

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**VIRGINIA IMPROPERLY CLAIMED  
FEDERAL REIMBURSEMENT  
FOR MOST REVIEWED  
MEDICAID PAYMENTS TO  
PIEDMONT GERIATRIC HOSPITAL**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Daniel R. Levinson  
Inspector General

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A-05-12-00056

# *Office of Inspector General*

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

#### **Medicaid Program**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

#### **Virginia Medicaid Program**

The Department of Medical Assistance Services (State Medicaid agency) administers the Virginia Medicaid program according to the CMS-approved State plan. The State Medicaid agency makes Medicaid payments to eligible hospitals and claims Federal reimbursement for a portion of the payments. The Virginia Department of Behavioral Health and Developmental Services operates two State-owned hospitals that focus on inpatient treatment for geriatric mental illnesses. Piedmont Geriatric Hospital (Piedmont) is one of those hospitals. The Virginia Department of Health is the State survey agency responsible for determining whether the hospitals meet the standards for Medicaid participation. During the audit period, January 1, 2006, through December 31, 2010, Piedmont was enrolled in Medicaid as a hospital and was an institution for mental diseases (IMD).

#### **Federal Requirements**

For States to claim Federal reimbursement for their Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs, those services must meet the Federal definition of such services. This definition requires the provider to demonstrate compliance with the basic Medicare Conditions of Participation (CoP) generally applicable to all hospitals and two special Medicare CoP applicable to IMDs providing such services. The basic Medicare CoP address issues such as licensing, quality of care, safety, patient rights, self-assessment and performance improvement, and service availability. The special Medicare CoP specify staffing and medical record requirements.

To demonstrate compliance with the basic and special Medicare CoP, facilities must undergo review by qualified health care professionals. That review provides CMS with reasonable assurance that participating facilities are improving the health and protecting the safety of Medicaid beneficiaries. For periods in which an IMD does not demonstrate compliance with the basic and special Medicare CoP, all payments it receives from the State Medicaid agency for inpatient hospital services to patients aged 65 or older are ineligible for Federal reimbursement.

CMS made a technical error when it issued regulations for Medicare transplant center CoP in 2007. Effective June 28, 2007, it inadvertently omitted certain regulations for Medicare CoP relevant to this audit. CMS formally reinstated the omitted regulations effective October 26, 2007. Despite the omission, CMS's implementing guidance remained in effect from June 28 through October 25, 2007 (the regulatory gap period).

## **OBJECTIVE**

Our objective was to determine whether the State Medicaid agency claimed Federal reimbursement for payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older in accordance with certain Federal requirements for those services.

## **SUMMARY OF FINDING**

Most of the State Medicaid agency's claims for Federal reimbursement for payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older were not in accordance with Federal requirements because Piedmont did not demonstrate compliance with the special Medicare CoP during the audit period. Of the \$39,365,326 in Federal reimbursement claimed for that period, \$36,903,169 for claims with dates of service outside the regulatory gap period was not allowable. We have not provided an opinion on the allowability of the remaining \$2,462,157, which was for claims with dates of service during the regulatory gap period. The State Medicaid agency claimed the \$39,365,326 in Federal reimbursement because it believed that Piedmont had met all requirements to be eligible for Medicaid payments for the inpatient hospital services it provided to patients aged 65 or older.

## **RECOMMENDATIONS**

We recommend that the State Medicaid agency:

- refund \$36,903,169 to the Federal Government for its share of payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates outside the regulatory gap period,
- work with CMS to determine whether the State Medicaid agency should refund an additional \$2,462,157 to the Federal Government for its share of payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates during the regulatory gap period, and
- ensure that it claims Federal reimbursement for Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs only if those IMDs can demonstrate compliance with the special Medicare CoP.

## **STATE MEDICAID AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State Medicaid agency did not concur with our first and second recommendations and did not comment on our third recommendation. The State Medicaid agency did not concur with our first and second recommendations because it believes that Piedmont demonstrated compliance with the special Medicare CoP throughout the audit period. The State Medicaid agency also did not concur with our second recommendation because it believes that Piedmont did not need to comply with regulations omitted during the regulatory gap period.

After reviewing the State Medicaid agency's comments, we maintain that our finding and recommendations are valid. Federal Medicaid requirements mandate that inpatient hospital services provided to patients aged 65 or older in IMDs are eligible for Federal reimbursement only if those IMDs demonstrate compliance with the special Medicare CoP. We maintain that Piedmont did not demonstrate such compliance during the audit period. Furthermore, CMS's inadvertent omission of regulations for Medicare CoP was a technical error, and its implementing guidance remained in effect during the regulatory gap period.

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## **INTRODUCTION**

### **BACKGROUND**

#### **Medicaid Program**

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

#### **Virginia Medicaid Program**

The Department of Medical Assistance Services (State Medicaid agency) administers the Virginia Medicaid program according to the CMS-approved State plan. The State Medicaid agency makes Medicaid payments to eligible hospitals and claims Federal reimbursement for a portion of the payments. The Virginia Department of Behavioral Health and Developmental Services operates two State-owned hospitals that focus on inpatient treatment for geriatric mental illnesses. Piedmont Geriatric Hospital (Piedmont) is one of those hospitals. The Virginia Department of Health is the State survey agency responsible for determining whether the hospitals meet the standards for Medicaid participation. During the audit period, January 1, 2006, through December 31, 2010, Piedmont was enrolled in Medicaid as a hospital and was an institution for mental diseases (IMD).

#### **Federal Requirements**

For States to claim Federal reimbursement for their Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs, those services must meet the Federal definition of such services. This definition requires the provider to demonstrate compliance with the basic Medicare Conditions of Participation (CoP) generally applicable to all hospitals and two special Medicare CoP applicable to IMDs providing such services. The basic Medicare CoP address issues such as licensing, quality of care, safety, patient rights, self-assessment and performance improvement, and service availability. The special Medicare CoP specify staffing and medical record requirements. For periods in which an IMD does not demonstrate compliance with the basic and special Medicare CoP, all payments it receives from the State Medicaid agency for inpatient hospital services to patients aged 65 or older are ineligible for Federal reimbursement.

In 72 Fed. Reg. 60787 (Oct. 26, 2007), CMS corrected a technical error that it had made when it issued regulations for Medicare transplant center CoP that became effective June 28, 2007. When it amended 42 CFR part 482, subpart E, in 72 Fed. Reg. 15198 (Mar. 30, 2007), CMS inadvertently omitted 42 CFR §§ 482.60–482.62, which are regulations for Medicare CoP relevant to this audit. The correction reinstated the omitted regulations effective

October 26, 2007. Despite the omission, CMS's implementing guidance (e.g., manuals) remained in effect from June 28 through October 25, 2007 (the regulatory gap period).

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State Medicaid agency claimed Federal reimbursement for payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older in accordance with certain Federal requirements for those services.

### **Scope**

We reviewed Piedmont's compliance for the period January 1, 2006, through December 31, 2010, with certain Federal requirements for inpatient hospital services provided to patients aged 65 or older in IMDs. We identified \$39,365,326 in Federal reimbursement for Medicaid payments to Piedmont for such services provided during the audit period. We limited our review of the State Medicaid agency's internal controls to those significant to the objective of our audit.

### **Methodology**

To accomplish our objective, we:

- examined Federal and State Medicaid requirements for inpatient hospital services provided to patients aged 65 or older in IMDs,
- identified periods for which neither the State Medicaid agency nor Piedmont could demonstrate Piedmont's compliance with certain Federal requirements for such services,
- held discussions with officials of the State Medicaid agency and reviewed its Medicaid payment records for such services, and
- determined the amount of Federal reimbursement for payments to Piedmont for claims with dates of service during periods when it did not demonstrate compliance.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## **FINDING AND RECOMMENDATIONS**

Most of the State Medicaid agency's claims for Federal reimbursement for payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older were not in accordance with Federal requirements because Piedmont did not demonstrate compliance with

the special Medicare CoP during the audit period. Of the \$39,365,326 in Federal reimbursement claimed for that period, \$36,903,169 for claims with dates of service outside the regulatory gap period was not allowable. We have not provided an opinion on the allowability of the remaining \$2,462,157, which was for claims with dates of service during the regulatory gap period. The State Medicaid agency claimed the \$39,365,326 in Federal reimbursement because it believed that Piedmont had met all requirements to be eligible for Medicaid payments for the inpatient hospital services it provided to patients aged 65 or older.

## **FEDERAL REQUIREMENTS**

For States to claim Federal reimbursement for their Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs, those services must meet the Federal definition of such services. This definition requires the provider to demonstrate compliance with the basic Medicare CoP generally applicable to all hospitals and two special Medicare CoP applicable to IMDs providing such services.

### **Medicaid Payments**

States may claim Federal reimbursement for a portion of their Medicaid medical assistance payments (section 1903(a)(1) of the Act). Medical assistance includes inpatient hospital services provided to patients aged 65 or older in IMDs (section 1905(a)(14) of the Act).

### **Medicaid Service Definition**

Regulations in 42 CFR § 440.140(a) implement section 1905(a)(14) of the Act and require IMDs that provide inpatient hospital services to patients aged 65 or older to meet Medicare psychiatric hospital requirements stated in 42 CFR § 482.60. Regulations in 42 CFR § 482.60(b) require such IMDs to meet the basic Medicare CoP generally applicable to all hospitals (42 CFR §§ 482.1–482.23 and 42 CFR §§ 482.25–482.57), and regulations in 42 CFR § 482.60(c) and (d) require the same IMDs to meet two special Medicare CoP applicable to psychiatric hospitals (42 CFR §§ 482.61 and 482.62).<sup>1</sup>

The Medicare CoP included in the Medicaid definition of inpatient hospital services provided to patients aged 65 or older in IMDs are minimum standards that provide a basis for improving quality of care and protecting the health and safety of Medicaid beneficiaries. The basic Medicare CoP address issues such as licensing, quality of care, safety, patient rights, self-assessment and performance improvement, and service availability (42 CFR §§ 482.1–482.23 and 42 CFR §§ 482.25–482.57). The special staffing Medicare CoP requires that IMDs that provide inpatient hospital services to patients aged 65 or older “have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning” (42 CFR § 482.62). The special medical record Medicare CoP requires that “medical

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<sup>1</sup> Psychiatric hospitals with more than 16 beds are both hospitals and IMDs (section 1905(i) of the Act), but not all facilities that are both hospitals and IMDs are classified as psychiatric hospitals, e.g., Piedmont. However, the cited statutes and regulations require all IMDs that provide inpatient hospital services to patients aged 65 or older to meet the Medicare CoP applicable to Medicare-participating psychiatric hospitals.

records ... permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution” (42 CFR § 482.61).

### **Demonstrating Compliance With Medicare Conditions of Participation**

To demonstrate compliance with the basic and special Medicare CoP, facilities must undergo review by qualified health care professionals. Facilities can demonstrate compliance with the basic and special Medicare CoP by successfully completing a survey of those CoP performed by the State survey agency (42 CFR § 488.10(a)). During our audit period, facilities could also generally demonstrate compliance with the *basic* Medicare CoP<sup>2</sup> by being accredited as a hospital by CMS-approved organizations, such as the Joint Commission.<sup>3</sup> However, during that time, such accreditation did not demonstrate compliance with the *special* Medicare CoP (42 CFR § 488.5(a)).<sup>4</sup> Instead, facilities had to be specially surveyed by qualified health care professionals to demonstrate compliance with the *special* Medicare CoP.<sup>5</sup> Accreditation or survey by qualified health care professionals provides CMS with reasonable assurance that participating facilities are improving the health and protecting the safety of Medicaid beneficiaries.

For periods in which an IMD does not demonstrate compliance with the basic and special Medicare CoP, all payments it receives from the State Medicaid agency for inpatient hospital services to patients aged 65 or older are ineligible for Federal reimbursement.

### **PIEDMONT DID NOT DEMONSTRATE COMPLIANCE WITH SPECIAL MEDICARE CONDITIONS OF PARTICIPATION DURING THE AUDIT PERIOD**

Piedmont did not demonstrate compliance with the special Medicare CoP during the audit period. The Joint Commission accredited Piedmont as a hospital throughout the audit period, and that accreditation generally demonstrated Piedmont’s compliance with the basic Medicare CoP. However, Piedmont was never specially surveyed to demonstrate compliance with the special Medicare CoP.<sup>6</sup> Therefore, Piedmont’s inpatient hospital services to patients aged 65 or

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<sup>2</sup> One exception is the utilization review requirement in 42 CFR § 482.30; however, compliance with the utilization review requirement was outside the scope of our audit.

<sup>3</sup> The Joint Commission was previously known as the Joint Commission on Accreditation of Healthcare Organizations and is so referenced in 42 CFR § 488.5(a).

<sup>4</sup> After the audit period (January 1, 2006, through December 31, 2010), CMS granted the Joint Commission deeming authority with respect to the two special Medicare CoP (76 Fed. Reg. 10598 (Feb. 25, 2011)).

<sup>5</sup> The CMS *State Operations Manual*, section 2718A, implements Medicare psychiatric hospital requirements in 42 CFR §§ 482.60–482.62, which are also applicable to IMDs that provide inpatient hospital services to patients aged 65 or older.

<sup>6</sup> The State Medicaid agency provided evidence that Piedmont demonstrated compliance with the special Medicare CoP via a November 2011 survey performed by the State survey agency. However, that survey cannot retroactively demonstrate Piedmont’s compliance with the special Medicare CoP during the audit period, which ended on December 31, 2010.

older did not meet the Medicaid definition of such services, and all payments it received from the State Medicaid agency for such services were ineligible for Federal reimbursement.

Of the \$39,365,326 in Federal reimbursement claimed for Medicaid payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates during the audit period, the State Medicaid agency improperly claimed \$36,903,169 for claims with dates of service outside the regulatory gap period. We have set aside for further review by CMS and the State Medicaid agency \$2,462,157 in Federal reimbursement for payments to Piedmont for claims with dates of service during the regulatory gap period.<sup>7</sup>

The State Medicaid agency claimed the \$39,365,326 in Federal reimbursement because it believed that Piedmont had met all requirements to be eligible for Medicaid payments for the inpatient hospital services it provided to patients aged 65 or older.

## **RECOMMENDATIONS**

We recommend that the State Medicaid agency:

- refund \$36,903,169 to the Federal Government for its share of payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates outside the regulatory gap period,
- work with CMS to determine whether the State Medicaid agency should refund an additional \$2,462,157 to the Federal Government for its share of payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates during the regulatory gap period, and
- ensure that it claims Federal reimbursement for Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs only if those IMDs can demonstrate compliance with the special Medicare CoP.

## **STATE MEDICAID AGENCY COMMENTS**

In written comments on our draft report, the State Medicaid agency did not concur with our first and second recommendations and did not comment on our third recommendation. The State Medicaid agency did not concur with our first and second recommendations because it believes that Piedmont demonstrated compliance with the special Medicare CoP throughout the audit period. The State Medicaid agency indicated that Piedmont demonstrated such compliance via surveys or inspections of Piedmont's compliance with "substantially equivalent" State requirements. During the audit period, these surveys or inspections were performed by various State agencies other than the State survey agency. The State Medicaid agency also did not concur with our second recommendation because it believes that Piedmont did not need to comply with regulations omitted from the Federal Register during the regulatory gap period.

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<sup>7</sup> Despite CMS's inadvertent omission of 42 CFR §§ 482.60–482.62 in 72 Fed. Reg. 15198 (Mar. 30, 2007), CMS's implementing guidance remained in effect during this period.

The State Medicaid agency's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the State Medicaid agency's comments, we maintain that our finding and recommendations are valid. Federal Medicaid requirements mandate that inpatient hospital services provided to patients aged 65 or older in IMDs are eligible for Federal reimbursement only if those IMDs demonstrate compliance with the special Medicare CoP.

The State Medicaid agency indicated that Piedmont demonstrated compliance with the special Medicare CoP throughout the audit period, but we disagree. CMS had written guidance in place that implemented Medicare psychiatric hospital requirements in 42 CFR §§ 482.60–482.62 and established how facilities should demonstrate compliance with the special Medicare CoP. CMS's *State Operations Manual*, section 2718A, required both Medicare- and Medicaid-participating facilities to undergo surveys performed by either the State survey agency or CMS contractors. Those surveys had to be performed by qualified health care professionals in accordance with guidance in Appendix AA of the manual. During our audit, we asked the State Medicaid agency to confirm or correct our understanding that Piedmont had never been "surveyed by CMS (or its contractors), State personnel, or any other qualified health care professionals to demonstrate ... compliance with the special Medicare CoP." The State Medicaid agency specified only one exception, a November 2011 survey that cannot retroactively demonstrate Piedmont's compliance with the special Medicare CoP during the audit period, which ended on December 31, 2010. Furthermore, in its written comments on our draft report, the State Medicaid agency did not show that Piedmont complied with the Federal regulatory requirements or CMS's guidance. Therefore, Piedmont did not demonstrate compliance with the special Medicare CoP during the audit period.

The State Medicaid agency also indicated that Piedmont did not need to comply with regulations omitted from the Federal Register during the regulatory gap period, but we maintain that our second recommendation is valid. In 72 Fed. Reg. 60787 (Oct. 26, 2007), CMS acknowledged that it inadvertently omitted regulations for Medicare CoP from the Federal Register, but it also corrected the omission and indicated that it was a technical error. Moreover, CMS's implementing guidance, e.g., the *State Operations Manual*, remained in effect during the regulatory gap period.

# **APPENDIX**

**APPENDIX: STATE MEDICAID AGENCY COMMENTS**



**COMMONWEALTH of VIRGINIA**  
*Department of Medical Assistance Services*

CYNTHIA B. JONES  
DIRECTOR

SUITE 1300  
600 EAST BROAD STREET  
RICHMOND, VA 23219  
804/786-7933  
800/343-0634 (TDD)  
www.dmas.virginia.gov

April 7, 2014

Sheri L. Fulcher  
Regional Inspector General for Audit Services  
Office of Audit Services, Region V  
233 North Michigan, Suite 1360  
Chicago, IL 60601

RE: OIG Report Numbers A-05-12-00055 and A-05-12-00056

Dear Ms. Fulcher:

The Virginia Department of Medical Assistance Services (DMAS) appreciates the opportunity to comment on two Office of Inspector General (OIG) draft reports entitled Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Catawba Hospital (A-12-05-000555) and Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Piedmont Geriatric Hospital (A-05-12-00056).

DMAS strongly disagrees with OIG's recommendation it refund to the federal government \$17,395,647 for payments made for patients at Catawba Hospital ("Catawba") and \$36,903,169 for payments made to patients at Piedmont Geriatric Hospital ("Piedmont") during the audit period (January 1, 2006 through December 31, 2010). The payments were allowable because, for the duration of the audit period, both hospitals met the requirements of the special Medicare conditions of participation (CoP). From January 1, 2006 to December 31, 2010, Catawba and Piedmont were subject to and in compliance with state requirements governing behavioral health, which impose requirements substantially equivalent to the standards set forth in the special Medicare CoPs.

DMAS also strongly disagrees with OIG's recommendation that it work with the Centers for Medicare & Medicaid Services (CMS) to determine whether the State should refund \$1,212,002 in federal funding for Catawba and \$2,462,157 in federal funding for Piedmont during the "regulatory gap" period between June and October 2007. Because those regulations were not published in the Federal Register, they were not in effect during that time period. In any event, the hospitals both met the requirements of the Medicare special CoPs during that time.

**I. The Draft Audit Does Not Establish That the Two Hospitals Did Not Comply with 42 C.F.R. § 440.140.**

The recommendations of the draft audit are based on the statement in 42 C.F.R. § 440.140 that inpatient hospitals for individuals age 65 or older means services provided in an

institution for mental diseases that “meets the requirements” specified in § 482.60(b), (c), and (e), which in turn reference the special conditions of participation for psychiatric hospitals set forth at § 482.61 and § 482.62. The audit assumes that this requires Medicare certification, but this is not what the regulation provides. This is apparent when contrasted with other language in the C.F.R. which clearly requires certification. For example, inpatient psychiatric services for individuals under age 21 is defined as services “provided by . . . a psychiatric hospital that *undergoes a State survey* to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital.” 42 C.F.R. § 440.160(b)(1) (emphasis added); *see also* 42 C.F.R. § 442.30(a) (“FFP is available in expenditures for NF and ICF/IID services only if the facility *has been certified as meeting the requirements* for Medicaid participation.”) (emphasis added). No such survey or certification requirement is included in the definition of the IMD service for individuals age 65 and older. While certification can confirm that a facility meets the standards set forth in the conditions of participation, the absence of certification is not indicative of a failure to meet those standards. The audit itself does not make any finding that the operations of the hospitals fell short of the requirements set forth in the special conditions of participation.

The special conditions of participation for psychiatric hospitals address certain medical record requirements, 42 C.F.R. § 482.61, and certain staff requirements, 42 C.F.R. § 482.62. The Commonwealth of Virginia has comparable requirements for both recordkeeping and staffing, and both hospitals were subject to these requirements during the audit period. These requirements are set forth in the following documents:

- Departmental Instruction 111(TX)01, Requirements for Treatment and Habilitation Planning. This document provides a uniform practice guidelines for state facilities licensed by the Department of Behavioral Health and Developmental Services (“DBHDS”).
- Departmental Instruction 107(TX)00, Assessment of Medical/Surgical Status. This document establishes policies and procedures for initial medical assessment and ongoing care of patients and for assessing changes in a client’s physical status in hospitals operated by DBHDS (previously known as the Department of Mental Health, Mental Retardation and Substance Abuse Services).
- Departmental Instruction No. 108(TX)00, Medical Emergency Response Systems. This document establishes policies and procedures governing emergency response in psychiatric hospitals.
- Departmental Instruction 701, Organization and Maintenance of the Clinical Record. This document governs the integrity of the clinical record and the information contained therein, including standardized requirements for the organization and maintenance of records. It includes facility procedures as well as training and oversight requirements.
- Discharge Protocols for Community Services Boards and State Mental Health Facilities. This document provides protocols governing discharge procedures. The document also addresses assessments and treatment planning.

- Health Information Management Manual. This document includes minimum requirements for documentation, storage, review, and release of clinical records and health information. It further addresses the content of quantitative and qualitative records reviews to ensure that required services are performed within established timeframes and the results are documented in the clinical record.
- Problem Oriented Records Manual (in effect at time of audit). This document governed the standards for documentation of service delivery to patients, including interdisciplinary progress notes.

Moreover, the State had in place a number of different monitoring protocols to ensure that the hospitals adhered to these policies and procedures. Taken together, these establish that the hospitals met the requirements of the relevant rules during the audit period.

Section 482.61 lays out five standards relating to medical record requirements which are also reflected in the state policies. The purpose of these standards is to permit determination of the “degree and intensity of the treatment provided to individuals who are furnished services in the institution.” § 482.61. The five standards are:

- a) *Development of assessment/diagnostic data*. This standard requires that “medical records must stress the psychiatric components of the record, including history of findings and treatment provided for psychiatric condition for which the patient is hospitalized.” Virginia’s governing protocols likewise require documentation of “significant events and information affecting the client’s psychiatric or medical condition.” Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at 11. Furthermore, the DBHDS Health Information Manual requires facilities to maintain active clinical records that fully and accurately describe the individual’s condition at the time of admission and discharge. Health Information Manual, at 4.
- b) *Psychiatric Evaluation*. This standard requires that each patient receive a thorough psychiatric evaluation within 60 hours of admission that documents specific factors in the patient’s medical history and current status. § 482.61(b). The Virginia protocols are more stringent, requiring the initial medical and psychiatric evaluation to be completed within 24 hours of admission. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at Appendix A.
- c) *Treatment plan*. This standard requires each individual to have a comprehensive treatment plan that is based on an inventory of the patient’s strengths and disabilities. § 482.61(c). The Virginia policies require a treatment/habilitation plan--including an initial treatment plan with annual revisions. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at Appendix A.
- d) *Recording progress*. This standard requires progress notes to be recorded on certain intervals with precise notes as to the patient’s progress. § 482.61(d). The Virginia policies likewise require, as part of the comprehensive treatment plan, that facilities include procedures for collecting data to assess progress towards achievement of the desired goals and objectives. Furthermore, the patient’s treatment team is required to

maintain documentation as to the patient's response to interventions and progress toward achieving goals and objectives. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at 9-11.

- e) *Discharge planning and discharge summary.* This standard requires that the record of each patient who has been discharged include a discharge summary that includes a recapitulation of the patient's hospitalization and recommendation from appropriation services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge. Similar requirements are required by Virginia's guidelines and discharge protocols for state mental health facilities. Discharge Protocols for Community Services Boards and State Mental Health Facilities.

Section 482.62 lays out five standards relating to staff requirements for psychiatric hospitals. The five standards are:

- a) *Personnel.* The standard requires the hospital employ sufficient numbers of personnel to evaluate patients, formulate treatment plans, provide treatment, and engage in discharge planning. § 482.62(a). The Commonwealth requires that initial treatment and habilitation plans be conducted by physicians, nurses, social workers, as well as experts in nutrition, and rehabilitation. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at Appendix A. Furthermore, while at the time there was no deeming status with regard to Joint Commission accreditation, both hospitals were in compliance with the Joint Commission requirement for hospitals that each facility have an adequate number and mix of staff to meet the care, treatment, and service needs of the patients. Joint Commission Hospital Accreditation Manual, 2007, HR1.10.
- b) *Director of Inpatient Psychiatric Services.* The standard requires that the hospital have a director of inpatient psychiatric services who meets certain requirements. § 482.62(b). Virginia likewise requires a facility director who ensures compliance with policies and procedures, provides staff with necessary training, and ensures the ongoing assessment of the facility's treatment planning process. Furthermore, the policies require that each treatment team have a team leader focused on the client's need who is qualified to perform this function. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at 3-4.
- c) *Availability of Medical Personnel.* The standard requires the availability of medical doctors or doctors of osteopathy. § 482.62(c). Furthermore, the rule requires there be a qualified director of nursing services as well as adequate nursing staff, with experience in psychiatric nursing. Nurses should be available 24 hours a day. § 482.62(d). Virginia requires that each treatment team include a physician, and Virginia State requirements provide that a psychiatrist must be board certified and have completed approved/accredited psychiatric residency program. Virginia Department of Human Resources, Physician II/Psychiatrist, Minimum Qualifications. Furthermore, the State requires that there be a senior nurse on site and a medical response team, which includes three nurses, available 24 hours a day to respond to emergencies. DL 107(TX)00, 107-5; D1 108 (TX)00-108-6.
- d) *Psychological Services.* The standard requires that hospitals have available psychological services and social services to meet the needs of the patients. § 482.62(e)-

(f). Similarly, Virginia requires that each team developing a comprehensive treatment and rehabilitation plan to include, at a minimum, the client, physician, psychologist, social worker, and a nurse. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at 5.

- e) *Therapeutic Activities*. The rule requires the hospital provide a therapeutic activities program that meets the needs of patients. § 482.62(g). As described above, the State's requirements for treatment and habilitation planning require assessments and treatment plans in psychology, social work, nutrition, and rehabilitation. Departmental Instruction 111 (TX) 01, Requirements for Treatment and Habilitation Planning, at Appendix A.

We would be happy to provide more detail on the state requirements, including the underlying documents referenced.

Furthermore, several state surveys done during the audit period demonstrate the hospitals' compliance with these requirements. For example, from January 2006 to September 2010, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) reviewed the timeliness and completeness of all required assessments, treatment plans, and treatment plan updates at Catawba. Findings of these reviews are documented on quarterly reports, which we would be happy to provide.

Throughout the audit period, the facilities were subject to unannounced inspection by the state Inspector General. Items reviewed included mission and values, active treatment, recovery initiatives, staffing, and environmental conditions. Neither Catawba nor Piedmont had any active findings requiring corrective action during this time period. In 2006, Catawba was complimented for the steps it had taken to recruit and retain nursing staff, and staff levels were found adequate during the visit. Among other things, the IG reported that the Catawba program had an "organizational approach that is clinically sound and recovery oriented," that "staff showed a remarkable level of pride and commitment to their jobs and the PSR [psychosocial rehabilitation] program;" and that "attendance levels were very high and no one was unaccounted for." In an inspection of Piedmont in November 2008, the state IG inspected Piedmont and reported that "[r]ecord reviews . . . demonstrated links between consumer goals, treatment plans and scheduled activities. Of the groups observed on the day of the inspection, all were well attended, led by the assigned facilitator and involved activities as noted on the schedule. Group facilitators were energetically involving consumers in the activities." In February 2009, the OIG conducted a follow-up visit in which it conducted systematic observations of very large samples of psychosocial rehabilitations [PSR] activities and that "all of the PSR programs performed well in these observations" and that Piedmont "scored above the mean in both years."

Moreover, as the draft audit notes on page 4, footnote 6 of the Piedmont report, Piedmont demonstrated compliance with the special Medicare CoPs in a November 2011 survey performed by the state survey agency. This survey indicates that in the year immediately following the audit period (2011), Piedmont was indeed in compliance with the special Medicare CoPs.

The fact that Piedmont was subsequently reviewed and certified soon after the audit period supports our view that the state policies and practices to which the hospitals are subject

are substantially equivalent to the federal requirements, and that both hospitals “met the requirements” of the special Medicare CoPs during the time of the audit period.

**II. There is no reason for DMAS to work with CMS to resolve the allowability of federal funds claimed during the regulatory gap period.**

The OIG recommended that DMAS work with CMS to determine the allowability of \$1,212,002 in federal funding for Catawba and \$2,462,157 in federal funding for Piedmont during what the OIG calls the “regulatory gap” period between June and October 2007. During this period, the regulations at 42 C.F.R. § 482.60–482.62 were omitted from the federal register. Accordingly, they were ineffective during that time period. *See* 5 U.S.C. § 552(a)(1) (“Each agency shall separately state and *currently* publish in the Federal Register for the guidance of the public substantive rules of general applicability authorized by law...” (emphasis added); *see also* 44 U.S.C. § 1505(a) (requiring regulations with legal effect to be published in the Federal Register). The Commonwealth cannot be penalized for failure to demonstrate compliance with these regulations when they were not published in the Federal Register. Regulations must be published in the federal register for public inspection and viewing to create legally binding rights or obligations. *See e.g., Andrews v. Knowlton*, 509 F.2d 898, 95 (2d. Cir. 1975).

Even if these regulations did apply, as described above, both Catawba and Piedmont were in compliance with the special Medicare CoPs during this time. Accordingly, the OIG’s recommendation that DSS work with CMS to resolve the allowability of these funds during the regulatory gap should be rejected.

**III. Conclusion**

During audit period at issue, Catawba and Piedmont were both subject to substantially the same requirements as the CMS Medicare special CoP applicable to psychiatric hospitals through state policies and procedures. Thus, there would be no basis for the hospitals to refund payments for patients made during this time, as the hospitals complied with the requirements.

Thank you for the opportunity to comment on the final audit report. We appreciate your consideration of the information provided in this letter. If you have any questions, feel free to contact Scott Crawford at 804-786-3639.

Sincerely,



Cynthia B. Jones  
Director