

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NURSING HOME ENFORCEMENT:
THE USE OF
CIVIL MONEY PENALTIES**



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OBJECTIVE

To describe reduction, assessment, and collection patterns for civil money penalties (CMP) imposed by the Centers for Medicare & Medicaid Services (CMS) in calendar years 2000 and 2001.

BACKGROUND

The CMPs are one of eight discretionary remedies CMS may use to address deficiencies in quality of care or safety standards. The CMPs may be assessed per day of noncompliance or per instance of noncompliance. Additionally, CMPs have required dollar ranges that correspond to the seriousness of harm to the patient(s).

We analyzed 100 percent of data from CMS's regionally-based Long-Term Care Enforcement Tracking System for enforcement cases beginning in 2000 and 2001 in which a CMP was imposed. These data were supplemented with information from the CMP Tracking System, housed in CMS's central office. We also interviewed staff at CMS's regional offices and the Department of Health and Human Services, Departmental Appeals Board.

FINDINGS

While \$81.7 million in CMPs was imposed during 2000 and 2001, \$34.6 million (42 percent) was paid by December 2002. The difference is primarily attributable to reductions authorized by regulation and delays in making and collecting payments. Although CMPs are used quite frequently (51 percent of CMS enforcement cases), the CMP amounts originally imposed are often substantially decreased before payment is due. Under current regulations, systematic reductions, appeals, settlements, and bankruptcies are the main factors contributing to this decrease.

Seventy percent of CMP cases (2,973) received a reduction from the full amount imposed prior to payment request. Every nursing home is entitled to a 35 percent reduction for waiving its right to appeal. Appeal waivers and appeal settlements account for \$22.7 million in reductions.

Fourteen percent of cases with CMPs due remained uncollected as of December 2002; bankruptcies and inconsistencies in the collections process were the primary causes. At the end of our tracking period, 550 cases, totaling \$11.7 million in CMPs due, were still outstanding.

The most frequent reasons for nonpayment were bankruptcies and cases for which there was no documentation that CMS attempted to collect.

Eight percent of all CMP cases were not yet due by December 2002. By the end of our data tracking period, 339 cases had been delayed for more than a year, almost exclusively the result of processing appeals and/or bankruptcies.

CMS does not utilize the full dollar range allowed for CMPs; impositions tend toward the lower ends of the ranges. The median per day imposition amount for the most severe (immediate jeopardy) cases was about \$4,000, at the 15th percentile of the allowable range (\$3,050 to \$10,000). The median per day imposition amount for less severe cases involving a CMP was \$250, at the 7th percentile of the allowable range (\$50 to \$3,000).

Cases not appealed took over 6 months to collect; appealed cases took substantially longer. The Social Security Act specifies that remedies should be designed “. . . to minimize the time between the identification of violations and final imposition of the remedies.” Required procedures slow this timeframe for all CMP cases, and appealed cases took twice as long to collect as cases not appealed. In those cases, CMS’s collection efforts cease until an administrative decision is reached; therefore, total collection time in appealed cases includes the time attributed to the administrative appeals process.

RECOMMENDATIONS

This inspection highlights several conditions within the current enforcement system that could be improved. We recommend that CMS:

- Provide written guidance to CMS staff and States regarding appropriate dollar ranges for individual ratings of scope and severity.
- Provide written guidance to CMS staff to clarify responsibilities with respect to past due CMPs and to conduct an internal process review that would enable CMS and States to streamline CMP processing.

Agency Comments

CMS concurred with our recommendations. The agency further commented it has already begun work to promote consistent imposition of CMPs and to develop appropriate policy guidance regarding

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responsibility for collection of past-due CMPs and streamlined CMP processing.

CMS noted that we included required reductions for appeal waivers, appeals, and settlements in a discussion of CMP amounts imposed and paid. CMS suggested that an Office of Inspector General (OIG) analysis of the collection process should more properly begin with the amount remaining after accounting for these required reductions and that doing otherwise may imply OIG criticism of CMS performance. We recognize that reductions for appeal waivers, appeals, and settlements are required by Federal regulations, and we appreciate CMS's concern in this matter. For this reason, we have made certain to clearly denote throughout the report which reductions are obligatory.

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OBJECTIVE

To describe reduction, assessment, and collection patterns for civil money penalties (CMP) imposed by the Centers for Medicare & Medicaid Services (CMS) in calendar years 2000 and 2001.

BACKGROUND

Sections 1819 and 1919 of the Social Security Act establish the requirements that nursing homes must meet to participate in the Medicare and Medicaid programs. The Secretary is responsible for ensuring that these requirements and their enforcement “are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.”¹

Nursing Home Enforcement

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) established a survey and certification process for States and CMS to verify that Federal standards are maintained in Medicare and Medicare/Medicaid dually-certified nursing homes. CMS contracts with State agencies to survey and certify compliance with Federal standards no less than once every 15 months. Additional surveys or abbreviated surveys are also used to investigate complaints. Any deficiency that puts the nursing home out of substantial compliance, as determined through the surveys, may initiate CMS enforcement action(s).

The State uses information from the surveys along with a nursing home's past record of compliance to determine what action(s) to take and/or to recommend.² Specific remedies recommended by the State are usually accepted and imposed by CMS. However, imposed remedies will not actually go into effect until after a formal notice period is observed, and the effective date given to the nursing home is reached. At any time during this enforcement cycle, the State may conduct a “revisit” to determine if deficiencies have been corrected. During revisits, surveyors may also revise (increase or decrease) deficiency rankings or cite new deficiencies. Enforcement actions may be rescinded, new actions imposed, or timeframes adjusted as a result of the revisit findings.

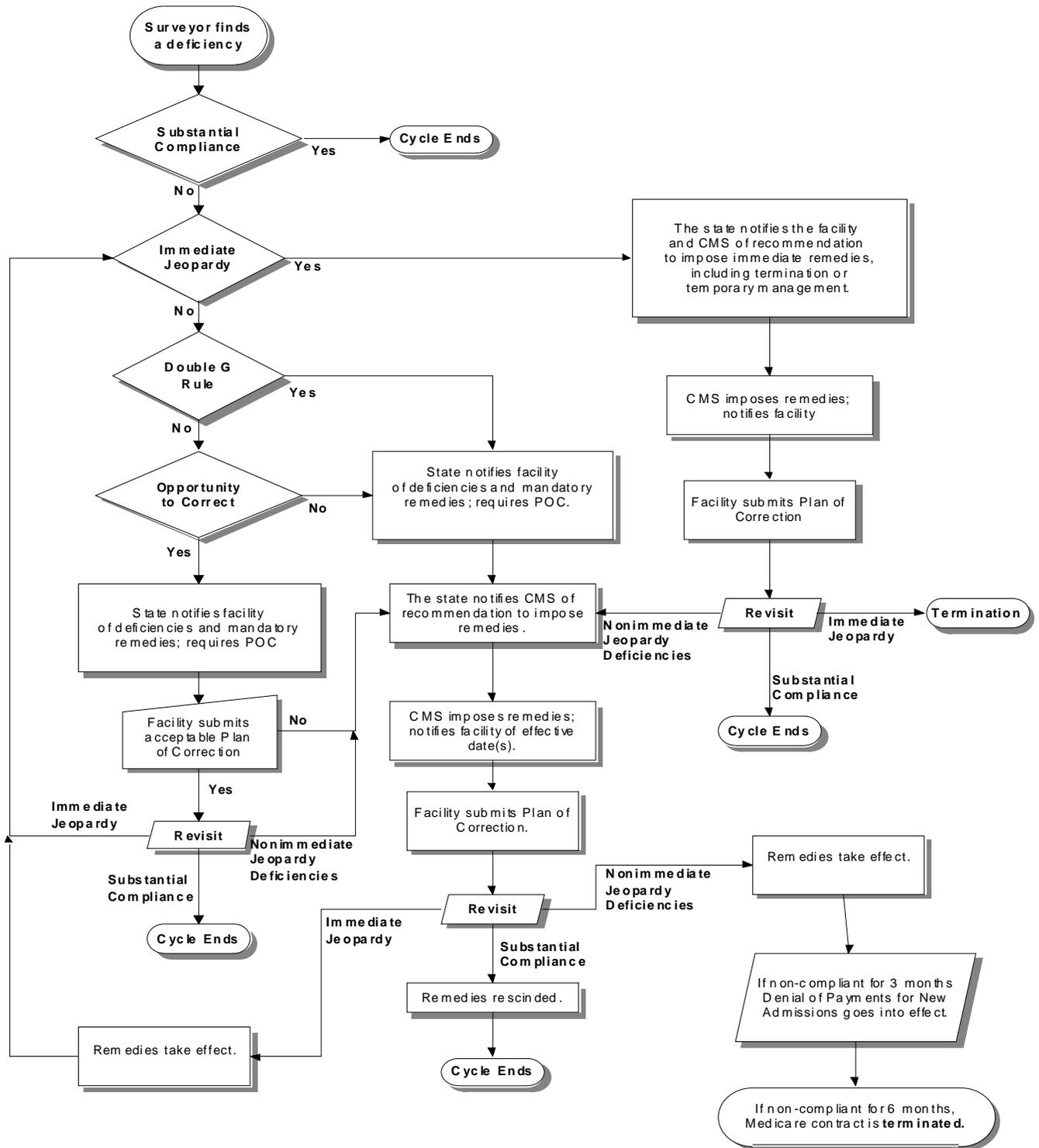
Each enforcement case (from initial finding of deficiency to either termination of the Medicare contract or substantial compliance) is characterized by rigidity in timeframes, but flexibility in course of action. The designed purpose is to create an environment in which

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enforcement staff may customize the process to appropriately address the uniqueness of each situation.

The following flow chart (Figure 1) provides an overview of the enforcement process for Medicare and Medicare/Medicaid dually-certified nursing homes. Terms within the flowchart are defined in subsequent sections. A number of variations from this diagram can, and will, frequently occur.³ Regardless of any exceptions that may occur, immediate jeopardy is to be resolved within 23 days and all nursing homes must be in substantial compliance within 6 months or CMS is required to terminate the Medicare contract.

Figure 1: Flowchart of the Enforcement Process



Source: Office of Inspector General Analysis of Documents, Regulations, and Interviews with CMS

Scope and Severity

The Scope and Severity Grid (Table 1) was created so that deficiencies could be ranked in accordance with outcomes, e.g., harm to patients, as required by regulations.⁴ The “severity” of the deficiency refers to the degree of harm, while the “scope” of the deficiency refers to the number of affected residents. These factors are combined to rank deficiencies on a scale from A through L. The ranking is then used to define specific levels of compliance and to select appropriate remedies.

Table 1: Scope and Severity Grid for Deficiencies			
Deficiency Severity	Deficiency Scope		
	Isolated	Pattern	Widespread
Actual or potential for death or serious injury (immediate jeopardy)	J Category 3 Optional: Category 1; Category 2	K Category 3 Optional: Category 1; Category 2	L Category 3 Optional: Category 1; Category 2
Actual harm that is not immediate jeopardy	G Category 2 Optional: Category 1	H Category 2 Optional: Category 1	I Category 2 Optional: Category 1; Temporary Management
Potential for more than minimal harm	D Category 1 Optional: Category 2	E Category 1 Optional: Category 2	F Category 2 Optional: Category 1
Potential for minimal harm, substantial compliance exists	A Substantial Compliance	B Substantial Compliance	C Substantial Compliance

Source: CMS State Operations Manual

As shown in Table 2 (next page), the category from which remedies will be chosen is determined by the highest “scope and severity” of the deficiencies (i.e., deficiencies with a scope and severity rating closest to L) rather than the number of deficiencies. However, for each category, there is an option to impose additional remedies from categories other than those indicated by the scope and severity rating, if that is determined to be appropriate. For example, a nursing home with at least one deficiency associated with “actual harm” (scope and severity ratings G through I) may receive one or more remedies from Category 2. Additional remedies from Category 1 may also be imposed.

Table 2: Discretionary Remedies by Category		
Category 1	Category 2	Category 3
Directed Plan of Correction	Denial of Payments for New Admissions	Temporary Management
State Monitoring	Denial of Payments for All Individuals	Termination
Directed In-Service Training	Civil Money Penalties \$50 - \$3,000 per day \$1,000 - \$10,000 per instance	Optional: Civil Money Penalties \$3,050 - \$10,000 per day \$1,000 - \$10,000 per instance

Source: CMS State Operations Manual

Remedies

The enforcement actions available to CMS include both mandatory and discretionary remedies. These remedies are used to bring nursing homes into compliance. The current remedy options are the result of the enforcement strategy established in OBRA '87 and implemented in 1995.^{5,6}

Mandatory remedies are those that must be imposed and take effect in accordance with statutory requirements, such as extended noncompliance ending in termination of the Medicare contract. Discretionary remedies are those that may be customized to address each nursing home’s circumstance; they are selected in accordance with the scope and severity grid. The stated purpose of remedies is “to ensure prompt compliance with program requirements.”⁷ Additional remedies may be imposed by individual States under their licensure authority and for Medicaid-only facilities; however, those will not be discussed within this report.

CMS has at its disposal eight discretionary remedies to address deficiencies found during a survey. One such remedy is the civil money penalty, with fines ranging from \$50 to \$10,000. All eight discretionary remedies are described in Appendix A.

Civil Money Penalties

The CMPs can either be per day or per instance; the fine amount can vary depending on the scope and severity of the deficiency. (See Table 2.) Per day fines usually begin accumulating on the last day of the survey and continue accruing until substantial compliance is achieved (i.e., deficiencies are corrected to the scope and severity level of

“C” or lower). Per instance CMPs (established in 1999) allow a set dollar amount to be imposed in relation to a particular deficiency.

Per day and/or per instance CMPs were imposed in 51 percent of the 8,309 enforcement cases referred to CMS during the years 2000 and 2001. They were imposed almost twice as often as the second most utilized remedy, denial of payments for new admissions.

Unlike other remedy options, CMPs have no notice requirement, and the effective date is usually retroactive to the last day of the survey. For many non-CMP remedies, the notice period and delayed effective date serve as an opportunity for nursing homes to achieve compliance and, consequently, preempt the remedy from going into effect.

Once CMS notifies a nursing home of the CMP amount due and requests payment, remittance is expected within 15 days, unless a payment schedule is negotiated or the nursing home files an appeal. Monies not received within the specified timeframes will begin to accrue interest. If collection efforts fail, Medicare’s fiscal intermediary and the appropriate State agency should be notified to withhold payments from the home until the balance is paid.⁸

Appeals

Facilities have the right to contest survey findings through an administrative appeal and/or an informal dispute resolution process. In both cases, there is potential for one or more deficiencies to be eliminated, or for a scope and severity rating to be revised.

Determinations made through an administrative appeal or informal dispute resolution are carried through to the enforcement actions pending or initiated. Remedies are retrospectively adjusted to reflect the new findings.

The CMPs differ from other remedies in that CMPs cannot go into effect (i.e., monies are not collected) until an administrative appeal decision is reached (this does not apply to informal dispute resolutions, nor does it extend to judicial appeals that may follow an administrative appeal). For this reason, nursing homes may use the administrative appeal to delay payment of a CMP. Other types of remedies are not delayed during an administrative appeal. A Government Accountability Office (GAO) report in March 1999 tracked the imposition of CMPs for a sample of nursing homes with multiple survey deficiencies identified between 1995 and 1998. In GAO’s sample, 115 CMPs were imposed, but 78 of those had not yet taken effect as of the report’s publication. Many of the 78 CMPs were still under appeal.⁹

Appeal Waivers

Regulations require that CMS or the State reduce the amount of the penalty by 35 percent if the nursing home chooses to waive its right to appeal the deficiency.¹⁰ In issuing this regulation, CMS stated that “. . . the reduction . . . would reflect the savings to both the government and the provider of costs that would otherwise be incurred to formally adjudicate the dispute.”¹¹ In spite of this waiver program, over 700 nursing home enforcement administrative appeals have been requested each year since 2000. This represents approximately 20 percent of CMP cases and 7 percent of cases not involving a CMP.¹²

METHODOLOGY

This study relies on data from CMS’s Long-Term Care Enforcement Tracking System (LTC), its Civil Money Penalty Tracking System (CMPTS), and a set of interviews. Analysis was conducted on 100 percent of the data for 9 of the 10 CMS regions (region II was excluded as the result of self-reported implementation difficulties), with the exception of cases eliminated because data were missing or incorrect.

Scope

This study is limited to the 4,253 cases involving CMPs imposed by CMS as the result of surveys or complaint visits during the years 2000 and 2001. The cases were tracked through December 16, 2002. Any actions that occurred after that date are not included in this report. Also, the data include only those cases that States referred to CMS. This means that all cases found to have deficiencies with a scope and severity level of A, B, or C, cases in which the nursing home successfully corrected after being given an “opportunity to correct,” and any cases mistakenly not referred by the State are not included. Other enforcement authorities rest with the States and the Office of Inspector General for the Department of Health and Human Services (HHS); however, the authorities and actions based on them are beyond the scope of this study.¹³

Long-Term Care Enforcement Tracking System

The LTC database is a compilation of each CMS region’s nursing home enforcement case files. In the nine regions used, caseworkers update this information as enforcement actions occur. More detailed information about the LTC database is provided in Appendix B.

Significant cleaning of the data was necessary.¹⁴ The data cleaning process, detailed in Appendix B, included elimination of cases with questionable values or pertinent missing data during the affected analysis, correction of typographical errors and inconsistent information, and deletion of duplicate files. A total of 4 percent (353 records) was eliminated from all analysis.

Civil Money Penalty Tracking System

The CMPTS is the centralized CMS database used for tracking the collection and allocation of CMP payments. For analysis involving monetary collections, we found it beneficial to capture fields regarding CMP payments through the CMPTS data rather than the LTC data. The CMPTS data were additionally useful for matching CMP amounts with the specific scope and severity levels that were used to determine those amounts.

After significant data cleaning, we found a match rate of more than 99 percent between CMPTS and LTC. For calendar years 2000 and 2001, we found 4,253 CMP cases included in both LTC and CMPTS. More detailed information about the CMPTS database is provided in Appendix B.

Interviews

CMS Regional Staff. Interviews with staff in all CMS regions regarding their use of the LTC database allowed us to better understand the operational differences between regions.

Departmental Appeals Board. Interviews with staff at the Departmental Appeals Board allowed us to better understand administrative appeals as they relate to nursing home enforcement. Staff also supplied us with information on case status and outcomes for particular cases within the LTC database and with aggregate numbers on the appeals caseloads.

Data Limitations

The LTC data were determined to be the best source of comprehensive enforcement data, and therefore are the primary data in our analysis. Certain limitations to the data are noted; however, they do not compromise the quality of our findings. The data include only 9 of the 10 regions, and only cases actually referred from States (rationale for excluding region II is included in Appendix B).

Estimation errors could result from the omission of cases with missing information in certain analyses. Of particular concern are dismissed CMPs and payment dates. The case notes in many files indicated that

revocation of a CMP resulting from a bankruptcy settlement or an appeal determination was reflected in the data by deleting the CMP from the case record. Therefore, both the aggregate impositions and reductions may be understated. Also, the data required for computing the time between the date the CMP was considered due and the date the CMP was paid were available for only 2,605 of the 3,850 applicable cases. We believe that these dates were missing because the cases were still in process at the end of our data tracking period. For this reason, the collection time may be significantly underestimated.

Terminology

A list of defined terms is located in Appendix C. This section establishes operational definitions, as well as the fundamental vocabulary used in the field of long-term care enforcement. For example, the term “actual harm” (customarily defined as scope and severity levels G, H, and I) is expanded to include scope and severity level F. These distinctions are important for precise interpretation of our findings.

Quality Standards

This study was conducted in accordance with the Quality Standards for Inspections issued by the President’s Council on Integrity and Efficiency.

► FINDINGS

While \$81.7 million in CMPs was imposed during 2000 and 2001, \$34.6 million (42 percent) was paid by December 2002. The difference is primarily attributable to reductions authorized by regulation and delays in making and collecting payments.

Although CMPs are used frequently (51 percent, 4,253, of all 8,309 enforcement cases), the CMP amounts originally imposed are often substantially decreased before payment is due. Under current regulations, systematic reductions,

appeals, settlements, and bankruptcies are the main factors contributing to this decrease. Of the \$81.7 million that was imposed by CMS during the years 2000 and 2001, \$34.6 million (42 percent) was paid by nursing homes. The unpaid portion, \$47.1 million (58 percent), was most affected by reductions to amounts imposed and by delays in due dates. (See Table 3.)

Table 3: Reductions and Delays in Due Dates Most Affected CMP Amounts (in millions)		
Total Imposed	\$81.7	
Total Paid	\$34.6	<i>(42% of imposed)</i>
Difference	\$47.1	<i>(58% of imposed)</i>
Difference of \$47.1 is attributable to:		
Reductions in Amount Due	\$22.7	<i>48% of difference</i>
<i>Appeal Waivers</i>	<i>\$11.8</i>	
<i>Appeals and Settlements</i>	<i>\$10.8</i>	
<i>Other</i>	<i>\$0.1</i>	
Not Yet Due	\$12.7	<i>27% of difference</i>
<i>Appeal</i>	<i>\$8.5</i>	
<i>Bankruptcy in Process</i>	<i>\$3.7</i>	
<i>Other</i>	<i>\$0.5</i>	
Partial Payment Made	\$3.3	<i>7% of difference</i>
<i>Installment: Not Fully Due</i>	<i>\$1.8</i>	
<i>Remainder Due is Late</i>	<i>\$1.3</i>	
<i>Other</i>	<i>\$0.2</i>	
No Payment Made	\$8.4	<i>18% of difference</i>
<i>Late</i>	<i>\$5.3</i>	
<i>Bankruptcy*</i>	<i>\$2.9</i>	
<i>Extended Due Date</i>	<i>\$0.2</i>	

Source: Office of Inspector General Analysis of LTC and CMPTS data, 2003

*For this subgroup, available data indicated that the CMPs were due and payable; however, some may be uncollectable. Either the case was incorrectly entered into CMPTS as due or the facility is unable to pay subsequent to the resolution of the bankruptcy case.

The unpaid portion included \$11.8 million in reductions resulting from nursing homes waiving their right to appeal and \$10.8 million in settlements and reductions resulting from appeals. An additional

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\$12.7 million was not yet due, generally as the result of delays caused by appeals or bankruptcy proceedings. Nonpayment of collectable CMPs accounted for only 14 percent (\$6.6 million) of the \$47.1 million in uncollected CMPs during the years 2000 and 2001; \$5.3 million from the category No Payment Made/Late and \$1.3 million from Partial Payment Made/Remainder Due is Late.

Seventy percent of CMP cases received a reduction from the full amount imposed prior to a payment request.

For 70 percent of cases (2,973 of 4,253 cases), an average reduction of 43 percent of the imposed amount occurred. Reductions to the amounts imposed were the results of nursing homes waiving their rights to appeal, appeals, and settlements.

	Average Amount Imposed	Average Amount Due	Average Reduction
Immediate Jeopardy	\$37,088	\$18,695	50%
Actual Harm	\$12,796	\$8,154	36%

Source: Office of Inspector General Analysis of LTC and CMPTS data (4,119 cases)

On average, as Table 4 shows, the cases with more serious immediate jeopardy deficiencies (scope and severity ratings of J, K, and L) received a higher percentage reduction to imposition amounts than the less serious actual harm cases.

Appeal Waivers. For the sample years 2000 through 2001, 59 percent of all cases (2,498 of 4,253) elected to waive their right to appeal; in return, they received a 35 percent reduction in their CMP amount as required by regulation. The waiver option and reduction amount are granted to nursing homes through Federal regulations.¹⁵ Reductions from the appeal waiver totaled \$11.8 million for the sample years, with an average reduction of \$4,717 per case. Facilities with higher dollar CMPs imposed were less likely to use the waiver, opting for the formal appeals process.¹⁶ The mean CMP imposed for cases that waived their rights to appeal was \$13,489, while the mean CMP imposed for cases requesting appeals was \$41,873.

Appeals and Settlements. Appeals and settlements reduced fine amounts in 11 percent of all CMP cases (466 of 4,253).¹⁷ Combined, appeals and settlements reduced CMP impositions by \$10.8 million during the

2-year sample period. Appeals were requested more frequently in cases involving a CMP (20 percent) than in non-CMP cases (7 percent).

Appeals have the potential to alter the scope and severity of the deficiencies that are driving enforcement or to eliminate one or more deficiencies altogether. If the deficiencies driving enforcement action are changed, the remedies must be modified to appropriately address the newly-defined circumstance. Of the 632 appealed CMP cases from 2000 and 2001 for which the final decision is known, 74 percent resulted in dollar amount reductions. The average reduction was 56 percent of the imposed amount (including pretrial settlements). Even those nursing homes that do not prevail at the hearing benefit by significant delays in due dates, deferring direct financial costs.

Bankruptcies. Bankruptcies are another source of dollar amount reductions that is not fully apparent in Table 3. CMS is required to consider the financial condition of the nursing home prior to imposing a CMP.¹⁸ For this reason, CMS may reduce the CMP amount recommended by the State or decide not to impose a CMP at all. When a CMP is imposed, a nursing home facing financial difficulties will likely choose the appeal waiver and receive a 35 percent reduction or will request a formal appeal, often resulting in a reduction. We did not consider these reductions to be a direct result of the bankruptcy, but realize that financial condition may influence the nursing home's behavior. Additionally, bankruptcy settlements often result in the CMP being discharged or reduced.

Overall, 14 percent of cases where CMPs were imposed involved nursing homes that filed for bankruptcy or were part of a chain that filed for bankruptcy (608 of the 4,253 CMP cases). Eighteen million dollars in CMPs (22 percent of the total amount imposed) were imposed on these nursing homes. These facilities paid only 50 percent of the amount that was due (\$4.3 million of \$8.7 million), and only 24 percent of the amount that was originally imposed (\$4.3 million of \$18 million).

Fourteen percent of cases with CMPs due remained uncollected as of December 2002; bankruptcies and inconsistencies in the collections process were the primary causes.

For 2000 and 2001, nearly 550 cases, totaling \$11.7 million in CMPs that were due and payable, were still outstanding as of December 2002 (\$3.3 million for partial payments and \$8.4 million for no payments). The most frequent reasons for nonpayment were bankruptcies (168 cases, which were included in the discussion above of bankruptcy,

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paid part or none of the amount due) and cases in which the data revealed no apparent collection effort (184 cases).

According to the centralized tracking system for CMP payments, the CMPTS, at least 174 of the 550 unpaid cases with data available (including some cases with collection activity and some without) remained outstanding for more than 1 year. The majority of the 174 cases had no payment as of December 2002. In cases of nonpayment, CMS may advise the fiscal intermediary and State agency to withhold or offset payments for services rendered up to the amount that is owed. However, according to interviews with CMS staff, this is not routinely done in all regions. It appears that some regions accept the onus of CMP collection efforts, while other regions expressed that their role ends after entering the necessary information into CMPTS and that the CMS central office is then responsible. There is opportunity for CMPs to remain uncollected for extended amounts of time.

Eight percent of all CMP cases were not yet due by December 2002.

Of the 4,253 CMP cases, 339 cases (almost exclusively appeal and/or bankruptcy cases) had been delayed for more than a year as the result of required abeyances (temporary inactivity). A CMP in the process of an appeal or bankruptcy cannot be collected until a decision is made as to whether all or a portion of the imposed amount should be dismissed. These cases (representing \$12.7 million in CMPs imposed) were initiated by a survey performed during the years 2000 or 2001. However, there was no “amount due” entered into CMPTS as of December 2002, the end of our data tracking period, nor was there evidence of collection efforts by CMS regional offices in the databases analyzed. Although the majority of these cases will likely have some reduction to their CMPs, reduction amounts are unknown.

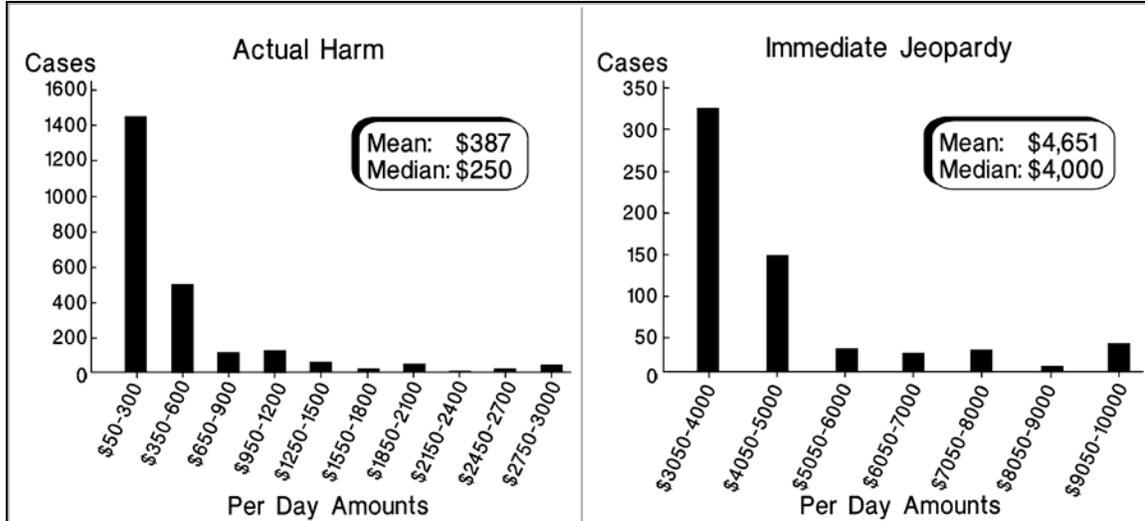
CMS does not utilize the full dollar range allowed for CMPs; impositions tend toward the lower ends of the ranges.

The CMP dollar amounts are required to be imposed within defined ranges, according to the degree of harm caused by the

deficiency, i.e., scope and severity rating.¹⁹ The ranges are inclusive of multiple scope and severity ratings and leave a great deal of discretion to regional enforcement staff. In practice, the allowable ranges are not utilized to their fullest extent.

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Figure 2: Per Day Imposition Amounts for Actual Harm and Immediate Jeopardy



Source: Office of Inspector General Analysis of LTC and CMPTS data, 2003

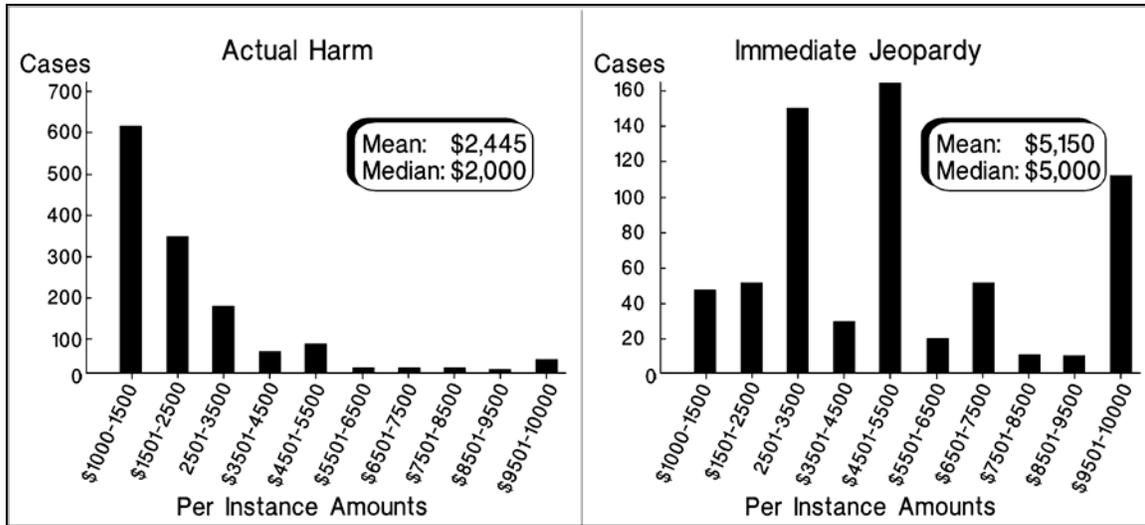
Per Day CMPs. Forty percent of documented immediate jeopardy cases had CMPs imposed at the bottom of the allowable per day range—\$3,050 (259 of 630 cases). In actual harm cases, over 80 percent of cases had CMPs imposed below the 15th percentile of the allowable range—\$500 or less (1,856 of 2,229 cases). The median-imposed CMP for immediate jeopardy cases was \$4,000 (the 14th percentile of the allowable range). The median-imposed CMP for actual harm cases was \$250 (the 7th percentile of the allowable range). The distributions are displayed in Figure 2 (next page).

The CMPs were imposed at the maximum amount in 8 percent of immediate jeopardy cases versus 1.2 percent of actual harm cases. In many of the immediate jeopardy cases for which the highest CMP amount was utilized, noncompliance was resolved within only a few days. (Deficiencies constituting immediate jeopardy are often corrected before the surveyors leave the nursing home.)

Per instance CMPs. Per instance CMPs do not accrue over time and may be imposed in amounts between \$1,000 and \$10,000. In immediate jeopardy cases, where per day CMP totals could rise to tens or even hundreds of thousands of dollars, per instance CMPs were chosen in over half the cases. Two-thirds of per instance CMPs were imposed at nonaccruing amounts of \$5,000 or less, and over 30 percent of actual harm cases were imposed at the minimum amount of \$1,000. The distributions are displayed in Figure 3 (next page).

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Figure 3: Per Instance Imposition Amounts for Actual Harm and Immediate Jeopardy



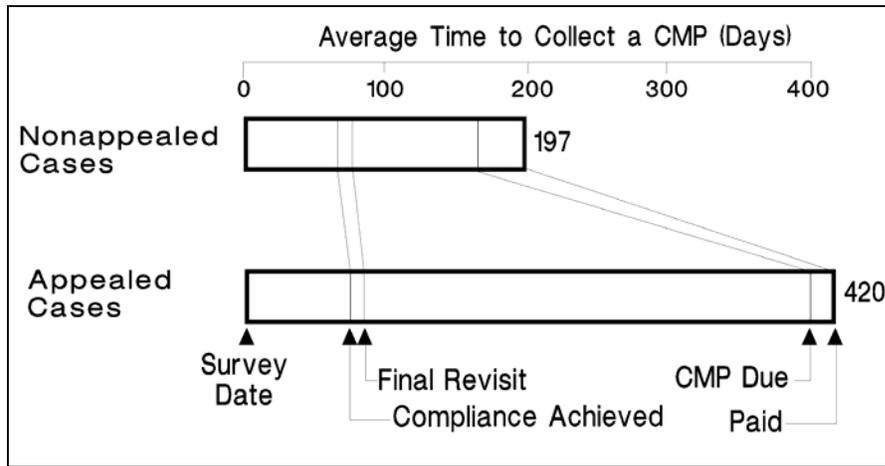
Source: Office of Inspector General Analysis of LTC and CMPTS data, 2003

The dollar ranges and availability of per instance CMPs allow CMS to customize remedies to address the unique circumstances of each instance of noncompliance; however, these options also allow for remedies that have minimal impact on noncompliant homes. For example, one nursing home was assessed only the minimum per instance CMP of \$1,000 during a period of noncompliance that included a deficiency of widespread immediate jeopardy relating to quality of care.²⁰ According to CMS, per instance CMPs may be used when high CMPs are warranted in an effort to avoid putting nursing homes out of business. A closure would displace numerous beneficiaries, potentially disrupting their care.²¹

Total Impositions. Impositions for combined per day and per instance CMPs rose above \$20,000 in less than 25 percent of cases (939 of 4,253 cases) and above \$50,000 in less than 10 percent of cases (384 of 4,253 cases). This may also be the result of CMS’s requirement to consider the nursing home’s financial status when determining imposition rates.²²

F I N D I N G S

FIGURE 4: Appealed Cases Took Significantly Longer to Collect



Source: Office of inspector General, Analysis of Appealed CMP Cases2003

Cases not appealed took over 6 months to collect; appealed cases took substantially longer.

The Social Security Act stipulates that imposition of remedies should be designed “to minimize the time between the identification of

violations and final imposition of the remedies.”²³ For CMPs imposed (excluding appealed cases) in 2000 and 2001, it took approximately 197 days (over 6 months) after a deficiency was found to actually collect the money.²⁴ Much of this time is the result of procedures that are required of CMS.

Required procedures increase the time between identification of violation and collection of the CMP.

For most CMPs (i.e., per day CMPs), final amounts cannot be calculated until compliance is achieved, as determined through a revisit.²⁵ For nonappealed cases, the final revisit affirming compliance (often retrospectively) occurred an average of 74 days (n = 3,376) after the survey initially finding a deficiency(ies). Once compliance is achieved, the State survey team must forward the information to the CMS regional office, which is then responsible for notifying the nursing home of the final CMP amount and due date. In addition, nursing homes must be granted 60 days, during which the nursing home may request an appeal for one or more deficiencies or may waive its right to appeal. In most circumstances, the CMP will not become due until at least 15 days after the expiration of the 60-day period or until an appeal request

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or waiver is received by CMS. On average, it took 89 days (n=3,077) from the final revisit until the CMP was due. Payments were made an average of 32 days (n = 1,482) after the actual due date.²⁶

Appealed cases took significantly longer to collect than cases not appealed.

Excluding time intervals that were exceptionally long, appealed cases took an average of 420 days to collect, a 110 percent increase in time over nonappealed cases (n = 399).²⁷ (See Figure 4.) The increase appears to be entirely attributable to abeyances resulting from the appeals process. The CMPs do not become due until the appeal is settled, or a decision is reached. Consequently, nursing homes are insulated from the repercussions of enforcement by well over a year. For appealed cases, the collection time line may be significantly underestimated, as payment dates were missing from 50 percent of cases. Those cases were likely still in the appeals process at the point that our data collection efforts ended. The HHS Departmental Appeals Board staff explained that the steps in the appeals process include time needed by the parties to prepare their cases or to negotiate. Additionally, the time period from the final revisit to the CMP due date includes some portion of the 60 days during which the nursing home may request a hearing, and another 60 days after the Administrative Law Judge's decision to request Board review.²⁸

► R E C O M M E N D A T I O N S

In this inspection, we found significant reductions in CMP amounts due and paid. These reductions, however, are permissible and many are required under the current regulations. While CMPs were designed to allow great flexibility in the amount imposed, in practice, the majority are imposed at the low end of their allowable range. Further, we found that process delays substantially extend the time for collection of CMP payments; and in some cases, collections did not appear to be pursued.

CMPs are the most widely used discretionary remedies by CMS and are often the only enforcement action noncompliant nursing homes will experience. As stated in the regulations, CMPs, along with other remedies, are designed to ensure prompt compliance with quality of care and safety standards. Our findings of routine reductions, combined with impositions at the lower end of the dollar range, and delays in collections suggest that current usage patterns could be improved.

We make the following recommendations to CMS in an effort to improve CMS's ability to utilize the CMP as an enforcement tool.

Provide written guidance to CMS staff and States regarding appropriate dollar ranges for individual scope and severity ratings. The current guidelines in the State Operations Manual group three to four individual scope and severity ratings into a single allowable dollar range; in practice, most CMPs are imposed at the lower end of their range. CMS's central office should revise the current guidance to encourage CMS regional offices to fully utilize the designated ranges. While maintaining the flexibility to address extreme situations or a nursing home's compliance history, the guidance should indicate how individual scope and severity ratings relate to specific dollar amounts or narrower dollar ranges, such that the full range of the scale is utilized. CMS's regional offices should then begin regular reviews for a sample of CMP impositions to ensure that this guidance is being followed.

Provide written guidance to CMS staff to clarify procedures with respect to past due CMPs and conduct an internal process review that would enable CMS and States to streamline CMP processing. It is our understanding that CMS's regional offices do not always track CMP collection efforts after the nursing home is notified that payment is due. Without reliable information on outstanding balances, CMS cannot utilize its most effective means of collection, withholding payments. Outstanding CMPs should be systematically referred to fiscal intermediaries and State agencies for collections. In addition, required procedures increase the

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time between identification of violations and collection of the CMP to almost six months. Scrutiny of the processes may reveal opportunities to minimize this time, as required by the Social Security Act.

Agency Comments

CMS concurred with our recommendations. The agency further commented that it has already begun work to promote consistent imposition of CMPs and to develop appropriate policy guidance regarding responsibility for collection of past-due CMPs and streamlined CMP processing.

CMS noted that we included required reductions for appeal waivers, appeals, and settlements in a discussion of CMP amounts imposed and paid. CMS suggested that an Office of Inspector General (OIG) analysis of the collection process should more properly begin with the amount remaining after accounting for these required reductions and that doing otherwise may imply OIG criticism of CMS performance.

We recognize that reductions for appeal waivers, appeals, and settlements are required by Federal regulations, and we appreciate CMS's concern in this matter. For this reason, we have made certain to clearly denote throughout the report which reductions are obligatory.

CMS also provided technical comments for which we made revisions where appropriate. The full text of CMS's comments is presented in Appendix D.

¹ Sections 1819(f)(1) and 1919(f)(1) of the Social Security Act.

² In situations that are not deemed to pose a threat of serious injury and where no historical pattern of noncompliance is found, the State may afford the facility an “opportunity to correct” prior to recommending remedies to CMS. If deficiencies are not corrected or if an “opportunity to correct” is denied, the State should then send the case to CMS with a recommendation for particular enforcement remedies to be imposed. Cases that do show a pattern of noncompliance and cases that are found to pose a threat of serious injury must be reported to CMS “immediately” so that action can be taken.

³ Some of those variations include:

- Category 1 remedies are generally imposed by the State at the time of the initial notification to the facility. Formal notice is not required for this class of action.
- Revisits may occur at any time during the process. A finding of substantial compliance during a revisit will always end the enforcement cycle. On average, two revisits are performed during each enforcement cycle.
- Revisits finding improvements or worsening of deficiencies could result in a change in effective dates or CMP amounts, thus requiring additional notifications and giving the facility an additional opportunity to establish substantial compliance.
- Additional steps may be taken to resolve an unacceptable Plan of Correction or a disagreement between the State and CMS.

⁴ 42 CFR § 488.404.

⁵ A number of changes resulted from OBRA '87. These statutory changes eliminate the distinction between level A and level B participation requirements; add additional remedies for use in enforcement action; codify the informal dispute resolution process; offer one hearing to dispute findings; classify seriousness of deficiencies for the purpose of

imposing a remedy through the use of scope and severity; establish and define “substantial compliance;” define “substandard quality of care;” establish two civil money penalty ranges; explain “repeat deficiencies” for purposes of increasing a civil money penalty; and establish a “tie breaker” rule, which applies when there are disagreements regarding enforcement between CMS and the State agency.

⁶ “Before the 1987 legislation, the only adverse actions available to [CMS] and the States against facilities that were determined to be out of compliance with Federal participation requirements included termination, nonrenewal, or automatic cancellation of provider agreements; denial of participation for prospective facilities; and denial of payment for new admissions in lieu of termination when the facilities had deficiencies that did not pose an immediate and serious threat to the health and safety of residents.” Source: 59 FR 56116, November 10, 1994.

⁷ 42 CFR § 488.402 and 59 FR 56116, November 10, 1994.

⁸ The collected money is divided between the Medicare general fund and the State Medicaid Agency in the same proportion as the split of Medicare and Medicaid beneficiaries in the offending facility. The State’s use of these funds is limited to programs that assist noncompliant facilities in achieving regulatory standards.

⁹ Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, March 1999).

¹⁰ 42 CFR § 488.436(b).

¹¹ 59 FR 56116, November 10, 1994.

¹² Aggregate numbers of nursing facility enforcement appeals were provided by the Departmental Appeals Board. In the calendar years 2000, 2001, and 2002, the numbers of hearing requests were 769, 773, and 710, respectively.

¹³ States oversee licensure of individual facilities and certification of Medicaid facilities. Failure to comply with State requirements may

result in the application of remedies or sanctions including money penalties. OIG may exclude providers or impose CMPs for failure to meet professionally recognized standards of care, licensure actions taken by the State, and certain civil and criminal convictions.

¹⁴ “Data cleaning” is defined as “the process of checking data for errors and correcting those errors whenever possible.” SPSS, Inc., Clementine 6.0 Users Guide; SPSS; Chicago, IL: 2001. p. 361.

¹⁵ 42 CFR § 488.436(a) and 42 CFR § 488.436(b).

¹⁶ The percent of cases requesting waivers is much higher than the percent requesting hearings (59 percent vs. 20 percent). However, for cases where the CMP imposed totals over \$50,000, 49 percent requested hearings compared with 33 percent that requested waivers.

¹⁷ Appeal rights and settlements are provided by regulation at 42 CFR §§ 488.432, 498.40, and 488.444, respectively.

¹⁸ 42 CFR § 488.438(f)(2).

¹⁹ 42 CFR § 488.408.

²⁰ Case notes revealed that this Kansas facility filed for bankruptcy in the same year as the \$1,000 CMP imposition and that the facility also received a discretionary denial of payments for new admissions. However, the facility was cited with an isolated immediate jeopardy in quality of care just months prior. For those two enforcement cycles, the facility was in compliance only 3 weeks out of an 8-month period.

²¹ CMS technical comments to draft report dated November 26, 2004.

²² 42 CFR § 488.438(f)(2).

²³ Sections 1819(h)(2)(B) and 1919(h)(2)(A) of the Social Security Act.

²⁴ Cases for which the identified deficiency constituted only past noncompliance and cases that remained outstanding at the end of our tracking period were omitted from time analysis.

²⁵ In a few situations, a revisit is not required to assert compliance.

²⁶ The number of days attributed to each interval (e.g., *survey date* to *final revisit*) during the collection process totals 197. However, the number of days from the *survey date* to the *paid date* averages 160 because the calculation is based on a different number of observations. Payment dates were missing on approximately 20 percent of the data; so the latter figure represents a smaller number of observations.

²⁷ Values for time intervals that were beyond three standard deviations from the mean were excluded so that questionable values did not affect our means.

²⁸ December 2002: Telephone interview with Departmental Appeals Board staff.

Discretionary Remedies

Termination of the Provider Agreement (42 CFR § 488.456)—Facility ceases to provide care for Medicare residents; Medicare residents must be transferred to another facility.

Civil Money Penalties (42 CFR §§ 488.430-488.444)—A per day or per instance fine ranging from \$50 to \$10,000.

Denial of Payments for New Admissions (42 CFR § 488.417)—Denial of payments for new Medicare or Medicaid admits.

Denial of Payments for All Patients (42 CFR § 488.418)—Denial of payments for all Medicare and Medicaid residents by CMS.

State Monitoring (42 CFR § 488.422)—Professional monitor identified by the State agency oversees the correction of cited deficiencies as a safeguard against further harm to residents.

Directed Plan of Correction (42 CFR § 488.424)—A plan which the State or regional office develops to require a nursing home to take action within specified timeframes; differs from a traditional Plan of Correction in that an entity other than the nursing home develops it.

Directed In-Service Training (42 CFR § 488.425)—Implementation of an educational program designed to increase the knowledge and skill of direct care staff regarding an issue of noncompliance.

Closure of Facility or Transfer of Residents or Both (42 CFR § 488.426)—In “emergency” situations, a State may close a nursing home and transfer all residents including private pay patients.

Data Description and Cleaning

The primary data for this study were obtained from the LTC and were supplemented with data from the CMPTS. The primary functions of these databases are administrative, e.g., reporting and case tracking.

Long-Term Care Enforcement Tracking System

This system was developed by CMS region V office as a tool to assist in the implementation of the new enforcement regulations.¹ The system was voluntarily adopted by several CMS regions in 1998 and 1999, with all regions required to use it by January 2000.

The LTC database is believed by CMS staff to be the best electronic source of enforcement information in almost every region. Combining basic nursing home descriptors with all aspects of the enforcement process and differentiating imposed and effected remedies, the LTC data contain significantly more information about the enforcement process than does the Online Survey, Certification, and Reporting database.

Civil Money Penalty Tracking System

The CMPTS is the centralized CMS database used for tracking the collection and allocation of CMP payments. For analysis involving monetary collections, we found it beneficial to capture fields regarding CMP payments through the CMPTS data rather than the LTC data. The CMPTS data were additionally useful for matching CMP amounts with the specific scope and severity levels that were used to determine those amounts.

Although payment information may be collected in LTC, the process is such that regional staff must independently look up collections through CMPTS and enter that information into LTC. Payments are received at the CMS central office in Baltimore, MD, and payment information is entered there. Many CMS regional staff advised us that they do not consistently follow up with this information, or that they keep this information in a separate spreadsheet.

¹ 'New regulations' refers to 42 CFR Chapter IV, Subpart F: Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

LTC/CMPTS Match

The CMPTS data were matched to the LTC data using a “CMP Collection Number” that was present (in parts or whole) in both databases. Cases that did not match initially were examined, CMP Collection Numbers were added, wherever necessary, and cases were combined when information indicated that it was necessary. For example, in many cases the CMP information for a single cycle was split across several cases in CMPTS; and it was necessary to combine them to one case and delete the duplicate information. Following the cleaning procedure, the databases were merged and slightly over a 99 percent match rate was achieved. Only 9 cases in LTC did not match the CMPTS, and 18 cases were found only in the CMPTS database. Additional data cleaning was necessary to incorporate information typed in note fields and to address incorrectly entered data.

Data Cleaning

Data for 8,662 cases were in the original LTC file received for the years 2000 and 2001 and 8,309 cases remained after the cleaning procedure, of which 51 percent had CMPs imposed.

Cleaning actions were based on information obtained from various sources. Staff at all 10 regional offices were interviewed to gather information about the use of the LTC at the regional level. Information obtained included the data entry processes and the extent of use of the various screens and data fields within each region. As analyses were performed, outliers and questionable values were examined on an individual case basis. Information used to verify the validity of data included alternative fields in both databases and the notes written in the LTC file.

Scope of the Data

Regional office interviews resulted in the omission of all data from one region. Staff from region II reported that there were database implementation difficulties. Exploration of data from this region indicated that there were excessive missing data and obvious data entry errors, raising concerns about reliability and validity. For these reasons, data from region II were omitted from all analyses (253 cases).

Analyses included only data from cycles in which the first visit was conducted in the years 2000 and 2001. We based our decision to use those years on two factors: (1) not all regions were consistently entering information in the LTC prior to 2000 and (2) data from 2002 were not yet complete, since many cycles were still in progress.

Additional Data Cleaning Actions

Listed below are the additional actions that were taken to clean the data.

Some cases were not included in all files. The data were structured in multiple relational databases. Some cases were deleted in the primary database, but were not deleted across all files. Seventy-seven cases were deleted for this reason.

Nonenforcement cases were deleted. Eighteen cases were referred or entered inappropriately and did not require enforcement actions. These cases were deleted because they were outside the scope of this study.

Duplicate cases were corrected and deleted. Five cases that were duplicated in the LTC during the database implementation process were deleted. There were also 34 duplicate records in the CMPTS, for which the total due and paid for a single cycle had been dispersed across several records. These amounts were combined into a single record, and the duplicates were deleted.

Cases in which the CMP status was designated incorrectly were corrected. There were 241 cases for which the CMP was rescinded after an Informal Dispute Resolution reduced the scope and severity of the deficiencies. In addition, 53 cases were marked as CMP cases in error. For another 126 cases, the CMP was never imposed because the nursing home came into compliance quickly, paperwork was too late, the nursing home was having financial difficulty, the CMP was past the statutory limit of two survey cycles, or the CMP was rescinded. These cases had originally been marked in the LTC as CMP cases and were recoded to indicate that they were not. Associated information was deleted from the CMPTS so that monetary totals would not be inappropriately included in analyses, because technically there was never an amount due. The CMP indicator variable was recoded for three cases where CMPs had been imposed, and they were not coded as CMP cases.

Missing and incorrect dates were added or corrected. Many of the dates necessary for analysis were available from more than one source. When analyses indicated the date was not correct, alternative data sources were reviewed. Date corrections were made for 81 cases.

Dollar amounts were corrected. Corrections were made to the amount imposed for 41 cases in the LTC, for which the amount was missing or entered in error. Information regarding the amount of the CMP due

and collected was available from both the LTC and CMPTS.

Mismatches between the amounts due and paid often indicated that data were entered into the wrong CMPTS fields. One-hundred thirty corrections were made using information contained in the LTC.

The amount due was deleted in 12 cases because the CMPs had been excused for bankruptcy or as the result of an appeal. Corrections were made for 77 appealed cases that had been settled or dismissed, and the final amount due had not been entered. Payment information entered in error was corrected for 82 cases.

Notes and other sources of information indicated that a variable was miscoded. Information from alternative sources facilitated 1,106 corrections for miscoded or missing information. These corrections included denoting bankruptcy cases, recoding the CMP payment status, correcting remedies imposed and effectuated, inserting CMP collection numbers, denoting immediate jeopardy cases, and adding hearing outcomes. This was possible because multiple indicators were present. For example, cases with a scope and severity rating of J, K, or L but having no designation as an immediate jeopardy case were revised to appropriately designate the case as immediate jeopardy.

Questionable dates were deleted from time analysis. Questionable dates were found to be problematic in time-related analysis. They skewed the distribution so that the average time to collect CMPs appeared to be inflated. Also, they did not appear to be legitimate for one reason or another. For these reasons, observations with values beyond three standard deviations from the mean were omitted from individual analysis.

Terminology

For the purposes of this study, we used the following terms and definitions:

Actual Harm—Actual harm is typically used to describe deficiencies with scope and severity ratings of G, H, and I. For the purposes of this report, the term actual harm refers to deficiency findings of (1) actual harm that is not immediate jeopardy and (2) a widespread potential for more than minimal harm. This term is used to represent all deficiencies that qualify for Category 2 remedies. Scope and severity ratings of F, G, H, and I are included.

Case—A case includes all the enforcement activity that happens with respect to a particular nursing home during a single period of noncompliance. Enforcement staff refer to this as a cycle. A nursing home may have more than one case in our analysis and a case may have more than one CMP.

Double G Rule—Cases in which nursing homes were cited for deficiencies of a level of G or higher on the scope and severity scale on the current survey and also the previous standard survey or any intervening survey require “immediate” action by CMS.

Due—Refers to cases for which the final amount of the CMP has been decided (hearing waiver received, settlement reached, or the date to waive a hearing or file an appeal has passed) and the date for which the CMP is listed as due and payable in the CMPTS. If this information is not available in the CMPTS, an alternative date is used that equates to 15 days after the date of the last regional office letter to the nursing home stating that the CMP is due.

Immediate Jeopardy—Deficiency findings that constitute an actual or potential for death or serious injury. This term is used to represent all deficiencies that qualify for Category 3 remedies. Scope and severity ratings of J, K, and L are included.

Nursing Home—A Medicare or Medicare/Medicaid dually certified skilled nursing facility. A nursing home may also be referred to as a facility.

Opportunity to Correct—A period of time (usually 60 days or less) afforded to noncompliant nursing homes during which they can return to compliance without the involvement of the CMS regional offices.

Facilities with immediate jeopardy deficiencies or a historical pattern of noncompliance are denied this “opportunity.”

Paid, Unpaid—Is limited to payments entered into the CMPTS prior to December 16, 2002. This represents a functional limitation of our data collection period.

Plan of Correction—A formal statement by the nursing home informing the State and CMS of actions that will be taken to address deficiencies identified through a survey.

Revisit—An abbreviated survey used to check the status of identified deficiencies.

Substantial Compliance—Compliance with Medicare regulations or deficiencies in the A, B, or C level.

Uncollectable—Uncollectable cases include those currently in an appeals process or bankruptcy status.

▶ A P P E N D I X ~ D

Agency Comments to Draft Report



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

NOV 26 2004
GENERAL
OFFICE OF INSPECTOR
GENERAL

DATE: NOV 26 2004

TO: Daniel R. Levinson
Acting Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator *MM*

SUBJECT: Office of Inspector General (OIG) Draft Report: *"Nursing Facility Enforcement: The Use of Civil Money Penalties."* (OEI-06-02-00720)

Thank you for the opportunity to review and comment on the above-referenced draft report. This report is informative and validates some of the Centers for Medicare & Medicaid Services' (CMS) findings regarding the assessment and collection of civil money penalties (CMPs). We have an existing action plan regarding CMPs that includes the recommendations in your report, but the report adds depth and very useful dimension to the issues. The report will advance our ability to make desired improvements.

There is one aspect of the report that warrants clarification. The report states that, "Although CMPs are used frequently...they are rarely paid as originally imposed Of the \$81.7 million that was imposed by CMS during the years 2000 and 2001, only \$46.3 million became due and eligible for CMS to collect by the end of 2002." The casual reader may interpret the above language as a criticism of either CMS or the system. If OIG intends to be critical of the regulation and how the system is designed, we suggest this be made explicit. If such criticism is not intended, we suggest the report separate out from all other issues the 35 percent reduction in penalty a provider may receive for waiving the right to appeal. This regulatory provision accounts for the largest share (\$22.7 million) of the "uncollected" CMPs.

A more appropriate starting point for analyzing the CMP collection process would be to start with the \$59 million that remains after accounting for the 35 percent discount. (See attached chart with breakouts of the \$59 million.) Of this amount, \$12.7 million was not yet due (appeals and bankruptcy in progress), \$2.9 million was uncollectable after completing the bankruptcy process, \$5.3 million was late, with \$0.2 million representing other factors. A total of \$37.9 million was paid. Therefore, of the remaining \$59 million, only a small portion of the amount due, \$5.5 million, had not been collected.

With regard to the 35 percent reduction in penalty, we believe the regulatory provision is working as intended. It avoids considerable expense and delay in collecting CMPs. The wisdom of such a design feature is substantiated by the data collected by OIG – the second largest category of uncollected CMPs consists of collections held in abeyance while appeals are in process. Without the 35 percent discount provision, the amount held up awaiting a lengthy appeal process would be even larger.

Page 2 – Daniel R. Levinson

Thank you for applying the resources of OIG to this important issue. We look forward to working with OIG on this and other issues pertinent to CMPs. Our responses to the recommendations follow. Our technical comments are also attached for your consideration.

OIG Recommendation

The CMS should provide written guidance to CMS staff and states regarding appropriate dollar ranges for individual ratings of scope and severity.

CMS Response

We concur. This issue was discussed recently at the annual Leadership Summit, a conference where states and CMS came together to work on a myriad of program issues. A national grid will be developed by a state and CMS workgroup to promote consistency nationally in the imposition of CMPs.

OIG Recommendation

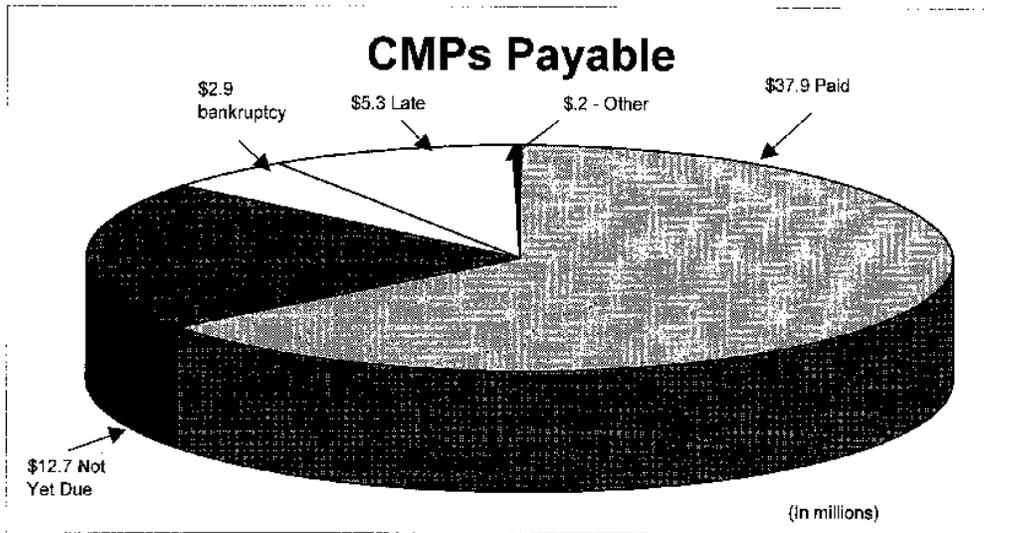
The CMS should provide written guidance to CMS staff to clarify responsibilities with respect to past due CMPs and conduct an internal process review that would enable CMS and states to streamline CMP processing.

CMS Response

We concur and had already chartered a CMP Quality Improvement Project in March 2004, based on our own recognition that these areas needed improvement. The team includes members of our regional offices, Office of Financial Management, Center for Medicaid and State Operations' Division of National Systems, and Survey and Certification staff. We will issue appropriate policy guidance once we have had an opportunity to map out the process and generate usable solutions.

Attachments

Attachment: Chart Depicting Breakout of CMPs Payable



Total Imposed	\$81.7
Reductions in Amount Due	\$22.7 (27% of imposed)
Difference	\$59.0
Difference of \$59 is attributed to:	
Amount Paid	\$37.9 (64% of amount payable)
Not Yet Due	\$12.7
Bankruptcy (Not Collectable)	\$ 2.9
Late	\$ 5.3
Other	\$.2



A C K N O W L E D G M E N T S

This report was prepared under the direction of Judith V. Tyler, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Kevin Golladay, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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