



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

April 15, 2004

Report Number: A-05-03-00052

Ms. Janet Olszewski, Director  
Michigan Department of Community Health  
Lewis Cass Building  
300 South Walnut Street  
Lansing, Michigan 48913

Dear Ms. Olszewski:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's final report providing the results of our self-initiated audit of "Nursing Homes and Denial of Payment Remedies in the State of Michigan." This audit was initiated to address the general public concern with nursing home quality of care. 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 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 500 nursing homes surveyed by the State, 84 warranted the mandatory denial of payment remedy for new Medicaid admissions and 57 homes warranted the optional denial of payment sanctions. From a statistical sampling of 100 payments to nursing homes under sanction, we found 24 unallowable payments to 15 homes, totaling \$31,598 (\$17,564 Federal share). The overpayments were associated with 12 nursing homes under mandatory denial of payment sanctions and 3 homes under optional denial of payment sanctions. Based on the results of the statistical sample, we

estimate unallowable Medicaid payments of \$509,670 (Federal share \$280,879)<sup>1</sup> were made to nursing homes under the denial of payment sanction.

We recommend the State:

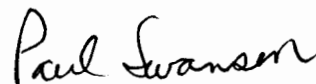
- Refund \$17,564 to the Centers for Medicare & Medicaid Services for the Federal share of identified unallowable payments.
- Identify and refund additional overpayments for unallowable payments made during the sanction period, estimated to be \$509,670 (Federal share \$280,879).
- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

Final determination as to actions taken on all matters 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.)

To facilitate identification, please refer to report number A-05-03-00052 in all correspondence relating to this report.

Sincerely,



Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosure - as stated

**Direct Reply to HHS Action Official:**

Associate Regional Administrator  
Centers for Medicare & Medicaid Services, Region V  
Division of Medicaid and State Operations  
233 North Michigan Ave., Suite 600  
Chicago, Illinois 60601

---

<sup>1</sup> The Federal financial participation rate used was 55.11 percent, the lowest of the rates in effect during the 2-year period (fiscal years 2000 and 2001).

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

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

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

**MICHIGAN DEPARTMENT OF  
COMMUNITY HEALTH**



**April 2004  
A-05-03-00052**

# ***Office of Inspector General***

**<http://oig.hhs.gov>**

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

## ***Office of Evaluation and Inspections***

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## ***Office of Investigations***

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees state Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

# *Notices*

---

## **THIS REPORT IS AVAILABLE TO THE PUBLIC at <http://oig.hhs.gov>**

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 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 500 nursing homes appropriately identified 84 that warranted the mandatory denial of payment remedy for new Medicaid admissions and 57 that warranted the optional denial of payment sanctions. From a statistical sampling of 100 payments to nursing homes under sanction, we found 24 unallowable payments to 15 homes, totaling \$31,598 (\$17,564 Federal share). The overpayments were associated with 12 nursing homes under mandatory denial of payment sanctions and 3 homes under optional denial of payment sanctions. Based on the results of the statistical sample, we estimate unallowable Medicaid payments totaling \$509,670 (Federal share \$280,879)<sup>1</sup> were made to nursing homes under the denial of payment sanction.

---

<sup>1</sup> The Federal financial participation rate used was 55.11 percent, the lowest of the rates in effect during the 2-year period (fiscal years 2000 and 2001).

## **RECOMMENDATIONS**

We recommend that the State:

- Refund \$17,564 to the Centers for Medicare & Medicaid Services (CMS) for the Federal share of identified unallowable payments.
- Identify and refund additional overpayments for unallowable payments made during the sanction period, estimated to be \$509,670 (Federal share \$280,879).
- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

In a written response dated March 30, 2004, State agency officials concurred with our recommendations. The response is summarized in the body of this report and is included in its entirety as Appendix B to this report.

# TABLE OF CONTENTS

	<b>Page</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>BACKGROUND</b> .....	<b>1</b>
Nursing Home Reform Act Requirements .....	1
Denial of Payment Sanctions .....	1
<b>OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	<b>2</b>
Objectives .....	2
Scope .....	2
Methodology .....	3
<b>FINDINGS AND RECOMMENDATION</b> .....	<b>4</b>
<b>FINDINGS</b> .....	<b>4</b>
Payments Made to Sanctioned Nursing Homes .....	4
<b>CRITERIA APPLICATION</b> .....	<b>5</b>
<b>RECOMMENDATION</b> .....	<b>5</b>
State Agency Comments .....	<b>6</b>
<b>APPENDICES</b>	
<b>SAMPLING METHODOLOGY</b> .....	<b>A</b>
<b>STATE AGENCY RESPONSE TO DRAFT REPORT</b> .....	<b>B</b>



## **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 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 three 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 Department of Health and Human Services Secretarial approval, is the denial of all payments for all Medicaid residents. In these instances, 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 surveyed nursing homes with deficiencies were properly sanctioned for mandatory denial of payment. We reviewed all nursing homes that provided 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 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 but did not have the mandatory denial of payment remedy enforced. We also evaluated whether nursing homes remained in non-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 Management 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 Michigan with the denial of payment remedy. Out of the identified 141 sanctioned nursing homes, 95 received Medicaid payments during the sanction periods in our audit. We identified 1,613 paid claims for services provided during the sanction period and amounting to \$1,967,055. We reviewed a statistical sample of 100 paid claims representing payments of \$114,466. Details of our sampling methodology are presented in Appendix A.

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 that 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 offices of the Michigan Department of Community Health and the Michigan Department of Consumer & Industry Services in Lansing, Michigan from March 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 500 nursing homes surveyed, the State properly identified 141 nursing homes that were out of compliance with quality of care standards but did not have adequate controls to prevent improper Medicaid payments for new admissions to these sanctioned nursing homes.

From the nursing homes surveyed, 84 warranted the mandatory denial of payment remedy and 57 warranted the optional denial of payment sanctions. 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. 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 additional nursing homes having three consecutive surveys with substandard quality of care findings or continuing noncompliance three months after the survey, thus warranting mandatory denial of payment sanctions. We did not assess whether additional nursing homes should have been placed under optional denial of payment sanctions.

#### *Payments Made to Sanctioned Nursing Homes*

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. From a statistical sampling of 100 payments to nursing homes under sanction, 24 unallowable payments totaling \$31,598 (\$17,564 Federal share) were made to 15 nursing homes. Based on the results of the statistical sample, we estimate unallowable Medicaid payments, amounting to \$509,670 (\$280,879 Federal share), were made to nursing homes under the denial of payment sanction. The overpayments were associated with 12 nursing homes under mandatory denial of payment sanctions (\$25,142) and 3 homes under optional denial of payment sanctions (\$6,456). The State controls were not adequate to prevent all improper Medicaid payments to nursing homes under sanction. The following schedule summarizes the results of our review.

<b>Nursing Home</b>	<b>Sanction Start</b>	<b>Sanction End</b>	<b>Resident Count</b>	<b>Sanction Days</b>	<b>Questioned Costs</b>	<b>Federal Share</b>
1	6/9/2001	7/23/2001	1	7	\$693	\$389
2	8/18/2001	11/7/2001	1	30	3,396	1,908
3	7/30/2001	9/7/2001	1	7	869	488
4	2/2/2001	5/8/2001	1	8	742	417
5	2/17/2001	5/11/2001	2	14	1,189	668
6	4/10/2000	6/12/2000	1	6	688	379
7	6/29/2001	8/2/2001	1	19	1,934	1,087
8	3/15/2000	4/18/2000	1	5	338	186
9	3/15/2000	4/27/2000	2	2	354	195
10	3/14/2001	5/10/2001	1	16	1,276	717
11	8/8/2001	9/30/2001	1	1	114	64
12	7/12/2000	8/25/2000	1	25	2,482	1,368
13	3/15/2000	7/18/2000	3	53	5,551	3,059
14	3/12/2000	7/3/2000	4	79	6,563	3,617
15	7/25/2000	10/30/2000	3	65	5,409	3,022
<b>15</b>			<b>24</b>	<b>337</b>	<b>\$31,598</b>	<b>\$17,564</b>

### ***Criteria Application***

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.

Medicaid payments made by the State for new admissions during the sanction period are unallowable.

### **RECOMMENDATION**

We recommend that the State:

- Refund \$17,564 to the Centers for Medicare & Medicaid Services for the Federal share of identified unallowable payments.
- Identify and refund additional overpayments for unallowable payments made during the sanction period, estimated to be \$509,670 (Federal share \$280,879).
- Implement procedures to ensure the timely suspension of payments to providers under the denial of payment remedy.

## **State Agency Comments**

State agency officials agreed with the findings and generally agreed with all three recommendations. The full text of the State agency's response is included as Appendix B to this report.

# **APPENDICES**

## SAMPLING METHODOLOGY

### POPULATION

Paid claims to nursing homes for Medicaid services provided during the denial of payment period. The services were provided during the period of October 1, 1999 through September 30, 2001. The universe consisted of 1,613 paid claims totaling \$1,967,055.

### SAMPLE DESIGN

A statistical random sample was used for this review. The Random Number Generator through the *OAS Statistical Sampling Software RATS-STATS* was used to select the random sample.

### RESULTS OF SAMPLE

The results of our review are, as follows:

<b>Number Of Claims</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Errors</b>	<b>Value of Errors</b>
1,613	100	\$114,466	24	\$31,598

The point estimate of the sample was \$509,670 with a lower limit at the 90% confidence interval of \$318,788.





JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

March 30, 2004

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

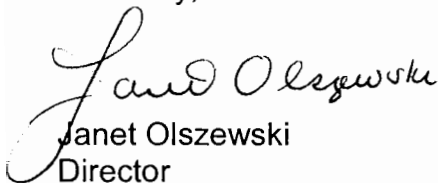
Re: Report Number (A-05-03-00052)

Dear Mr. Swanson:

Enclosed is the Michigan Department of Community Health's response to the draft report entitled "Audit of Nursing Homes and Denial of Payment Remedies – State of Michigan" that covered the period October 1, 1999 through September 30, 2001.

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Jim Hennessey at (517) 335-5323.

Sincerely,

  
Janet Olszewski  
Director

JO:kk

Enclosure

cc: Michael Ezzo  
Paul Reinhart  
Nick Lyon  
Dave McLaury  
Jim Hennessey

**Audit of Nursing Homes and Denial of Payment Remedies – State of Michigan****MDCH Response**

Finding Title: Payments Made to Sanctioned Nursing Homes

Recommendations:

We recommend the State Agency:

Refund \$17,564 to the Centers for Medicare & Medicaid Services (CMS) for the Federal share of identified unallowable payments.

Identify and refund additional overpayments for unallowable payments made during the sanction period, estimated to be \$506,709 (Federal share \$280,879).

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

Response:

The MDCH agrees with the finding that it needs to improve its controls to prevent improper Medicaid payment to sanctioned nursing homes, and generally agrees with all three recommendations.

With respect to the first recommendation, the MDCH has recovered \$14,075 of the \$31,598 from the identified nursing homes and has returned the \$7,866 federal share. For the remaining \$17,523 (\$9,698 federal share), the MDCH has been unable to confirm whether these were actually new admissions subject to the payment sanctions. All of the facilities related to the remaining \$17,523 were sold subsequent to the sanction period and are under new ownership. The MDCH will review these cases and refund the federal share if required by federal regulations. However, even if it is determined that the payments were subject to the sanctions, there are circumstances where repayment of the federal share is not required in cases such as facility closure or bankruptcy.

The MDCH agrees and has substantially complied with the second recommendation. The MDCH has reviewed the entire universe of 1,614 potentially unallowable claims identified during the audit period. Through this review, the MDCH identified 330 unallowable claims totaling \$410,442, 211 potentially unallowable claims totaling \$334,775 for nursing providers that have had a change in ownership subsequent to the sanction period, and 34 unallowable claims totaling \$40,326 pertaining to providers that are in bankruptcy. All of the remaining claims totaling \$943,687 were found to be allowable. For the 330 claims, the entire \$410,442 has been collected from the subject nursing home providers and the federal share returned. The MDCH has not yet completed its review of the 211 claims pertaining to providers that had a change in ownership. A final determination for these claims will be completed when the final settlements are processed and the federal share of any identified overpayment will be returned. The MDCH is not required to return the federal share for the 34 claims involving providers that are in bankruptcy.

In response to the third recommendation, the MDCH has implemented post payment review procedures to more timely identify, recover, and return the federal share of any overpayments made to nursing facilities that are under a denial of payment remedy. Specifically, the MDCH has implemented the following:

- The Medical Services Administration (MSA) notifies nursing home providers in writing when it has determined that the provider is subject to the payment sanctions for new admissions, and when the sanction has been removed.
- On a quarterly basis, MSA will perform query of its paid claims database to determine if any new admissions occurred during the sanction period.
- For any new admissions identified through the above query, a letter is sent to the nursing home provider asking for documentation to confirm whether the identified recipients were actually new admissions subject to the payment sanctions. MSA then processes claim adjustments to recover any unallowable payments and the federal share is refunded to CMS.

In addition to the above, the MDCH has decided to replace its legacy MMIS system. It is expected that the new system, which is targeted for implementation in FY 05, will include edits to identify and prevent payments from being processed for new admissions during the sanction period.

## ACKNOWLEDGMENTS

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

Mike Barton, *Audit Manager*  
Mitchell Collier, *Senior Auditor*  
Kathryn Cartwright, *Auditor*  
Mano Hardies, *Auditor*  
Clarence Hightower, *Auditor*  
Aner Sanchez, *Auditor*

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