Spotlight On... Skilled Nursing Facilities

Consider this scenario: a patient with a bedsore is admitted into a nursing facility. During her stay, she develops three more bedsores. The facility fails to track and treat each wound properly, further complicating and prolonging her healing. Unfortunately, it is not hypothetical - OIG found this and many other examples of substandard care while conducting a recent review of skilled nursing facilities (SNF [pronounced "sniff"]).

A SNF is a nursing home that provides skilled nursing care; rehabilitation services like physical, occupational, or speech therapy; and other services such as assistance with eating, bathing, and toileting. When SNFs are managed properly and administer quality care, as is most often the case, they can be a vital part of a patient's recovery. Medicare spent more than $32 billion on SNFs in fiscal year 2012 alone. However, OIG has found that not all the money is well spent.

A recent OIG report found that SNFs often did not meet quality-of-care requirements. SNFs are required to develop care plans that describe the patient's medical, nursing, and psychosocial needs and describe how they will meet these needs. Yet for 37 percent of SNF stays in 2009, either the plan did not meet Medicare requirements or the care was not administered according to the plan. For example, a care plan did not address a patient's specific problems or a patient did not receive a service that was listed in his or her care plan. Medicare paid approximately $4.5 billion for stays that had such care-plan problems.

In addition, SNFs must produce a discharge plan to safely transition the patient into his or her new setting at the end of the stay. For 31 percent of stays, the discharge plan was missing at least one of the required elements - a summary of the patient's stay, the patient's status at discharge, or the post-discharge plan of care - putting the patient's future health at risk. Medicare paid approximately $1.9 billion for stays that had deficient discharge plans.

This is not the first time OIG uncovered questionable practices at SNFs. The current Medicare payment system provides incentives to SNFs to bill for more expensive levels of care that include therapy, even when those levels of care may not be necessary. OIG found that one-quarter of all SNF claims in 2009 were incorrect, $1.5 billion in total. The majority of the incorrect claims were billed for higher amounts than owed. OIG also found that from 2006 to 2008, SNFs increasingly billed for more expensive levels of care. For-profit SNFs were far more likely than nonprofit or government SNFs bill for expensive levels of care, raising concerns about the validity of the claims.

OIG may investigate a SNF when we suspect that overbilling is not simply a mistake but part of a fraud scheme. In one example, RehabCare Group, Inc., in Ohio, allegedly billed for medically unnecessary therapy in order to falsely inflate claims. RehabCare settled for $399,780 and entered into a corporate integrity agreement, meaning they agree to be monitored by OIG for a certain time.

Fraud and problems with the SNF payment system waste taxpayer dollars and threaten the integrity of Medicare. However, issues OIG uncovered with regard to quality of care are even
more disturbing. Notably, **OIG found that 74% of the facilities surveyed in 2007 had at least one quality-of-care deficiency.** A more recent report also identified several egregious examples of poor-quality wound care, medication management, and therapy. In one case, a SNF physician gave antipsychotic drugs to a patient with no history of mood disorders or psychosis. Despite noting that the patient was confused while on this drug, the physician increased the dosage. This is consistent with prior work on the use of antipsychotic drugs in nursing homes. OIG reviewed medical records of Medicare nursing home patients taking **atypical antipsychotic drugs** and found nearly all failed to meet all Medicare requirements for patient assessments or care plans. (For more information on OIG's work on antipsychotic drugs, read the Inspector General's op-ed and the report [Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents](OEI-07-08-00150).)

Although most examples of inappropriate billing and substandard care represent the exceptions, cumulatively these findings raise concerns about what Medicare is paying for when funding SNF care. Overbilled therapy, substandard services, poorly planned or mismanaged care: these problems clearly need to be addressed. While the Centers for Medicare & Medicaid Services (CMS) has recently made changes to SNF payments, more needs to be done to reduce overbilling and ensure quality of care. For example, OIG recommends that CMS increase its monitoring of SNF payments, especially for the more expensive levels of care that include therapy, and adjust the rates annually if necessary. Furthermore, CMS should change how it determines appropriate therapy levels and follow up on all questionable billing and payment errors. CMS should strengthen regulations on care planning and discharge planning, while holding accountable those that do not meet these regulations. In addition, in line with current trends in emphasizing coordinated health care, OIG recommends that payments for SNF care should be linked to meeting quality-of-care requirements. This would ensure that SNFs would be committed to providing worthwhile health care and help prevent the quality and payment problems OIG all-too-often uncovers.

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**Criminally Poor Care:**
**Nursing Home Owner Convicted of Billing for Worthless Services**

George Houser owned and operated several nursing facilities in the Atlanta, Georgia, region for which he accepted almost $33 million in Medicare and Medicaid funds. However, OIG investigators found that he neglected to buy food and basic nursing and hygiene supplies for the 400 residents. He failed to fix leaky roofs, provided worthless heating/air conditioning systems, and did not pay for trash service, resulting in insects and rodents living in the buildings. One patient eventually died while in this facility, suffering from serious malnutrition and dehydration. Billing for services that were of no value or worse, Houser's claims to Medicare and Medicaid were fraudulent. He was convicted of health care fraud and sentenced to 20 years in prison and ordered to pay $6.7 million in restitution.
Future Work on Skilled Nursing Facilities

OIG continues to study SNFs through upcoming work on adverse events, a preventable or nonpreventable event that causes harm to a patient as a result of medical care. OIG previously examined adverse events in hospitals and is doing similar work on SNFs. The study will report on the incidence, preventability, and costs to Medicare for patients experiencing an adverse event while receiving care at a SNF. The report will also describe factors contributing to the events, such as problems in the transition from a hospital to a SNF.