



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-03-00037

May 5, 2004

Mr. Tom Hayes
Director
Ohio Department of Job and Family Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215

Dear Mr. Hayes:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's final report entitled "*Nursing Homes and Denial of Payment Remedies in the State of Ohio.*" This audit was initiated due to the general public concern with nursing home issues. Our primary focus was with the measures for enforcing nursing home compliance with quality of care standards for Medicaid recipients.

The objectives of our audit were to ensure that the mandatory denial of payment remedy for substandard quality of care was applied to nursing homes that were not in substantial compliance with the prescribed Medicaid participation requirements and to evaluate whether State controls were adequate to prevent improper Medicaid payments to nursing homes under the denial of payment remedy. Our audit included denial of payment sanctions, which were in effect from October 1, 1999 to September 30, 2001.

Title XIX, section 1919 of the Social Security Act established the requirements for nursing facilities, which are implemented by the State and Secretary of the U.S. Department of Health and Human Services. As part of these requirements, nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements. 42 CFR § 488 sets forth the regulations governing the survey, certification, and enforcement process. Denial of payment is an enforcement remedy for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements.

Although the State correctly identified nursing homes providing substandard quality of care and meeting the criteria for mandatory denial of payment remedies, State controls were not adequate to prevent improper Medicaid payments to sanctioned nursing homes, as required in Title XIX, section 1919 of the Social Security Act and 42 CFR § 488. Out of approximately 1,000 nursing homes surveyed by the State, 13 warranted the mandatory denial of payment remedy for new Medicaid admissions and 39 homes warranted the optional denial of payment sanctions. From these 52 sanctioned nursing homes, unallowable Medicaid payments for 9 homes totaled \$30,223 (\$17,796 Federal share). The overpayments were associated with 2 nursing homes under mandatory denial of payment sanctions and 7 homes under optional denial of payment sanctions.

We recommend the State:

- Refund \$17,796 to the Centers for Medicare & Medicaid Services for the Federal share of the unallowable payments.
- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

In a written response dated March 19, 2004, Ohio officials did not agree with the reported amount of unallowable payments, but did concur with our recommendation to implement additional procedures and agreed to take corrective actions. The dollar amount of overpayments was adjusted. The response is summarized in the body of the report and is included in its entirety as Appendix A to the report.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov/>.

If you have any questions or comments about this report, please do not hesitate to call me or your staff may call Mike Barton, Audit Manager, at (614)-469-2543 or through e-mail at Mike.Barton@oig.hhs.gov. To facilitate identification, please refer to report number A-05-03-00037 in all correspondence.

Sincerely,



Paul Swanson
Regional Inspector General
for Audit Services

Enclosure - as stated

Direct Reply to HHS Action Official:
Associate Regional Administrator
Division of Medicaid and Children's Health
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services, Region V
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF NURSING HOMES
AND DENIAL OF PAYMENT
REMEDIES – STATE OF OHIO**

**OCTOBER 1, 1999 THROUGH
SEPTEMBER 30, 2001**

**OHIO DEPARTMENT OF JOB
AND FAMILY SERVICES**



**MAY 2004
A-05-03-00037**

Office of Inspector General

<http://oig.hhs.gov>

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

OBJECTIVES

The objectives of our audit were to ensure that the mandatory denial of payment remedy for substandard quality of care was applied to nursing homes that were not in substantial compliance with the prescribed Medicaid participation requirements and to evaluate whether State controls were adequate to prevent improper Medicaid payments to nursing homes under the denial of payment remedy.

BACKGROUND

This audit was initiated to address the general public concern with nursing home quality of care. Our primary focus was on measures for enforcing nursing home compliance with quality of care standards for Medicaid recipients. We audited denial of payment sanctions, which were in effect from October 1, 1999 to September 30, 2001.

Due to widespread need for nursing home reform, Congress passed the Omnibus Budget Reconciliation Act of 1987. This legislation included the Nursing Home Reform Act, which ensured residents received quality care in nursing homes through the establishment of a Residents' Bill of Rights and the provision of certain services to each resident. It also required nursing homes participating in the Medicaid and Medicare programs to comply with the requirements for standards of care as prescribed by Federal laws.

Title XIX, section 1919 of the Social Security Act established these requirements for nursing facilities, which are implemented by the State and the Secretary of the U.S. Department of Health and Human Services. As part of these requirements, nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements.

FINDINGS

Although the State correctly identified nursing homes providing substandard quality of care and meeting the criteria for mandatory denial of payment remedies, the State did not have adequate controls to prevent improper Medicaid payments to sanctioned nursing homes. State surveys of approximately 1,000 nursing homes appropriately identified 13 that warranted the mandatory denial of payment remedy for new Medicaid admissions and 39 that warranted the optional denial of payment sanctions. We found that 46 of the 52 sanctioned nursing homes received Medicaid payments, while subject to the denial of payment sanction. Of these 46 nursing homes, 9 had unallowable Medicaid payments totaling \$30,223 (\$17,796 Federal share). The overpayments were associated with 2 nursing homes under mandatory denial of payment sanctions and 7 homes under optional denial of payment sanctions.

RECOMMENDATIONS

We recommend that the State:

- Refund \$17,796 to the Centers for Medicare & Medicaid Services for the Federal share of the unallowable payments.
- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

In a written response dated March 19, 2004, Ohio officials did not agree with the reported amount of unallowable payments but did concur with our recommendation to implement additional procedures and agreed to take corrective actions. The dollar amount of overpayments was adjusted. The response is summarized in the body of the report and is included in its entirety as Appendix A to the report.

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INTRODUCTION

BACKGROUND

Nursing Home Reform Act Requirements

Due to widespread need for nursing home reform, Congress passed the Omnibus Budget Reconciliation Act of 1987. This legislation included the Nursing Home Reform Act, which ensured that residents received quality care in nursing homes by establishing a Residents' Bill of Rights and requiring the provision of certain services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. It also required nursing homes participating in the Medicaid and Medicare programs to comply with the requirements for standards of care as prescribed by Federal laws. Title XIX, section 1919 of the Social Security Act, established these requirements for nursing facilities, which are implemented by the State and the Secretary of the U.S. Department of Health and Human Services.

As part of these requirements, nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements. Substantial compliance means a level of compliance such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Deficiencies result from noncompliance or substandard quality of care in the nursing home. Facilities not in substantial compliance with these Federal standards of care are deficient and may have enforcement remedies imposed against them. Denial of payment sanctions may be imposed alone or in combination with other remedies when certification standards of care are not met.

Denial of Payment Sanctions

42 CFR § 488, subpart F, sets forth the regulations governing the enforcement of remedies against nursing homes with compliance deficiencies. The remedies imposed on a nursing home result from the seriousness of the deficiency, which is measured by the severity and scope of the deficiency. Certification of noncompliance means that the nursing home is not eligible to participate in the Medicaid program. The State survey agency must re-certify the nursing home for substantial compliance before the enforcement remedies are lifted. The denial of payment remedies are used for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements. There are two types of the denial of payment sanctions.

The first type of denial of payment pertains to new admissions for all Medicaid residents, whether considered an optional or mandatory sanction based on the seriousness of the deficiency. The optional remedy states that CMS or the State may deny payment for all new Medicaid admissions when a facility is not in substantial compliance with the Medicaid participation requirements. The mandatory remedy must be imposed, when the facility is not in substantial compliance 3 months after the last day of the survey identifying the deficiency or a facility has been found to have furnished substandard quality of care on the last three consecutive standard surveys. The State Medicaid agency must deny payment to the facility, and CMS must deny

Federal financial participation to the State Medicaid agency for all new Medicaid admissions to the facility (State Operations Manual, section 7506 (C) (2)). The manual defines *substandard quality of care* as:

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

The second type, requiring U.S. Department of Health and Human Services Secretarial approval, is the denial of all payments for all Medicaid residents. In instances of denial of all payments for all Medicaid residents, no payments are made for the period between the date that the remedy was imposed and the date that CMS verified that the facility is in substantial compliance with Federal requirements. Once the facility achieves substantial compliance, CMS resumes payments to the facility prospectively (State Operations Manual, section 7508).

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to ensure that the mandatory denial of payment remedy for substandard quality of care was applied in nursing homes that were not in substantial compliance with the prescribed Medicaid participation requirements and to evaluate whether State controls were adequate to prevent improper Medicaid payments to nursing homes under the denial of payment remedy.

Scope

We obtained information from the CMS regional office, State agencies, and selected nursing homes as applicable. Data obtained included, but was not limited to:

- Medicaid paid claims information,
- nursing home admission and discharge records,
- select billing documentation,
- denial of payment letters,
- list of noncompliant nursing facilities,
- State nursing home surveys, and
- other support documentation as applicable.

Our audit included denial of payment sanctions, which were in effect from October 1, 1999 to September 30, 2001. Our review was limited in scope. It was not intended to be a full-scale internal control assessment of the Medicaid agency operations. The objectives of our audit did not require an understanding or assessment of the overall internal control structure of the agency.

Methodology

For the first objective, we determined whether all nursing homes surveyed with deficiencies were properly sanctioned for mandatory denial of payment. We reviewed all nursing homes that were categorized as providing substandard quality of care, but were not placed under the denial of payment remedy. We requested the CMS listing of nursing homes indicating substandard quality of care during our audit period and reviewed each of the annual surveys for non-sanctioned nursing homes with substandard quality of care deficiencies. In addition, we requested and reviewed the two previous annual surveys to determine whether the nursing homes were sanctioned three consecutive times for substandard quality of care that did not have the mandatory denial of payment remedy enforced or were not in compliance three months after the last day of the survey.

For the second objective, we obtained a State file of sanctioned nursing facilities with the denial of payment remedies and reconciled this information with CMS's Long Term Care Denial of Payment Report. We then obtained the Medicaid paid claims from the Medicaid Statistical Information System to determine whether the State made improper payments to sanctioned nursing homes during our audit period of October 1, 1999 to September 30, 2001. The reconciliation was used to determine the total number of sanctioned nursing homes in Ohio with the denial of payment remedy. For the resulting list of 52 sanctioned nursing homes, we determined that 46 nursing homes were receiving Medicaid payment during the audit period. We reviewed admission records and select billing documentation provided by the nursing homes for the sanction period to determine whether the payments were for new Medicaid admissions and, therefore, subject to denial of payment remedy. Based on the State Operations Manual, Publication 7, we established whether each payment for admissions during the sanction period was allowable or unallowable. The payments were considered unallowable if the resident was a new admission to the nursing home, while it was under the denial of payment remedy. The portion of the claim(s) paid for new admissions during the sanction period was deemed unallowable.

The audit work was performed at the Ohio Department of Health and the Ohio Department of Job and Family Services offices in Columbus, Ohio from January to November 2003. Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATION

FINDINGS

Although the State correctly identified the nursing homes providing substandard quality of care and meeting the criteria for mandatory denial of payment, State controls were not adequate to prevent improper Medicaid payments to sanctioned nursing homes, as required in Title XIX, section 1919 of the Social Security Act and 42 CFR § 488. Out of approximately 1,000 nursing homes surveyed, the State properly identified 52 nursing homes that were out of compliance with quality of care standards. The State did not have adequate controls to prevent improper Medicaid payments for new admissions to sanctioned nursing homes.

Deficient Nursing Homes Not Sanctioned

From the nursing homes surveyed, 13 warranted the mandatory denial of payment remedy. The State correctly applied the mandatory denial of payment remedy to all nursing homes providing substandard quality of care and meeting the criteria for mandatory denial of payment. We determined that there were no nursing homes with three consecutive surveys with substandard quality of care findings or continuing noncompliance three months after the survey.

Denial of Payment for Sanctioned Nursing Homes

Out of 52 sanctioned nursing homes, 46 received Medicaid payments during the sanction periods in our audit, but only 9 received unallowable Medicaid payments totaling \$30,223. The overpayments were associated with two nursing homes under mandatory denial of payment sanctions (\$238) and seven homes under optional denial of payment sanctions (\$29,985). The State controls were not adequate to prevent all improper Medicaid payments to nursing homes under sanction. The Federal financial participation for the improper payments totaled \$17,796. The following schedule summarizes the results of our review.

NURSING HOME	SANCTION START	SANCTION END	RESIDENT COUNT	SANCTION DAYS	QUESTIONED COSTS	FEDERAL SHARE
1	12/19/2000	02/01/2001	1	1	\$ 89	\$ 53
2	12/06/2000	12/21/2000	1	7	922	544
3	11/01/2000	01/05/2001	1	5	565	334
4	10/15/2000	11/06/2000	1	7	798	471
5	02/21/2000	03/22/2000	4	60	6,448	3,783
6	11/06/1999	12/31/1999	4	53	4,752	2,788
7	06/05/2001	07/17/2001	1	1	149	88
8	10/01/2000	12/26/2000	3	173	15,249	9,001
9	10/03/1999	10/31/1999	1	17	1,251	734
9			17	324	\$ 30,223	\$ 17,796

The denial of payment status of a resident is determined by the admission date. According to 42 CFR § 488.401, a new admission is defined as:

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

The Medicaid unallowable payments resulted from improper payments made by the State for new admissions during the sanction period.

CONCLUSION

The denial of payment is an enforcement remedy for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements. The severity of the deficiency and level of harm to the resident requires imposition of the denial of payment remedies. Although the State properly identified nursing homes that were out of compliance with quality of care standards, State controls were inadequate to prevent improper Medicaid payment to sanctioned nursing homes.

RECOMMENDATION

We recommend that the State:

- Refund \$17,796 to the Centers for Medicare & Medicaid Services for the Federal share of the unallowable payments.

- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

AUDITEE COMMENTS

The State agreed that claims totaling \$24,073 were improperly paid. They responded that \$20,068 of reported overpayments were either properly paid or already recovered. The State concurred with our recommendation for the implementation of additional procedures to ensure the timely suspension of payments to providers. The State is preparing to implement a two-stage corrective plan to prevent improper payments and to identify and pursue recovery of overpayments.

OFFICE OF INSPECTOR GENERAL RESPONSE

Through further communications with the State, we concluded that unallowable payments amounted to \$30,223 (\$17,796 Federal share). The report was changed to reflect the revised amount.

APPENDIX

Bob Taft
Governor



Tom Hayes
Director

30 East Broad Street • Columbus, Ohio 43215-3414
www.state.oh.us/odjfs

March 19, 2004

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
233 North Michigan Avenue
Chicago, Illinois 60601

RE: "Audit of Nursing Homes and Denial of Payment Remedies – State of Ohio" October 1, 1999 Through September 30, 2001
Ohio Department of Job and Family Services
Report Number: A-05-03-00037

Dear Mr. Swanson:

Thank you for allowing us to respond to the draft report, "Audit of Nursing Homes and Denial of Payment Remedies in the State of Ohio." The focus of this audit was to determine the State of Ohio's compliance with the quality of care standards for Medicaid recipients and to determine whether State controls were adequate to prevent improper Medicaid payments when a "denial of payment for new admissions" intermediate sanction remedy was imposed.

The report's preliminary findings indicated that the State of Ohio did not have adequate control to prevent improper Medicaid payments to sanctioned nursing homes, as required in Title XIX section 1010 of the Social Security Act and 42 CFR section §488. The draft OIG report states that out of 1,000 nursing facilities surveyed, fifty-two facilities were sanctioned correctly by the Ohio Department of Health. From these 52 sanctioned facilities the OIG audit identified 36 potentially unallowable Medicaid payments to eleven facilities representing services provided to 27 residents. The report indicated that payments for the nursing facility per diem totaling \$44,145 were made in error. The federal share of those overpayments was \$25,976.

The Regional Inspector General for Audit Services recommended the following actions in response to the audit.

- Refund the \$25, 976 to the Centers for Medicare & Medicaid Services for the federal share of the unallowable payments totaling \$44,145.
- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

ODJFS has completed additional analyses of the claims to verify the OIG's estimate for payment of inappropriate claims. Our review indicates that fifteen claims, for eleven residents for a total amount of \$20,068, were either paid properly or already recovered. Ohio has been able to confirm that 21 claims for sixteen residents totaling \$24,073 indeed were paid improperly for new admissions during a DPNA time span. (It is assumed that the four dollar difference in grand totals can be attributable to the rounded numbers on the spreadsheet you provided us.) ODJFS is willing to provide the additional information gathered to make these payment verifications.

The remainder of this document summarizes the steps taken to verify the estimated overpayment and a proposed corrective action plan to avoid future overpayments.

Analysis to verify the OIG estimate of improper claims

ODJFS initially checked to verify whether or not any identified payments had already been adjusted to correct for overpayments. In that first review of the claims, we were able to ascertain that three claims for two residents, totaling \$6470 had been adjusted and recovered since they were first processed. We relayed that information to you earlier.

ODJFS has made further study of some of the payments identified during the audited time span. The second review looked at whether any of the identified claims were associated with residents that a) had newly initiated Medicaid payments during the DPNA span report but were not "new admissions" in accordance with federal guidelines, or 2) had other circumstances that would explain the reason for the paid claim. Verifying whether or not newly initiated claims represented claims for a "new admission" required searching the CRIS-E comment sections entered by the case workers at the local county departments of Job and Family Services, checking the Medicaid Management Information System (MMIS) records, and asking facility staff to recheck their files.

ODJFS asserts that in three claims for three residents, of the 36 potential overpayments, \$10,233 in payments were made properly because the residents' stay did not meet the definition of a "new admission". In each of these cases, the new payment for Medicaid was initiated for an ongoing private pay resident of the facility who converted to the Medicaid pay source during the DPNA time span. The DPNA remedy does not apply to these circumstances.

ODJFS asserts that in seven claims for six residents, \$537 in payments were made. However, MMIS records indicate that none of the six residents resided at that particular facility under a DPNA sanction. The other facility that actually received vendor payment for these six residents was not under a DPNA sanction during that timeframe. (The amounts of each of those claims also suggest that the claims were not for a nursing facility's per diem reimbursement.)

Lastly, ODFJS asserts that CRIS-E records indicate that two claims for one resident, totaling \$2,828, were properly paid because the admission date was June 1st, not June 11th as indicated, and the DPNA period went into effect on June 5th.

In addition, research into additional details surrounding the targeted payments revealed the infinite scenarios and complexity of the real life circumstances that predicate entry into a nursing facility. The results highlight both the need for clarification about a new admission and the extreme difficulty in attempting to automate the application of the DPNA sanction. These variations often do not surface in any precursory review of DPNA time frames and paid claims. In one case, payment stemmed from a Medicare co-payment claim in which new payment was initiated for a person through the Medicare fiscal intermediary crossover payment process. Several other cases involved transfers from other facilities, which may not have flagged "new admissions" to the county caseworkers or facility bookkeepers that are accustomed to classifying residents who "transfer" in a different category from "newly admitted" residents. In other cases, persons were receiving temporary respite care and were enrolled on HCBS waivers, another situation that may not have been flagged correctly by staff as "new admissions."

Proposed Corrective Action Plan

ODJFS is preparing to implement a two-stage corrective plan to prevent improper payments and, when notice time provided to ODJFS is insufficient to prevent payment denial or suspension, to identify and pursue recovery of overpayments.

Attached to this letter are:

1. A listing of the recipient claims that were paid correctly according to federal guidelines clarifying what constitutes a new admission, which exclude from that definition any claims paid to ongoing residents who converted to Medicaid during the DPNA period, and ongoing Medicaid residents who were readmitted during the DPNA period after a temporary absence (e.g., hospital stay.)
2. A summary of the corrective action plan to be implemented by ODJFS, including: a) steps that will be taken to re-educate involved parties about their role in the process, and to notify involved parties when ODJFS receives sufficient advance notice from CMS or ODH to prevent payment from occurring, and b) steps to take annually to conduct a post-payment review to identify any improper payments.

The ability to actually suspend payment is predicated on prompt and prospective notice to ODJFS about the imposition of DPNA remedies from the state survey agency and/or the Centers for Medicaid Services. It relies on the interface of electronic systems for eligibility and payment. Applying the DPNA remedy correctly requires timely and detailed inter-agency and intra-agency communication, as well as seamless coordination among work units at both the state Medicaid agency and respective county agencies collectively responsible for enforcement, recipient eligibility, and provider claims processing. It involves differentiating the targeted claims for new admissions from other claims, using databases that are not equipped to handle the level of detail needed to discern the different reasons for payment to be initiated. Even if such claims could be more readily identified, the systems and system interfaces do not yet have the capacity to automatically suspend or deny payment for that targeted group while continuing to process other payments. What remains are sanctions that must be entirely manually monitored.

Prompt notice from the state survey agency and/or CMS is also required when the DPNA notice is discontinued or rescinded, to make the suspension and payment reinstatement process work as smoothly as possible and to minimize disruption of the facility's cash flow. Our department's available records on those facilities with questionable costs which are identified in this audit indicated that there was an average of 55 days between the date that the sanction period ended and the date that ODJFS received notice that a DPNA sanction was discontinued.

When payments improperly made for services rendered during DPNA spans cannot be prevented due to the complex nature and interdependent timing of this task, overpayments made during the state fiscal year will be identified and they will be included in the facility's annual final fiscal audit process. Our department's corrective plan addresses the systemic and pervasive requirements of implementing the DPNA intermediate sanction requirements from both prospective and retrospective timeframes.

Thank you for the opportunity to respond to the findings. We believe the two-stage improvement plan should result in increased actual denials/suspensions of payments made prospectively during a DPNA period, improved post-payment review of improper payments, and improved pursuit of recovery of overpayments.

ODJFS will await CMS' response to the adjusted estimate of improper payment before taking action on repayment of the federal share.

If you have any further questions please feel free to contact me or Kim Irwin, Chief, Facility Contracting Section at (614) 466-6467.

Sincerely,



Harry W. Saxe, Chief
Bureau of Long Term Care Facilities
Office of Ohio Health Plans
Ohio Department of Job and Family Services

HS/ki

C: Patricia Martin, Chief of Staff, Office of Ohio Health Plans, ODJFS
Kim N. Irwin, Chief, Facility Contracting Services, BLTCF, ODJFS

Attachment 1: ODJFS Findings Indicating Properly Paid Claims During Facility DPNA Time Periods

Claim Line	First 4 digits of Medicaid Provider Number	Begin Date of Service Reviewed	End Date of Service	Days of Service	DPNA Effective Date	DPNA last day	Days Questioned by OIG	Costs Questioned by OIG	Explanation of ODJFS Findings	Admission Date
2	2111	04/01/00	04/30/00	30	03/18/00	05/18/00	30	\$3,994	private pay resident status before DPNA, pd & 15/01. Facility confirms was admitted in 1996.	04/01/00
3	2111	04/01/00	04/30/00	30	03/18/00	05/18/00	30	\$3,305	private pay resident status since Dec. 1996 & in NF when DPNA went into effect	04/01/00
4	2111	05/01/00	05/31/00	31	03/18/00	05/18/00	18	\$2,934	private pay resident since Nov. 1997	05/01/00
							Total for facility:	\$19,233		
11	2056	03/02/00	03/31/00	30	02/21/00	03/22/00	21	\$2,428	entered 01/06/00 through 02/24/00, no payment shown for March 2000, but also not a new admission	03/02/00
							Total for facility:	\$2,428		
23	0565	11/01/00	11/30/00	30	10/01/00	12/26/00	30	\$2,139	was private pay resident prior to DPNA, no payment shown	10/20/00
24	0565	12/01/00	12/31/00	31	10/01/00	12/26/00	26	\$1,903	was private pay resident prior to DPNA, no payment shown	10/21/00
							Total for facility:	\$4,042		
18	0801	07/01/01	07/31/01	31	06/05/01	07/17/01	17	\$2,679	CRIS-E indicates admission was on 6/01/01, not 6/11/01 so claim is outside DPNA period.	06/11/01
19	0801	06/30/01	06/30/01	1	06/05/01	07/17/01	1	\$149	CRIS-E indicates admission was on 6/01/01, not 6/11/01 so claim is outside DPNA period.	06/11/01
							Total for facility:	\$2,828		

Attachment 1: ODJFS Findings Indicating Properly Paid Claims During Facility DPNA Time Periods

Claim Line	First 4 digits of Medicaid Provider Number	Begin Date of Service Reviewed	End Date of Service	Days of Service	DPNA Effective Date	DPNA last day	Days Questioned by OIG	Costs Questioned by OIG	Explanation of ODJFS Findings	Admission Date
29	0038	12/04/00	12/22/00	19	11/27/00	12/19/00	18	\$147	Not a resident of this facility. Resided at other NF during timeperiod of DPNA.	12/01/00
30	0038	12/11/00	12/29/00	19	11/27/00	12/19/00	9	\$108	Not a resident of this facility. Resided at other NF during timeperiod of DPNA.	12/01/00
31	0038	12/15/00	12/22/00	8	11/27/00	12/19/00	5	\$25	Not a resident of this facility/Aftercare. Resided at other NF during timeperiod of DPNA.	12/01/00
32	0038	12/15/00	12/22/00	8	11/27/00	12/19/00	5	\$25	Not a resident of this facility. Resided at other NF during timeperiod of DPNA.	12/01/00
33	0038	12/02/00	12/29/00	28	11/27/00	12/19/00	18	\$73	Not a resident of this facility. Resided at other NF during timeperiod of DPNA.	12/01/00
34	0038	12/15/00	12/29/00	15	11/27/00	12/19/00	5	\$87	Not a resident of this facility. Resided at other NF during timeperiod of DPNA.	12/01/00
35	0038	12/09/00	12/29/00	22	11/27/00	12/19/00	12	\$72	Not a resident of this facility. Resided at other NF during timeperiod of DPNA.	12/01/00
							Total for facility:	\$637		

Grand Total:	\$20,068
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Attachment 2:

Corrective Plan to assure that Denial of Payment for New Admission (DPNA) remedies will be correctly administered by the Ohio Department of Job and Family Services (ODJFS):

Prospective Denial/Suspension of Payments

1. The Facility Contracting Section (FCS) will modify its notification letter to facilities and
 - a. require the facility to submit names of residents that have been newly admitted, readmitted after a temporary leave, and newly converted to the Medicaid payer source during the denial of payment span, within a specific timeframe after the last date of the DPNA period, and
 - b. require the facility to notify FCS and fax in any notice or letter from the Centers for Medicare and Medicaid Services or the Ohio Department of Health that would indicate the ban has been discontinued or rescinded
2. The Facility Contracting Section will add a rule to the Ohio Administrative Code about applying the DPNA sanction that will:
 - a. Define new admissions (and clarify situations involving readmissions and conversions to Medicaid payment for ongoing residents).
 - b. Define the denial of payment remedy
 - c. Explain notification process for initial imposition
 - d. Explain notification process for rescission
 - e. Explain notification process for final effective date of an imposed ban
 - f. Require NF to notify ODJFS with list of residents

Attachment 2: Corrective Action Plan
Ohio's Response to Audit on Nursing Homes and Denial of Payment Remedies

- g. Require NF to notify ODJFS with correction adjustment if NF submitted a claim for an actual new admission during an imposed ban span of dates
 - h. Require county DJFS to suspend eligibility start dates for new admissions that occur during spans with CRIS-E system.
 - i. Require Long Term Care Payment Unit to deny/suspend payments for new admissions.
 - j. Explain how a facility with an expired DPNA can begin the payment/billing process for a person newly admitted during the DPNA period, with payment to begin on the day that the DPNA time span expires.
 - k. Explain how ODJFS. will identify overpayments in a post payment review period and include the amounts in the CPAO process.
 - l. Explain that identified overpayments will be recovered as part of the final fiscal audit.
3. The Facility Contracting Section will request that the Centers for Medicare and Medicaid Services add headings to their e-mail correspondence that contain "DPNA memo" so they can be more quickly identified.
 4. The Facility Contracting Section will request that the Ohio Department of Health add a new process of notification to ODJFS via e-mail memorandums for Medicaid-only NFs, using the same methods that the Centers for Medicare and Medicaid Services uses to notify FCS about DPNAs for SNF/NF dually certified homes.
 5. The Facility Contracting Section will add an instructional sheet in each notification letter explaining how a facility should comply with the imposition and expiration of a DPNA remedy.
 6. The Facility Contracting Section will post these instructions on the ODJFS Long Term Care web site as an instructional memorandum.

**Attachment 2: Corrective Action Plan
Ohio's Response to Audit on Nursing Homes and Denial of Payment
Remedies**

7. The Facility Contracting Section will develop instructions for the CDJFS LTC Units and the Bureau of Plan Operations Long Term Care Payment Unit for handling the information that will be forwarded to them about DPNA sanction periods. The County DJFS caseworker can update the CRIS-E system for new residents with appropriate vendor begin dates, which passes over to the MMIS system. The LTC Payment Unit can use the PF2 screen (without going through CRIS-E first) to adjust NH eligibility for any impacted recipients and providers to designate that no payment should be/have been made.
8. The Facility Contracting Section will develop a mechanism (other than using a copy of the ODJFS to facility notice letter) to notify involved work units after the section receives the electronic memorandums from the Centers for Medicare and Medicaid Services (for dually certified SNF/NFs) or the hard-copy or electronic memorandums from the Ohio Dept. of Health (for Medicaid-only NFs) about facilities' DPNA remedies that are proposed, rescinded, actually imposed, and discontinued/expired. Involved parties include:
 - a. the CDJFS Long Term Care Unit supervisors,
 - b. the Medical Assistance Coordinators in the districts, and
 - c. the Bureau of Plan Operations Long Term Care Payment Unit.

Post-Payment Review Process
for Identification and Recovery of Overpayments

1. At the end of every state fiscal year, FCS will request information from the Case Mix Section's MDS data base on the facility admission tracking data about any residents admitted during any actual DPNA spans during the past state fiscal year.

Attachment 2: Corrective Action Plan
Ohio's Response to Audit on Nursing Homes and Denial of Payment Remedies

2. This information and the information supplied by the facilities about admissions, readmissions, and conversions to Medicaid during the DPNA period will be compiled. FCS will relay to the Combined Proposed Adjudication Order (CPAO) Project Team all newly admitted recipients' Medicaid billing numbers, affiliated provider numbers, and dates of the DPNA span to the CPAO Team
3. The CPAO Project Team will compare paid claims against the list of impacted recipients and facilities to see if any of the identified names that were newly admitted are linked with any payment for per diem services during the DPNA time span.
4. The CPAO Project Team will identify any potential overpayments and add these to the facility's CPAO.
5. The CPAO process will result in a final fiscal audit finding and the offering of a hearing process allowing the provider to provide evidence to dispute the alleged overpayments. If no evidence to overturn the decision is provided, the overpayment will be recovered:
 - a. for active providers, as part of a vendor offset or direct payment; and
 - b. for inactive providers, as part of the amount to be recovered through the security process (escrow, promissory notes, direct payment or vendor offset of related facility).

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed include:

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Lisa Martz, *Auditor*

Chip Leckway, *Auditor*

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