID PRIOR TO AUDIT

4	06/23/01	07/29/01	1	23	\$ 2,758.23	\$ 2,758.23	\$ -	\$ -	\$ -
1			1	23	\$ 2,758.23	\$ 2,758.23	\$ -	\$ -	\$ -
Federal Financial Participation Amount					\$ 1,478.96	\$ 1,478.96	\$ -	\$ -	\$ -
TOTAL MEDICAID UNALLOWABLE PAYMENTS									
13			32	639	\$ 75,342.15	\$ 46,335.56	\$ 26,430.41	\$ 2,576.18	\$ 3,798.95
Federal Financial Participation Amount					\$ 40,553.03	\$ 24,911.50	\$ 14,260.18	\$ 1,381.35	\$ 2,035.73

¹The collected amounts include the calculation differences made by the nursing home. We accepted those calculations as accurate.

AUDITEE COMMENTS – CENTERS FOR MEDICARE & MEDICAID SERVICES



Memorandum

Centers for Medicare & Medicaid Services

Region III

Suite 216, The Public Ledger Bldg
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Date: MAR 4 2004

To: Regional Inspector General for Audit Services

From: Manager, Financial Review Branch
Division of Medicaid & Children's Health

Subject: Draft Audit Report #A-03-03-00211 – Pennsylvania Medicaid Denial of Payment for New Admissions for Sanctioned Nursing Homes

We have reviewed the subject draft report and have the following comments:

1. On page 1 in the fourth line from the bottom, the word "and" should be deleted after the words "nursing homes."
2. While it is technically correct that a certified nursing home is to have an unannounced survey at least once every 15 months, a state would fail its annual evaluation if it inspected all of its nursing homes only every 15 months. The law also requires that the average statewide interval between consecutive standard surveys is no greater than twelve (12) months. It is misleading to not acknowledge the second part of this requirement.
3. On page 4 of the draft, you state "Based on discussions with personnel from the CMS Region III office, the OSCAR database was not designed as an "enforcement tracking system." In fact, the OSCAR/ODIE database does have a component designed for tracking enforcements. Some states and Regional Offices continue to maintain that dataset in ODIE, others do not. Generally, the information captured was found inadequate for tracking all of the enforcement actions and an OSCAR report was never designed for data output. The Chicago RO designed its own LTC enforcement tracking system to address the shortcomings of the ODIE system. Beginning in CY1999, all Regional Offices were required to use the Chicago RO system for tracking nursing home enforcement actions.

If your staff should have any questions regarding these comments, they may contact Mr. Thomas Zlakowski, of my staff, at (215) 861-4242.

Ted Gallagher

AUDITEE COMMENTS – COMMONWEALTH OF PENNSYLVANIA



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

MAY 10 2004

Michael Stauffer
Deputy Secretary for Administration

(717) 787-3422
Email: MikeS@dpw.state.pa.us

Mr. Stephen Virbitsky, Regional
Inspector General for Audit Services
Office of Inspector General
Department of Health & Human Services
Public Ledger Building, Suite 316
150 South Independence Mall West
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Virbitsky:

Thank you for your February 17, 2004, letter in which you transmitted the draft report entitled "Medicaid Denial of Payment Remedy for Sanctioned Nursing Homes in the Commonwealth of Pennsylvania" (Report Number A-03-03-00211).

The Department of Public Welfare (DPW) has reviewed the findings and recommendations contained in the report and have determined that two of the Bans on Admission were cancelled, and that the majority of the claims have been appropriately recovered from the payment system. The DPW has recovered \$60,532.12 out of the \$76,274.00 that the auditors determined to be unallowable Medicaid payments. Documentation supporting the findings of recovery is enclosed. The nursing facilities will be notified concerning the recovery of the remaining Medicaid payments. Furthermore, the new PROMISe™, the DPW's claims processing and management information system, now has the edits and new functions in place to prevent nursing facilities from billing when Bans on Admissions have been imposed.

Thank you for the opportunity to respond to this report. Please contact Andrew Johnson, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-6329 if you need any further assistance.

Sincerely,

A handwritten signature in cursive script that reads "Michael Stauffer".

Michael Stauffer

Enclosures

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed includes:

Bernard Siegel, *Audit Manager*

Anita Anderson, *Senior Auditor*

Calvin Jones, *Auditor*

Technical Assistance

James Rodgers, *Advanced Audit Techniques*

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