Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING HOME ENFORCEMENT: COLLECTION OF CIVIL MONEY PENALTIES

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Inspector General

July 2005
OEI-06-03-00420

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) collected civil money penalties (CMPs) and took required collection actions for nursing home enforcement cases initiated in calendar year (CY) 2002.

BACKGROUND

CMPs are fines that CMS can impose on Medicare- and Medicaid-certified nursing facilities that are found to be noncompliant with Federal safety and quality of care standards. CMS is charged with ensuring that facilities pay their fines and is required by Federal law, regulations, and policies to take specified collection actions. Delays in collections, or lack of collections, have the potential to undermine the CMPs' intended effect of ensuring that facilities promptly return to compliance.

Required collection actions include providing facilities with complete notification that the CMP is due, assessing interest on unpaid balances, referring past-due CMPs to fiscal intermediaries and State Medicaid agencies to be offset from funds owed to facilities, and transferring debt over 180 days past due to the Department of the Treasury.

We examined case information obtained from CMS to determine whether each of the CMPs initiated in CY 2002 were collected in full, partially collected, or remained uncollected as of March 2004. We also assessed timeliness of collections. Through analysis of documentary evidence we determined the extent to which CMS took all required actions to collect the 228 CMPs that became past due by more than 30 days. Information obtained from interviews with CMS staff in the central office and each of the 10 regional offices provided additional information about collection procedures.

FINDINGS

As of March 2004, CMS did not fully collect 4 percent of the CMPs imposed in CY 2002 and collected another 8 percent well after the due dates. We found that 12 percent (228 out of 1,938) of collectable CMPs initiated in CY 2002 became past due by more than 30 days. CMS had not fully collected 79 CMPs (4 percent of the total) by March 2004, the end of our study period. Further, the collection that did occur (149 collected cases) was often very late, with an average collection time of 115 days past the due date.

Forty-four CMPs had no collections during this time period. Of these CMPs, 31 were for facilities that were found to be out of compliance in an inspection following the one that resulted in the imposition of the CMP.

CMS did not take all required actions to collect 94 percent of past-due CMPs, but took some actions beyond those required that improved collection results. For 40 percent of past-due CMPs, CMS failed to provide complete notification with all required information, including when the CMPs were due. CMS did not assess interest on 72 percent of the past-due CMPs as required and did not refer 71 percent of past-due CMPs to fiscal intermediaries and State Medicaid agencies to initiate collection through offsetting of funds owed to the facilities. Finally, CMS did not transfer any of the 95 CMPs that became over 180 days past due to the Department of the Treasury as required. However, we found that CMS sometimes took additional collection actions that are not required, such as sending past-due letters or making telephone calls to facility administrators. About half of the facilities contacted submitted payments to CMS within a month following such contact.

Responsibilities for CMP collections are neither clearly defined nor commonly agreed upon. CMS central office staff view CMP collections as primarily a regional office responsibility. While some regional office staffs agree that their offices are primarily responsible for collecting CMPs, others expressed the belief that collection efforts are the responsibility of the central office.

Databases used for tracking CMP collections contained inaccurate and incomplete information, causing collection errors and frustrating staff. In some cases, inaccurate information in CMS databases used for tracking CMP payments made them erroneously appear to be past due. CMS regional office staff reported that such data inaccuracies create a disincentive for them to attempt to collect past-due CMPs because they do not want to request payment for a CMP that is not collectable or has been paid. In part, CMP data errors are attributable to CMS's using three different databases to process CMPs. These databases do not interface with each other and lack an effective means for staff to identify data errors. Lack of feedback to CMS about offsets by State Medicaid agencies also results in incomplete data.

RECOMMENDATIONS

To ensure that all CMPs are fully collected as timely as possible, we recommend that CMS:

Provide oversight to ensure that all required actions for collecting CMPs are taken. Specifically, CMS should ensure that collection staff provide facilities with complete notice when CMPs are due, assess interest on all past-due CMPs, routinely refer past-due CMPs to fiscal intermediaries and State Medicaid agencies to initiate collection through offsets from funds owed to the facilities, and routinely transfer CMPs over 180 days past due to the Department of the Treasury.

Educate staff with written guidelines to clarify responsibilities for, and priority of, CMP collections. CMS should issue a new set of guidelines with more clearly delineated responsibilities and increased emphasis on the importance of collections to provide staff with needed clarity about expectations for various actions.

Ensure the accuracy of information contained in databases used for tracking CMP collections while making them easier to use. A review of CMP cases from CY 2002 revealed multiple instances of inaccurate data, which reportedly create a disincentive for staff to engage in required collection actions because they do not want to attempt to collect an incorrect amount or to collect CMPs that are not due or have already been paid.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has recently or will soon implement all of the OIG recommendations.

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INTRODUCTION

OBJECTIVE

To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) collected civil money penalties (CMPs) and took required collection actions for nursing home enforcement cases initiated in CY 2002.

BACKGROUND

The Social Security Act requires States to use a survey and certification process to verify that skilled nursing facilities and nursing facilities certified to participate in the Medicare and Medicaid programs maintain Federal standards regarding quality of care, safety, and patient rights.[1] Whenever State survey agencies determine that facilities are out of compliance with one or more of these standards, CMS may initiate enforcement remedies. The stated purpose of such enforcement remedies is "to ensure prompt compliance with program requirements."[2]

One enforcement remedy that CMS may use to address noncompliance found during nursing facility surveys is the CMP. A CMP fine will vary, depending on the nature of the noncompliance, and may range from $50 to $10,000 per day until the facility is found to have returned to compliance or from $1,000 to $10,000 per instance of noncompliance. CMS has discretion to impose CMPs on facilities in a wide range of noncompliance situations. These include less serious situations, such as when surveyors find the potential for minimal harm to residents; instances when actual harm has occurred; and the most severe situations when noncompliance has already led, or could lead, to "serious injury, harm, impairment or death to a resident."[3]

In a recent study, the Office of Inspector General (OIG) found that, in CYs 2000 and 2001, CMS imposed CMPs in 51 percent of enforcement cases, with 85 percent of those cases involving citations for noncompliance at the level of actual harm or immediate jeopardy to residents' health or safety.[4] However, by December 2002, CMS had not fully collected from the facilities 14 percent of the CMPs that were considered collectable.[5]

CMPs are the discretionary remedy CMS uses most frequently.[6] Delays in collections, or lack of collections, could potentially undermine CMPs' intended effect of ensuring that facilities promptly return to compliance. This inspection of the CMP collections process is part of OIG's ongoing evaluation of the quality of care provided to nursing facility residents, particularly as measured by survey deficiencies and by how States and

CMS manage the enforcement process. This report builds on prior OIG work by thoroughly examining CMS's performance in and processes for collecting CMPs.

CMP Due Date

When CMS notifies a nursing facility that a CMP is being imposed, the nursing facility has 60 days to either file a request for an appeal or waive its right to an appeal.[7, 8] The CMP becomes due 15 days after: (1) the 60 days has expired, (2) CMS receives an appeal waiver, (3) an appeal decision is made, or (4) the facility is terminated from the program and no appeal request is received. The Social Security Act requires that CMS "minimize the time between the identification of violations and final imposition of the remedies;" thus, time between imposition and collection of the CMP should be as short as possible.[9]

Required CMP Collection Actions

CMS is required by Federal laws, regulation, and/or policy to take the following collection actions for CMPs:

- Providing notification—Regulations require that CMS provide written notification to the facility that the CMP is due, including in that notification the amount of the CMP imposed, the amount due, the due date, the rate of interest to be charged on unpaid balances, and, for per-day penalties, the days during which the CMP accrued.[10]
- Assessing interest—Regulations require that CMS assess interest on any unpaid balances beginning on the CMP due date and that CMS use a rate of interest that is determined by the Secretary of the Treasury.[11]
- Initiating offsets—CMS policy requires that "if a check is not received by the due date of the CMP, the [CMS regional office] initiates action to collect the CMP through offset of monies owed or owing to the nursing home."[12] To initiate such an offset, CMS staff must instruct the appropriate fiscal intermediaries and State Medicaid agencies to deduct unpaid CMP balances from money owed to the facility.[13]
- Transferring debt—The Debt Collection Improvement Act of 1996 requires all debt owed to any Federal agency that is more than 180 days delinquent to be transferred to the Department of the Treasury for debt collection services.[14]

In a 1999 program memorandum, CMS outlined its procedures for conducting the first three of these procedures. Although this memorandum has an expiration date of May 1, 2000, CMS staff indicated that they still

consider it in effect and that it contains the most current policies and procedures related to the collection of CMPs by CMS.

OIG and GAO Reports Regarding CMP Collections

The OIG report, "Nursing Facility Enforcement: The Use of Civil Money Penalties" (2004), found that CMS had not fully collected 14 percent of the CMPs imposed in CYs 2000 and 2001.[15] These unpaid CMPs involved nearly 550 cases and totaled $11.7 million for that 2-year period. Further, the report revealed that CMS did not routinely refer past-due CMPs for offset by fiscal intermediaries and State Medicaid agencies.

In its report, "Civil Fines and Penalties Debt: Review of CMS' Management and Collection Processes" (2001), the Government Accountability Office (GAO) found that CMS did not transfer CMP debt to the Department of the Treasury for collection as required.[16] In response to GAO's recommendation to implement procedures for meeting this requirement, CMS stated that it planned to begin referring all eligible debt, including CMPs, to the Department of the Treasury in fiscal year 2002.

METHODOLOGY

Scope

This inspection focused on the 228 nursing facility enforcement cases in which (1) a CMP was imposed as a result of actions initiated during calendar year 2002 and (2) the CMP was collectable and more than 30 days past due as of March 31, 2004.

Methods

The databases utilized in the course of this inspection included CMS's Long Term Care Enforcement Tracking System (LTC), Civil Money Penalty Tracking System (CMPTS), and Online Survey, Certification and Reporting System (OSCAR). We also obtained case documentation from CMS for all 228 enforcement cases with past-due CMPs and interviewed staff at CMS central and regional offices about collection practices. (See Appendix A for a detailed description of the inspection methodology.)

To determine the extent to which CMS collected past-due CMPs, we examined data in CMPTS and reviewed case documentation obtained from CMS. Specifically, we determined whether each CMP had been collected in full, partially collected, or remained uncollected as of March 2004. We also examined timeliness of collections.

To determine the extent to which CMS took required collections actions, we examined case documentation of actions taken for the collection of each of the 228 past-due CMPs. We also analyzed interview responses regarding

CMS processes, procedures, and automated systems used to collect past-due CMPs.

Quality Standards

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

As of March 2004, CMS did not fully collect 4 percent of the CMPs imposed in 2002 and collected another 8 percent well after the due date

Similar to OIG findings regarding CMPs imposed in 2000 and 2001, we found that 12 percent (228 out of 1,938) of collectable CMPs initiated in calendar year 2002 became past due by more than 30 days. This 12 percent is composed of 4 percent of CMPs that were not fully collected by the end of our study period in March 2004, and 8 percent that were fully collected well past their due dates.

CMS did not fully collect 79 past-due CMPs (4 percent of the total).

By March 2004, over a year after the last of the 228 CMPs had been initiated, 79 (4 percent of the collectable CMPs) had not been fully collected. (See Table 1.) Thirty-five of these CMPs had only part of their fines collected, and 44 CMPs had no money collected. The total uncollected amount for these CMPs was $1.2 million.

Table 1: CMPs More Than 30 Days Past Due

Collection Status (March 2004)	Past Due CMPs		Amount Due** *(millions)*	Amount Uncollected** *(millions)*
	CMPs	Percent*		
Not Fully Collected	79	4%	$1.5	$1.2
Partially Collected	*35*	*2%*	*$0.7*	*$0.4*
Nothing Collected	*44*	*2%*	*$0.8*	*$0.8*
Fully Collected Very Late	149	8%	$1.6	$0.0
Total Past Due	228	12%	$3.1	$1.2

Source: OIG Analysis of 1,938 collectable CMP cases initiated in 2002
*Percentage of the total 1,938 collectable CMPs.
**The amounts due and uncollected do not include interest.

Among the 149 past-due CMPs that CMS eventually collected (8 percent of the total), the average collection time was 115 days.

Once a due date for a CMP is initiated, facilities have 60 days in which they must accept the fine (waive their appeal rights), informally dispute the case, or file a formal appeal. However, once these processes are completed or the 60 days have expired, a firm due date for the CMP is established. For the 149 CMPs CMS collected that were more than 30 days past due, the average collection time was 115 days.[17] Seventeen percent of the 149 collected CMPs were collected more than 6 months late, with the longest case taking 580 days to collect.

Facilities were out of compliance on a subsequent inspection in 36 of the 44 uncollected CMPs.

CMPs are imposed primarily on nursing facilities cited for serious deficiencies and are part of an enforcement process designed to encourage prompt compliance with Federal standards. If collection is not timely, the intended effect of ensuring that facilities promptly return to and remain in compliance may be undermined. We found that as of March 2004, the facilities associated with 36 of the 44 uncollected CMPs were out of compliance during an inspection following the enforcement cycle when the unpaid CMP was imposed.[18] Nineteen of the deficiencies were of a scope and severity level of G (actual harm that is not immediate jeopardy) or higher, and 18 of the subsequent cases were referred to CMS for further enforcement. For example, one facility was cited for noncompliance two more times in calendar years 2002 and 2003 and had two more CMPs imposed as a result, while the first CMP remained uncollected. One of the subsequent CMPs resulted from an incident in which a resident had to be hospitalized for pressure ulcers (bed sores) so severe that surgery was required. At the time of our data collection, only partial collection had occurred on the second CMP, while the first and third remained entirely uncollected.

CMS did not take all required actions to collect 94 percent of past-due CMPs, but did take some actions beyond those required that improved collection results

Federal requirements specify certain actions that CMS is required to take to ensure that CMPs are collected from noncompliant facilities: providing facilities with complete notification that the CMP is due, assessing interest on unpaid balances, offsetting CMPs from funds owed to facilities, and transferring delinquent debt to the Department of the Treasury. We found that CMS took all actions that were required for only 6 percent of past due CMPs, with the remaining 94 percent missing at least one required action. (See Table 2.)

The first of these actions, complete notification that the CMP is due, is required for all CMPs unless there is a settlement agreement containing the necessary information. CMS need take the remaining actions only if facilities do not pay by the due date. The second action, assessment of interest, serves as an incentive for facilities to promptly remit payment. The last two actions, offsets and referrals to the Department of the Treasury, recognize that some facilities may not promptly pay their fines and that the Government must collect payment through other means.

Table 2: CMS Did Not Take All Required Actions

Required Action	Applicable CMPs*	Past-Due CMPs With Required Action Not Taken	
		CMPs	Percent
Complete Notice	221	88	40%
Interest Assessment	228	164	72%
Referral for Offset	228	162	71%
Transfer to Treasury*	95	95	100%
Total (All Applicable Actions)	228	215**	94%

Source: OIG analysis of 228 CMPs initiated in 2002 and past due by more than 30 days
*Not required for cases with settlement agreements; transfer to Treasury only required for cases that were unpaid after 180 days.
**This figure is not intended to represent the sum of the individual actions listed above.

CMS did not send complete notification of their fines to 40 percent of facilities with past-due CMPs.

Case documentation showed that CMS did not provide any written notice to 4 percent (10 out of the 228 past-due CMPs) of the facilities with CMPs that became past due by more than 30 days. In the remaining cases, we examined the notices to determine whether they contained required information, including the amount of the CMP; the amount due; the due date; the rate of interest to be charged on unpaid balances; and, for per-day penalties, the dates the CMP accrued. Thirteen percent of notices did not include a due date for the CMP and one notice omitted the amount that was due, both of which are critical pieces of information facilities need to remit payment on time. The most commonly omitted information, the interest rate to be charged on any unpaid balances, was missing from 23 percent of notices.

CMS did not assess interest in 72 percent of past-due CMPs as required.

Regulations require the assessment of interest on unpaid balances after the due date.[19] CMS assessed interest on only 28 percent of past-due CMPs and actually collected it for only 21 percent.

CMS did not refer 71 percent of past-due CMPs to fiscal intermediaries and State Medicaid agencies to initiate offsets.

Regulations permit CMS to collect CMPs via a deduction from monies owed to the facilities, called offsets, and CMS has instructed the regional offices to do so if a check is not received by the due date.[20,21] We found that CMS only initiated offsets for 29 percent of past-due CMPs. Further, many of these referrals occurred well after the CMPs were due—an average of 83

days after the due date for referrals to fiscal intermediaries and 88 days after the due date for referrals to State Medicaid agencies.

CMS did not transfer any CMPs that were over 180 days past due to the Department of the Treasury, as required.

CMS documented that, following issuance of GAO's report in 2001, it transferred 10 CMPs imposed between 1996 and 1998 to the Department of the Treasury. We found no evidence that any further CMP debt has been transferred, including the 95 eligible CMPs that were initiated in 2002.

CMS sometimes uses past-due letters or telephone calls to improve collection results.

CMS mailed past-due letters to 27 percent of facilities with CMPs that were not paid more than 30 days after their due dates and received payment from 48 percent (30 out of 62) of these facilities within a month of the letter, avoiding the need for further collection efforts. Similarly, CMS staff reported making direct telephone calls to facility administrators in 18 percent of past-due cases and received payment within a month from 50 percent (21 out of 42) of these facilities.

Responsibilities for CMP collections are neither clearly defined nor commonly agreed upon

Interviews with CMS staff in central and regional offices suggest that there is uncertainty about responsibilities for collection of CMPs. CMS central office staff viewed CMP collections as primarily a regional office responsibility, citing written guidance in a 1999 Program Memorandum (since expired) describing which CMS staffs were responsible for various aspects of CMP collections. Regional office staff perceptions varied. Staff in one regional office expressed the view that all collection efforts, from receiving payments to following up on late cases, are the responsibility of the central office. Other regional staff felt they were primarily responsible for collecting CMPs, but argued that regional offices should not act as "collection agencies" and suggested that collection efforts should be either fully centralized or should become a contracted function.

The failure to complete required collection activities described earlier is partially attributable to the lack of clarity of responsibilities and procedures. For example, interviews with CMS staff suggested that there are problems that may contribute to interest not being assessed as it should. Some regional office staff reported that the rules for calculating and applying interest are not well defined, and others expressed confusion

about who within CMS is responsible for assessing interest. Even when a rate is known, staff indicated that calculating the interest can be difficult.

Another example of lack of clarity involves transferring cases to the Department of the Treasury for collections. Regional offices were unaware that it is required and some did not even know that this is an option.

Databases used for tracking CMP collections contained inaccurate and incomplete information, causing collection errors and frustrating staff

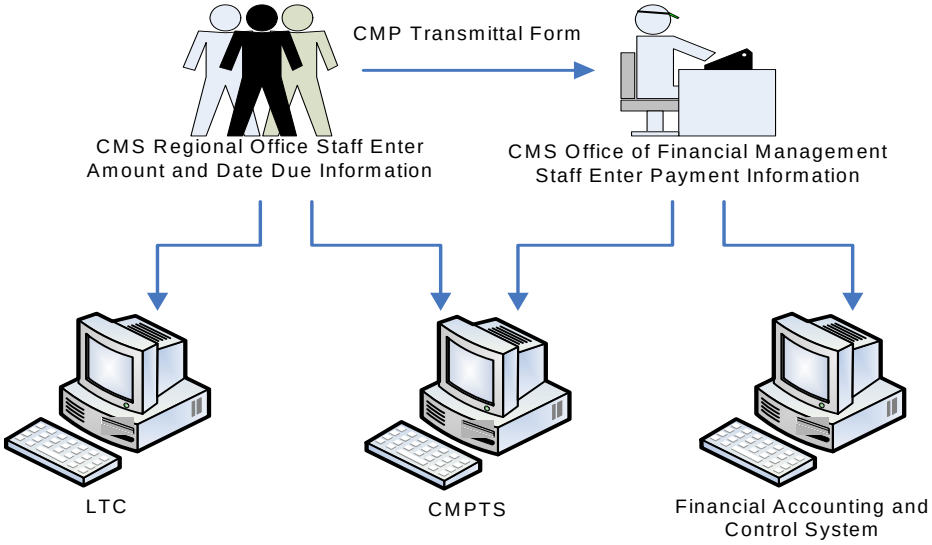
Based on a comparison of data contained in CMS's CMPTS to documents obtained from CMS's regional offices, we determined that 32 percent (109 out of 337) of CMPs that appeared to be past due by more than 30 days were identified incorrectly as the result of inaccurate data. Adjustments resulting from these errors produced the 228 past-due CMPs we focused on in our inspection. (See Table A2 in Appendix A.) Specifically, 65 of the 109 incorrectly identified CMPs showed past-due balances that had already been paid in full or were not due for other reasons. Another 41 of the 109 CMPs were missing information to indicate that the case was on hold for an appeal, bankruptcy, or criminal investigation by the Department of Justice. Finally, three CMPs had been rescinded, yet the database still listed the CMPs as owed and delinquent. In addition to inaccuracies that made CMPs erroneously appear past due, we found other data errors such as incorrect CMP due dates and amounts.[22]

CMS regional office staff reported that data inaccuracies create a disincentive for them to pursue collection of past-due CMPs. Staff reported that inaccurate data make it difficult to determine which CMPs need collection efforts and that they do not want to request payment for a CMP that is not due. One region reported having sent letters to facilities requesting payment for past-due CMPs only to find that some payments had been remitted on time but not recorded in CMPTS. Regional staff also reported that, rather than being able to examine multiple past-due cases at once, they must review CMP cases individually in the CMPTS, making collection activities time consuming. If errors lead to facilities making payments for the wrong amount, staff reported that extra steps must then be taken to refund any overpayment or to collect the remainder of the CMP.

Shortcomings in the database systems increase the potential for data errors and missing information.

In part, CMP data errors and staff frustration are attributable to how the information is accumulated and entered into the three distinct databases that CMS uses for processing CMPs. (See Figure 1.) Because these three systems do not interface, information for the same CMP must be entered into them separately. Entering data multiple times increases the opportunities for data-entry errors, missing data, and inconsistent updates across systems.

Figure 1: CMS Database Information Entry Process



Source: OIG analysis of databases and interviews with CMS staff, 2004

To help identify and correct inaccurate information, CMS's Office of Financial Management generates and distributes a monthly report of all CMPs listed in CMPTS as uncollected. In theory, regional staff could use this report to validate information in paper files and the LTC database. While some regional staff reported that they use the report each month, others reported they were unaware of its existence and still others indicated that it is not useful, difficult to read, and often not current.

State Medicaid agencies do not always notify CMS of collections through offsets, resulting in incomplete collections data.

Another source of data inaccuracies involves offsets. CMS referred 66 CMPs to State Medicaid agencies for offset. For 29 of those, State Medicaid

agencies either failed to collect the Medicaid portions or failed to notify CMS that they had collected them.

CMS staff report that they do not always know when State Medicaid agencies actually offset the funds; therefore, this information is sometimes not entered into CMPTS. Collections made by the State Medicaid agency are retained by the State. If State Medicaid agencies do not send CMS a notice of the collection, the Medicaid portion of the CMP appears to be uncollected in the CMPTS. CMS staffs report that States are inconsistent in sending such notices.

Based on prior and current OIG studies, it is clear that nursing facilities pay the majority of CMPs when they are due, meaning that CMS does not need to take additional steps to collect most fines. However, our analysis demonstrates that when extra collection efforts are called for, CMS is not fully successful and often does not take required actions. Of the 228 CMPs initiated in 2002 that became more than 30 days past due, 79 were not fully collected by March 2004, the end of our study period. Further, when collection occurred in cases that became more than 30 days past due, it was often very late, with an average collection time of 115 days past the due date.

Several factors within CMS's control affect timeliness of CMP collections. For example, CMS did not take all required collection actions for 94 percent of the past-due CMPs. Further, lack of clear roles and responsibilities and problems with automated systems create disincentives for CMS staff to follow up on past-due cases.

Timely collection of all CMPs is important for ensuring that nursing facilities return to and remain in compliance with Federal standards of patient care. To ensure that all CMPs are fully collected as timely as possible, we recommend the following to CMS:

Provide Oversight to Ensure That All Required Actions for Collecting CMPs Are Taken.

Specifically, CMS should ensure that staff:

Provide a complete notice to all facilities upon which CMPs are imposed Not sending notification, or not including information such as the due date or the amount due, can make it difficult for facilities to make payments accurately and timely. Development of a standardized notice for use by CMS staff could help eliminate some errors.

Assess interest on all past-due CMPs Clarifying the circumstances under which headquarters or regional office staffs are responsible for assessing interest would be helpful, as would having the appropriate interest rates easily accessible by regional office staff. An electronic tool that calculates payments and interest on installment plans may be useful.

Routinely refer past-due CMPs to fiscal intermediaries and State Medicaid agencies for collection using offsets from funds owed to the facilities Setting a specific point in time after the due date for initiation of offsets could assist in making collection of past-due CMPs by offset more routine.

Transfer CMPs over 180 days past due to the Department of the Treasury as required

Provide Staff With Written Guidelines to Clarify Responsibilities For and Priority of CMP Collections.

Although CMS outlined CMP collections procedures in 1999, they have expired. A new communication, with more clearly delineated responsibilities and increased emphasis on the importance of collections, would provide staff with needed clarity about expectations for various actions. Guidelines could be most useful if they included timelines for actions such as assessing and collecting interest, referring cases for offset, and transferring debt to the Department of the Treasury. New guidelines should also articulate the importance of CMP collections for ensuring that nursing facilities meet standards of care for Medicare and Medicaid beneficiaries.

Ensure the Accuracy of Information Contained in Databases Used for Tracking CMP Collections and Make Them Easier to Use.

A review of CMP cases from 2002 revealed multiple instances in which inaccurate data made CMPs appear to be past due—and thus in need of collection actions—when in fact no collection was needed. These inaccuracies included incomplete data, unrecorded payments, inconsistent information between databases, and incorrect due dates and dollar amounts. Some likely causes of these data errors are multiple data entry points and separate databases that are unable to communicate or update information. Reports that could be used to detect errors are often not used by CMS staff.

Data inaccuracies reportedly create a disincentive for staff to engage in necessary and required collection actions because they do not want to attempt collection of incorrect amounts or CMPs that are not due or have already been paid. Several options for improvements include:

Reducing, where possible, the number of multiple data entry points for the same information and increasing the interfaces between databases Dual data entry at both the regional offices and central office increases the effort expended and creates more opportunity for errors.

Reducing data entry errors Data entry errors could also be reduced by building logic safeguards into various fields in the database. For example, date fields could be programmed to reject an impossible date.

Routine reconciliation between CMP collection data sources Routine use of monthly reports regarding uncollected CMPs could help identify data inaccuracies and place increased emphasis on collections.

Providing regional office staffs with an easier method for tracking payments Providing regional offices with the ability to print reports directly from CMPTS, rather than requiring them to look up each CMP individually, could make it easier for staff to take required collection actions and eliminate a source of frustration.

Developing reliable and consistent feedback methods with State Medicaid agencies to better track offsets

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OIG separately furnished CMS with information regarding the CMPs reviewed so that CMS may take appropriate collection actions in these cases.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has recently or will soon implement all of the OIG recommendations and had initiated an internal quality improvement project in March 2004. The full text of CMS's comments is presented in Appendix B.

ENDNOTES

[1] Sections 1819(f)(1) and 1919(f)(1) of the Social Security Act, 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1).

[2] 42 C.F.R. § 488.402(a) (2003).

[3] 42 C.F.R. § 488.301 (2003).

[4] Department of Health & Human Services, Office of Inspector General, Draft Report, "Nursing Facility Enforcement: The Use of Civil Money Penalties," OEI-06-02-00720, March 2004.

[5] CMPs are not collectable when an appeal hearing is pending, a bankruptcy settlement is in process, the Department of Justice has requested that collection is held while a criminal investigation is being conducted, or the due date has been extended by an agreement with CMS (e.g., the facility is paying in installments).

[6] Department of Health and Human Services, Office of Inspector General, Draft Report, "Nursing Facility Enforcement: The Use of Civil Money Penalties," OEI-06-02-00720, March 2004.

[7] 42 C.F.R. § 498.40(a)(2) (2003).

[8] 42 C.F.R. § 488.436(a) (2003).

[9] Section 1819(h)(2)(B) of the Social Security Act.

[10] 42 C.F.R. § 488.440(d) (2003).

[11] 42 C.F.R. § 488.442(d) (2003).

[12] CMS Program Memorandum Regional Offices Standards and Certification, Transmittal No. 99-1, April 1999.

[13] 42 C.F.R. § 488.442(c) (2003).

[14] Debt Collection Improvement Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321 (1996).

[15] Department of Health and Human Services, Office of Inspector General, Draft Report, "Nursing Facility Enforcement: The Use of Civil Money Penalties," OEI-06-02-00720, March 2004.

[16] U.S. Government Accountability Office, "Civil Fines and Penalties Debt: Review of CMS' Management and Collection Processes," GAO-02-116, Appendix II, page 3(2), December 2001.

[17] The median time past due was 73 days.

[18] These facilities were out of compliance with deficiencies of a scope and severity of D (potential for more than minimal harm) or higher.

[19] 42 C.F.R. § 488.442(d) (2003).

[20] 42 C.F.R. § 488.442(c) (2003).

[21] CMS Program Memorandum Regional Offices Standards and Certification, Transmittal No. 99-1, April 1999.

[22] Data errors found were corrected prior to data analysis and do not affect any of the above findings.

DETAILED METHODOLOGY

Data Sources

Documentary Evidence

We requested case information and supporting documentation from the CMS regional offices for each of the cases we initially identified as more than 30 days past due. Information requested included whether additional payments had been made, whether CMS staff had taken the required actions, whether additional actions beyond those required had been taken, and difficulties experienced in trying to collect the CMP. We requested all collection information from the time the CMP became due through March 2004 (the end of our documentation data collection period). We also requested supporting documentation, including copies of all letters to facilities notifying them that the CMP was due. We received responses for 100 percent of the requested cases. Finally, we used a worksheet to capture data extracted from the regional office responses as supporting documentation.

Interviews

We conducted interviews with staff in CMS central and regional offices in September 2003. Interviews with staff at CMS regional offices provided information about the procedures used in each region and any difficulties encountered when collecting CMPs. CMS central office staff in the Office of Financial Management participated in interviews designed to capture the role of CMS's central office in the collection of CMPs and difficulties with tracking CMP payments. OFM staff also demonstrated the procedures for processing CMP payments, including use of the management information systems.

Databases

The CMS databases used for this study were LTC, CMPTS, and OSCAR.

LTC The LTC database is a compilation of each CMS region's nursing facility enforcement case files. Caseworkers update this information as enforcement actions occur. The database contains information about remedy imposition, including CMPs, as well as the dates of the surveys conducted during the enforcement cycle.

CMPTS The CMPTS is the centralized CMS database used for tracking the collection and allocation of CMP payments. There are two parts to this database: payments due and payments received. CMS regional office staff enter information into the CMP payments due part; CMS central office staff enters information about payments collected. This database

was the source of information about the CMP amount due, the due date, the amount paid, and the date of payment.

OSCAR We used CMS's nationwide database of nursing facility surveys, OSCAR, to explore the performance of the facilities with unpaid past-due CMPs. OSCAR maintains information on the four most recent standard surveys of certified nursing facilities nationwide, as well as complaint-generated surveys.

Initial Case Identification

Identification of Enforcement Cases With CMPs Imposed Using LTC, we identified 4,173 enforcement cases initiated in CY 2002. From that group, we identified 2,149 cases in which CMPs were imposed. These CMPs resulted from both standard and complaint surveys. We used the year 2002 because it was the most recent year in which we could expect the majority of CMPs to have become due. CMP due dates are often delayed by appeals. (See Table A1.)

Table A1: Initial CMP Collections Cases Selected

Use of CMPs	
CMS Enforcement Cases	4,173 cases
CMPs Imposed	2,149 cases
Collectability of CMPs	
Uncollectable	167 CMPs
Collectable	1,982 CMPs
Payment Status for Collectable CMPs	
Paid in Full on Time	928 CMPs
Paid 1 to 30 Days Late	717 CMPs
CMPs More Than 30 Days Late	337 CMPs

Source: OIG analysis of 4,173 nursing facility enforcement cases initiated in 2002

We matched the imposed CMPs we found in LTC to CMPs listed in CMPTS.[1] We used the due date from CMPTS to identify CMPs that became past due, and the amounts due and paid to determine whether the CMPs had been paid, partially paid, or remained unpaid.

[1] Some cleaning of the LTC and CMPTS data was necessary. We were able to match all 2,149 CMPs between the CMPTS and LTC databases using the CMP collection number (present in both databases). In LTC, cases in which a CMP was rescinded by an Informal Dispute Resolution or regional office decision were recoded, missing CMP collection numbers were added to match those in the CMPTS, and amounts and dates entered in error were corrected using data obtained from alternative sources. In CMPTS, cases in which the CMP had been rescinded were eliminated, duplicate files were deleted, and amounts due and paid and missing or incorrect dates were reconciled with LTC.

Identification of Collectable CMPs We used information from LTC to determine whether the CMPs imposed were collectable. One hundred sixty-seven CMPs were uncollectable because they were on hold while the facility appealed the CMP (115), the facility was undergoing bankruptcy proceedings (19), the CMP was being paid in installments and the final installment was not yet due (30), or the CMP had not yet reached the due date (3). This process yielded 1,982 collectable CMPs.

Determining Timeliness of Payment The LTC and CMPTS data showed that 53 percent (1,054) of the 1,982 collectable CMPs imposed in 2002 and due as of February 1, 2004, were paid at least 1 day late, partially paid, or not paid at all.[2] The 2004 OIG study found that, on average, CMPs were paid 32 days after the due date.[3] Thus, for this inspection, we chose to more thoroughly examine all 337 CMPs that were more than 30 days past due to capture the more extreme cases that were overdue by more days than average.

Data Collection

Using a structured data collection instrument, we sent data requests to the corresponding regional offices for each of the 337 CMPs identified as past due by more than 30 days. Each request included information on the CMP, such as the facility identifiers, the CMP collection number, the survey completion date, the CMP due date, the amount due, and any amounts paid. We asked whether any additional payments were made on the CMP. We also asked regional office staff to place a check next to each of the actions taken for each CMP case and to describe any additional actions that we had not listed. The actions listed were sending a letter of notification that the CMP was due, assessing interest, referring the case for offset by the fiscal intermediary and/or State Medicaid agency, transferring the case to the Department of the Treasury, sending additional letters or e-mails to the provider, making telephone calls to the provider, and other actions. We also asked staff to describe any difficulties their offices experienced in trying to collect the CMP and requested that they attach supporting documentation for each action taken. We received information for 100 percent of the CMP case requests.

[2] Before we requested data from the regional offices, we captured all CMPs past due as of February 1, 2004, because that was the date the data were downloaded and sent to us from CMS. We were later able to document payments through March 2004 from data received from regional offices.

[3] Department of Health and Human Services, Office of Inspector General, Draft Report, "Nursing Facility Enforcement: The Use of Civil Money Penalties," OEI-06-02-00720.

We also requested information and documentation from the CMS Office of Financial Management regarding all nursing facility CMPs transferred to the Department of the Treasury.[4]

Data Analysis

We performed data processing and analyses using SAS, Microsoft Access, and Microsoft Excel.

Qualitative Data We transcribed notes from all responses to CMS regional office and central office interviews. Analysts then reviewed the material from all of the interviews to identify similarities and differences among the responses of different offices and to gauge the impact of the information on CMP collections. In conjunction with the quantitative case data, this qualitative analysis of staff interviews is used throughout the report to further explain our findings.

Documentary Evidence We entered qualitative and quantitative information from the documents received from the regional offices into an Access database. We used information that was provided by regional office staff about CMP payments or dates to update information. We also added data extracted from the documentation about the presence and completeness of letters notifying the facility that the CMP was due, interest assessed, offsets, other collection efforts, and reported difficulties encountered by CMS staff.

Obtaining the Final Cases Analysis of data from the documentary evidence indicated that 109 of the 337 CMPs were inappropriately coded as past due because of data errors or incomplete information. Three CMPs had been rescinded, reducing the number of CMPs imposed from 2,149 to 2,146. Forty-one CMPs were on hold for appeals, bankruptcies, installments, or criminal investigation by the Department of Justice, increasing the number of uncollectable CMPs from 167 to 208. Sixty-five CMPs were misidentified as past due because of inaccurate information in the database, increasing the number paid in full on time from 928 to 993. Table A2 presents the final, corrected numbers of CMPs imposed and their collection status.

[4] Our interviews with CMS regional and central office staff indicated that, to date, any transfer of cases to the Department of the Treasury was done by the CMS Office of Financial Management.

Table A2: Final CMP Collections Cases	
Use of CMPs	
CMS Enforcement Cases	4,173 cases
CMPs Imposed	2,146 cases
Collectability of CMPs	
Uncollectable	208 CMPs
Collectable	1,938 CMPs
Payment Status for Collectable CMPs	
Paid in Full on Time	928 CMPs
Paid 1 to 30 Days Late	717 CMPs
CMPs More Than 30 Days Late	228 CMPs

Source: OIG analysis of 4,173 nursing facility enforcement cases initiated in 2002

Eventual Collection of CMPs We used information in CMPTS, supplemented by updated information from the documentary evidence, to determine the proportion of the 228 past-due CMPs that were fully, partially, or not at all collected by March 31, 2004, the end of our study period. The due date was subtracted from the collection date to determine the number of days past due. February 1, 2004 (the date the data were extracted), was used as the default collection date for cases that were not yet collected so we could compute the number of days they were past due as of the time of this study. Descriptive statistics were used to find the minimum and maximum days late per group, average days late, percentage over 180 days past due, and the numbers with outstanding balances for over 1 year.

Facility Performance for Uncollected CMPs Provider numbers were used to match the LTC files for the uncollected CMPs with OSCAR data to explore past and subsequent performance of the facilities. Each facility's performance on standard and complaint surveys was reviewed and summarized. Information in the Notes field in LTC was used to provide additional details of visit findings.

Actions Taken by CMS Data extracted from the documentary evidence provided by CMS regional offices, data in CMPTS, and data from the Office of Financial Management were used to determine actions taken. The past-due letters received from the regional offices were each reviewed to describe completeness of their content. We did not receive letters for 29 CMPs: 7 CMPs did not require letters to be sent (i.e., settlement agreements); the regional office reported that a letter was sent but failed to attach it for 12 CMPs; and no letters were sent at all for 10 CMPs.

Interest assessment and payment information was obtained from CMPTS. Information regarding referrals for offsets and additional actions was obtained from the documentary evidence provided by the regional offices. The CMS Office of Financial Management provided information on CMPs transferred to the Department of the Treasury for collection.

Contributors to Noncollection Qualitative interview data were used to explore database shortcomings, clarity of roles and responsibilities, and staff incentive to follow up on past-due cases. Whenever possible, the qualitative data findings were supplemented by quantitative data from the databases and coded regional office documentation.

Data Limitations

Despite extensive data cleaning efforts, it is possible that identification of some past-due CMPs may have been impeded by dates entered erroneously in the CMPTS data that were not discovered during data cleaning.

APPENDIX B

Agency Comments to Draft Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAY 18 2005

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OFFICE OF INSPECTOR GENERAL

TO: Daniel R. Levinson
Acting Inspector General
Office of Inspector General

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

SUBJECT: Office of Inspector General Draft Report: "Nursing Home Enforcement: Collection of Civil Money Penalties" (OEI-06-03-00420)

Thank you for the opportunity to comment on the above OIG draft report. This report determines the extent to which the Centers for Medicare & Medicaid Services (CMS) collected civil money penalties (CMPs) and took collection actions for nursing home enforcement cases that were begun in 2002.

The draft report validates many of our own findings regarding the collection of CMPs. The report also confirms the advisability of the improvement actions we began in 2004.

We are pleased to learn that, despite clear problems in the system, collections have been in the 96 - 98 percent range. Recent improvements we have undertaken will build on that performance. Our goal is 100 percent, and we believe our internal quality improvement effort will enable that goal to be achieved.

CMPs are fines that CMS may levy on Medicare-certified and Medicaid-certified nursing facilities that are found to have violated Federal safety and quality of care standards. CMS is responsible for ensuring that facilities pay their fines. CMS is also required by Federal law, regulations, and CMS' own policies to take specified collection actions.

As the OIG report correctly observes, delays in collections, or lack of collections, have the potential to undermine the CMPs' intended effect of ensuring that facilities promptly return to compliance. Required collection actions include providing facilities with complete notification that the CMP is due, assessing interest on unpaid balances, referring past-due CMPs to fiscal intermediaries and State Medicaid agencies to be offset from funds owed to facilities, and transferring debt over 180 days past due to the Department of the Treasury.

The OIG report indicates that CMS fully collected about 96 percent of CMPs imposed in 2002, but did not fully collect 4 percent of such CMPs (2 percent partially collected, and 2 percent not collected at all). Total funds not collected amounted to $1.2 million.

We initiated an internal quality improvement project in March 2004 because collections in the

96 – 98 percent range, while close to our expectations, still fall short of our goal of 100 percent. A CMS workgroup identified challenges in the existing process. In March 2005, this workgroup produced draft recommendations for a revised process that will be more efficient, reduce data entry duplication, establish clearer staff roles, responsibilities, and accountabilities, and require a more consistent approach for all regional offices.

ervices

The CMS quality improvement workgroup recommendations will also result in upgrades to existing computer systems to facilitate workload processing and accuracy, produce more useful reports, and properly account for funds received. CMS is in the process of implementing the recommendations of our internal workgroup. We are confident that the additional steps we initiated in 2004 will enabled our goal of 100 percent to be achieved.

We fully concur - and have recently or will soon implement - all of the OIG recommendations.

Below are more specific comments to the recommendations in this report.

OIG Recommendation

Provide oversight to ensure that all required actions are taken for collecting CMPs.

CMS Response

We concur. In March 2004, we chartered a CMP Quality Improvement Project team, based on our own recognition that these areas needed improvement. The team included members of our Regional Offices, Office of Financial Management, Center for Medicaid and State Operation's Division of National Systems, and Survey and Certification staff. The workgroup mapped out the existing process, identified problems with the existing process, and then generated recommendations for an improved process. The workgroup is developing guidance that will clarify specific procedures, identify roles and responsibilities, and recommend systems enhancement to facilitate workload processing and accuracy.

OIG Recommendation

Provide staff with written guidelines to clarify responsibilities for, and priority of, CMP collections.

CMS Response

We concur and, as mentioned above, have already chartered a CMP Quality Improvement Project in March 2004, based on our own recognition that these areas needed improvement. The workgroup now is developing guidelines that establish revised policies and procedures for collection of CMPs, as well as a clarify roles and responsibilities.

OIG Recommendation

Ensure the accuracy of information contained in databases used for tracking CMP collections while making them easier to use.

Page 3 – Daniel R. Levinson

CMS Response

We concur. These issues, along with other CMP issues, were discussed at the annual Leadership Summit last year, a yearly conference where states and CMS come together to work on a myriad of program issues. At this year's Leadership Summit in April, we presented the workgroup's recommendations for addressing deficiencies in CMP collections and ask for comment. After formal review and clearance we will issue policy guidance.

ACKNOWLEDGMENTS

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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