



Client Alert

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OIG Report Finds Skilled Nursing Facilities Often Fail to Meet Requirements for Care and Discharge Planning

As part of its ongoing scrutiny of Skilled Nursing Facilities (SNF), the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released its latest report, *Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements*, OEI-02-09-00201, on February 28, 2013. The report is the latest in a series of studies examining SNF payments and quality of care, which have launched and informed a number of recent OIG investigations. In December 2010, the OIG reported on *Questionable Billing by Skilled Nursing Facilities*, OEI-02-09-00202, asserting that from 2006 to 2008, SNFs increasingly billed for higher paying categories, even though, it said, beneficiary characteristic remained largely unchanged. In November 2012, the OIG's report, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, announced that SNFs had billed one-quarter of claims in error in 2009, causing \$1.5 billion in inappropriate Medicare payments. Of significance to the current study, the November 2012 Report also concluded that, for 47 percent of claims, SNFs had misreported information on the beneficiary assessment used to create care plans.¹

To ensure quality of care, SNFs are required to develop a customized care plan for each beneficiary based on the beneficiary's medical, nursing, and psychosocial needs, and to provide services in accordance with the care plans. Similarly, to ensure safe transitions to the next care setting, SNFs are required to plan for each beneficiary's discharge to another care setting or home, and to provide a post-discharge plan of care. In order to be eligible for Medicare reimbursements for SNF stays, the care and discharge plans must comply with Medicare requirements for the plans, and the beneficiary must have received the services described in the plans.

The objectives of the most recent study were: 1) to determine the extent to which SNFs met Medicare requirements for care planning; 2) to determine the extent to which SNFs met Medicare requirements for discharge planning; and 3) to describe instances of poor quality care provided by SNFs. To conduct the study, the OIG selected a stratified simple random sample of 245 SNF stays with dates of service in 2009, which was then refined to include only stays that were for 21 days or longer, because care plans must be completed within

¹ An upcoming Report, *Adverse Events in Post-Acute Care: Skilled Nursing Facilities*, OEI-06-11-00370, is expected to review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to SNFs.

21 days of admission to an SNF.² This resulted in a sample of 190 stays, for which care plans were included, which the OIG projected to 1,104,692 stays in the population. In analyzing the discharge plans, the sample was further reduced to 83 stays, as the “analysis did not include stays in which the beneficiaries died, went to the hospital unexpectedly because of medical emergencies, or remained in the SNFs after the Part A stays ended.” (*Report*, p. 6)

For each stay, the OIG’s contractor collected the medical records for each of the beneficiaries. Three registered nurses with SNF experience reviewed the records and “consulted with the therapists [i.e., a physical therapist, an occupational therapist, and a speech therapist] as needed.” (*Id.*) The reviewers used a standardized data collection instrument that had been tested to ensure consistency among the reviewers, and “also identified any instances of poor quality care that they determined to be egregious.” (*Id.*)

The medical reviewers concluded that the SNFs did not develop care plans that met requirements or provide services in accordance with care plans for 37 percent of stays, and that Medicare paid approximately \$4.5 billion for these stays. According to the reviewers, for 26 percent of stays, the SNFs’ care plans did not meet at least one of the Medicare requirements for care plans; for 19 percent of stays, the SNFs developed care plans that did not address one or more problem areas identified in the beneficiaries’ assessments; for 7 percent of stays, the SNFs’ care plans did not include measurable objectives or detailed timeframes; and for 2 percent of stays, an interdisciplinary team did not complete the care plans. The reviewers also noted that care plans were not always customized to the beneficiaries’ needs. The medical reviewers further determined that for 15 percent of stays, the SNFs failed to provide at least one service as prescribed in the care plans – and reported examples in which SNFs provided fewer services than were prescribed in the care plans.

With respect to discharge planning, the medical reviewers reported that, for 31 percent of stays, the SNFs failed to meet at least one of the discharge planning requirements, and that Medicare paid approximately \$1.9 billion for these stays. According to the reviewers, for 16 percent of stays, SNFs did not have summaries of the beneficiaries’ stays or statuses at discharge, and for 23 percent of stays, SNFs did not have post-discharge plans of care.

Within the medical records, the reviewers identified a number of “egregious examples of poor quality care,” including three instances in which SNFs provided poor wound care; five instances in which SNFs did not appropriately manage beneficiaries’ medications; and two instances in which SNFs provided inappropriately high levels of therapy to beneficiaries. The OIG further linked the latter two findings of poor medication management and inappropriate therapy to its previous reports on both issues: *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150, May 2011, and *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

² The sample of 245 stays was the same sample used to conduct the November 2012 study, *Inappropriate Payments To Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*.

Based on the findings in the report, the OIG recommended that the Centers for Medicare & Medicaid Services (CMS) strengthen its oversight of SNFs and, specifically, that CMS:

- 1) Strengthen the regulations on care planning and discharge planning;
- 2) Provide guidance to SNFs to improve care planning and discharge planning;
- 3) Increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable;
- 4) Link payments to meeting quality-of-care requirements; and
- 5) Follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality of care.

The report notes that CMS concurred with all five recommendations.

In fiscal year 2012, Medicare payments for SNF services totaled \$32.2 billion. With the Medicare population and care costs both expected to swell in the next two decades, SNFs can expect further scrutiny of their care practices and their billings, as well as increased oversight and stricter regulations generally.

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