Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS

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Inspector General

February 2013
OEI-02-09-00201

EXECUTIVE SUMMARY: SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS
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WHY WE DID THIS STUDY

Skilled nursing facilities (SNF) are required to develop a care plan for each beneficiary and provide services in accordance with the care plan, as well as to plan for each beneficiary's discharge. These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another. Several Office of Inspector General studies and investigations found that SNFs had deficiencies in quality of care, did not develop appropriate care plans, and failed to provide adequate care to beneficiaries. In fiscal year 2012, Medicare paid $32.2 billion for SNF services. This study is part of a larger body of work about SNF payments and quality of care.

HOW WE DID THIS STUDY

We based this study on a medical record review of a stratified simple random sample of SNF stays from 2009. The reviewers determined the extent to which SNFs developed care plans that met Medicare requirements, provided services in accordance with care plans, and planned for beneficiaries' discharges as required. Reviewers also identified examples of poor quality care.

WHAT WE FOUND

For 37 percent of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Medicare paid approximately $5.1 billion for stays in which SNFs did not meet these quality-of-care requirements. Additionally, reviewers found examples of poor quality care related to wound care, medication management, and therapy. These findings raise concerns about what Medicare is paying for. They also demonstrate that SNF oversight needs to be strengthened to ensure that SNFs perform appropriate care planning and discharge planning.

WHAT WE RECOMMEND

We recommend that the Centers for Medicare & Medicaid Services (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 care. CMS concurred with all five of our recommendations.

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OBJECTIVES

1. To determine the extent to which skilled nursing facilities (SNFs) met Medicare requirements for care planning.
2. To determine the extent to which SNFs met Medicare requirements for discharge planning.
3. To describe instances of poor quality care provided by SNFs.

BACKGROUND

SNFs provide skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. In fiscal year (FY) 2012, Medicare paid $32.2 billion for SNF services.[1] To participate in Medicare, SNFs must meet certain quality-of-care requirements. SNFs must develop a care plan for each beneficiary and provide services in accordance with the care plan, as well as plan for each beneficiary's discharge.[2] These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another.

The Office of Inspector General (OIG) has identified a number of problems with the quality of care provided in nursing facilities. Notably, OIG found that 74 percent of nursing facilities surveyed in 2007 had at least one deficiency related to quality of care.[3] Another OIG report about psychosocial services found that SNFs often did not develop appropriate care plans or provide all services identified in care plans.[4] In another report about atypical antipsychotic drugs, OIG found that nearly all records reviewed failed to meet one or more Medicare requirements for beneficiary assessments or care plans.[5] OIG also

[1] Centers for Medicare & Medicaid Services (CMS), *2012 CMS Statistics*, Table III.6. Accessed at https://www.cms.gov/ResearchGenInfo/02_CMSStatistics.asp on September 14, 2012. Note that 9.3 million Americans, or 21 percent of all Medicare enrollees in 2008 (see the CMS Web site at https://dnav.cms.gov/), were eligible for both Medicare and Medicaid and participated in both programs.

[2] Social Security Act (SSA), § 1819(b)(2) and (c)(2), 42 U.S.C. § 1395i-3(b)(2) and (c)(2), 42 CFR § 483.20(k) and (l).

[3] OIG, *Trends in Nursing Home Deficiencies and Complaints*, OEI-02-08-00140, *September* 2008.

[4] OIG, *Psychosocial Services in Skilled Nursing Facilities*, OEI-02-01-00610, March 2003.

[5] OIG, *Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*, OEI-07-08-00151, July 2012.

found quality-of-care problems associated with beneficiaries discharged between SNFs and other facilities.[6]

Further, recent investigations have found a number of SNFs that failed to provide adequate care to beneficiaries. In one case, five facilities did not provide adequate staffing and services to beneficiaries, resulting in beneficiaries' developing pressure ulcers, malnutrition, dehydration, and side effects from not receiving medications.[7] In another case, three facilities were charged with providing inadequate food and medication to beneficiaries.[8] In a third case, inadequate staffing caused numerous beneficiaries to develop pressure ulcers, some of which were left untreated.[9]

This study is part of a larger body of work about SNF payments and quality of care. The first study found that from 2006 to 2008, SNFs increasingly billed for higher paying categories, even though beneficiary characteristics remained largely unchanged.[10] Another study found that SNFs billed one-quarter of claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments.[11] Moreover, the study found that for 47 percent of claims, SNFs misreported information on the beneficiary assessment, which is used to create care plans. Lastly, an upcoming study will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to SNFs.[12]

Medicare Coverage Requirements for Part A SNF Stays

The Part A SNF benefit covers skilled nursing care, rehabilitation services, and other services. These services commonly include physical, occupational, and

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[6] OIG, *Consecutive Medicare Stays Involving Inpatient and Skilled Nursing Facilities*, OEI-07-05-00340, June 2007.

[7] Department of Justice (DOJ), *Cathedral Rock Nursing Homes and a Nursing Home Operator Resolve Criminal and Civil Health Care Fraud Allegations Related to Failure of Care and Agree to Pay the United States over $1.6 Million*, January 7, 2010. Accessed at http://www.justice.gov/usao/moe/press_releases/archived_press_releases/2010_press_releases/january/cathedral_rock.html on November 10, 2011.

[8] DOJ, *Rome Couple Charged With $30 Million Medicare & Medicaid Fraud Through Failure of Care at Three Nursing Homes*, April 16, 2010. Accessed at http://www.justice.gov/usao/gan/press/2010/04-16-10b.pdf on November 10, 2011.

[9] Keenan Cummings, "Nursing Home Puts Residents in Jeopardy," *The Daily Athenaeum*, December 6, 2007.

[10] OIG, *Questionable Billing by Skilled Nursing Facilities*, OEI-02-09-00202, December 2010.

[11] OIG, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

[12] OIG, *Adverse Events in Post-Acute Care: Skilled Nursing Facilities*, OEI-06-11-00370, forthcoming.

speech therapy; skin treatments; and assistance with eating, bathing, and toileting. Medicare covers these services for up to 100 days during any spell of illness.[13]

To qualify for the SNF benefit, the beneficiary must have been in the hospital for at least 3 consecutive days and the hospital stay must have occurred within 30 days of the admission to the SNF.[14] The beneficiary must need skilled services daily in an inpatient setting and must require the skills of technical or professional personnel to provide these services.[15] In addition, these services must be ordered by a physician and must be for the same condition that the beneficiary was treated for in the hospital.[16]

Medicare Requirements Related to Quality of Care

To ensure quality of care, SNFs are required to develop a care plan for each beneficiary and provide services in accordance with care plans.[17] Specifically, Section 1819 of the SSA requires SNFs to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each beneficiary in accordance with the care plan.[18] To ensure that beneficiaries safely transition to the next care setting, SNFs are required to plan for each beneficiary's discharge when facilities anticipate a discharge.[19]

Developing Care Plans and Providing Services. SNFs are required to develop care plans that describe the beneficiary's medical, nursing, and psychosocial needs and how the SNF will meet these needs.[20] Care plans must include measurable objectives and timetables and be customized to the beneficiary.[21] To develop a care plan, SNFs use a tool called the Minimum Data Set (MDS) to assess the beneficiary's clinical condition, functional status, and

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[13] SSA, § 1812(a)(2)(A), 42 U.S.C. § 1395d(a)(2)(A).

[14] 42 CFR § 409.30(a)(1) and (b)(1).

[15] 42 CFR §§ 409.31(b)(1) and (3) and 409.31(a)(2).

[16] 42 CFR § 409.31(a)(1) and (b)(2). Medicare also covers SNF services if the condition requiring such services arose when the beneficiary was receiving care in a SNF for a condition treated during the prior hospital stay.

[17] SSA, § 1819(b)(2) and (c)(2), 42 U.S.C. § 1395i-3(b)(2) and (c)(2), 42 CFR § 483.20(k).

[18] SSA, § 1819(b)(2), 42 U.S.C. § 1395i-3(b)(2).

[19] 42 CFR § 483.20(l).

[20] SSA, § 1819(b)(2), 42 U.S.C. § 1395i-3(b)(2).

[21] 42 CFR § 483.20(k)(1). See also CMS, *Revised Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0 (RAI Version 2.0 Manual)*, Dec. 2002, rev. Dec. 2008, § 1.1. The *RAI Manual* was updated October 2010 to Version 3.0 (*RAI Version 3.0 Manual*); however, we used the 2008 revision of version 2.0 because it was in effect during the time period we were studying.

expected and actual use of services.[22] SNFs must develop the care plan within 7 days of this assessment and no more than 21 days after admission.[23] Depending upon the responses to the assessment, different Resident Assessment Protocols (RAP) may be "triggered" that indicate the beneficiary may be at risk for certain problems, such as delirium, falls, and pressure ulcers.[24] See Appendix A for a list of all the RAPs.

If a RAP is triggered, the SNF must assess the beneficiary further to determine whether the beneficiary is at risk of developing, or currently has, the problem associated with that RAP. If so, the SNF must specify in the beneficiary's care plan how the SNF will prevent or address the problem.[25] If the SNF determines that the RAP problem area does not need to be addressed in the care plan, the SNF must document the reason in the medical record.[26]

An interdisciplinary team that includes at least the attending physician and a registered nurse with responsibility for the beneficiary must prepare the care plan.[27] In addition, to the extent practicable, the beneficiary, the beneficiary's family, or the beneficiary's legal representative should participate in the initial care planning.[28] This participation helps to ensure that the interdisciplinary team develops a care plan that addresses all of the beneficiary's needs.[29]

Discharge planning. When the SNF anticipates the discharge of a beneficiary to another care setting or home, it must plan for the discharge. As part of this planning, the SNF must develop a discharge summary to help ensure that the beneficiary's care is coordinated and that the beneficiary transitions safely to his

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[22] 42 CFR §§ 483.315(e) and 483.20(d); *RAI Version 2.0 Manual*, § 2.3. The MDS is part of a comprehensive assessment called the Resident Assessment Instrument (RAI); the RAI also includes Resident Assessment Protocols and Utilization Guidelines. CMS implemented a new version of the MDS for FY 2011. The new version puts more focus on assessing the beneficiary for certain MDS items through interviews with the beneficiary rather than on observations or document reviews. See *RAI Version 3.0 Manual,* § 1.5.

[23] SSA, § 1819(b)(3)(C), 42 U.S.C. § 1395i-3(b)(3)(C); 42 CFR § 483.20(b)(2)(i); 42 CFR § 483.20(k)(2)(i). See also *RAI Version 2.0 Manual*, §§ 2.2 and 2.3. Specifically, the admission assessment must be completed within 14 days of the admission date, and the care plan must be completed within 7 days of the completion of the admission assessment.

[24] *RAI Version 2.0 Manual,* §§ 4.1 and 4.2. As of October 1, 2010, CMS updated the RAPs and renamed them "Care Area Assessments" (CAA). See *RAI Version 3.0 Manual*, ch. 3, section V.

[25] *RAI Version 2.0 Manual,* § 4.2.

[26] Ibid., § 4.6.

[27] SSA, § 1819(b)(2)(B), 42 U.S.C. 1395i–3(b)(2)(B).

[28] Ibid.

[29] CMS, *State Operations Manual [SOM]*, Appendix PP, Tags F279 and F280.

or her new setting. The discharge summary should include a summary of the beneficiary's stay, a summary of the beneficiary's status at the time of discharge, and a post-discharge plan of care.[30] The post-discharge plan of care should describe what the beneficiary's and family's preferences for care are, how the beneficiary and family will access these services, how care should be coordinated if continuing treatment involves multiple caregivers, and what education or instructions should be provided to the beneficiary and his or her family.[31]

Monitoring by State Surveyors

CMS contracts with State Survey and Certification agencies to determine whether nursing facilities are in compliance with Medicare requirements.[32] The State agencies conduct periodic surveys of each facility. If facilities are out of compliance with one or more requirements, surveyors cite them for deficiencies. In 2011, 22 percent of facilities surveyed did not meet care planning requirements, 14 percent did not provide services in accordance with care plans, and 1 percent did not meet the discharge planning requirements.

When facilities are cited for deficiencies, CMS or the State may choose to impose a number of different enforcement actions depending upon the scope and severity of the deficiencies found.[33] These actions include requiring a plan of correction, denying future payment, or terminating the provider agreement.

METHODOLOGY

We based this study on a medical record review of a stratified simple random sample of Part A SNF stays from calendar year 2009.

Selection of Sample for Medical Review

Using CMS's National Claims History File, we first identified all Part A SNF claims with dates of service in 2009. We grouped these claims by stay using the admission dates and identified the stays that ended in 2009. We then grouped these stays into three strata defined by the length of the stay and the number of claims. We selected a stratified simple random sample of 245 stays. See

[30] 42 CFR § 483.20(l).

[31] CMS, *SOM,* Appendix PP, Tags F283 and F284.

[32] CMS, *SOM*, ch. 1, §§ 1004 and 1016. The surveys are conducted in accordance with CMS's *SOM*. This manual includes the interpretive guidelines that surveyors follow to determine whether a facility complies with Medicare requirements.

[33] CMS, *SOM*, ch. 7.

Appendix B for more information about how we selected the sample. We used this sample to meet the objectives of this study and a companion study.[34] In our companion study, we included all stays. However, for this study, we focused on the stays that were 21 days or longer, because care plans must be completed within 21 days of admission to a SNF. This resulted in a sample of 190 stays that projects to 1,104,692 stays in the population.

Medical Record Review

We used a contractor to collect the medical records for each of the beneficiaries associated with the sampled stays. The contractor requested the medical record for each stay, which included the care plan; the beneficiary assessment, including the MDS and RAP information; and the post-discharge care plan; as well as physician orders, progress notes, therapy records and logs, and other documentation of the services that the beneficiary received. We had a 100-percent response rate.

We also contracted with medical record reviewers, who consisted of three registered nurses, each of whom had at least 12 years of SNF experience; and a physical therapist, an occupational therapist, and a speech therapist. The nurses reviewed the records and consulted with the therapists as needed. The reviewers used a standardized data collection instrument that was developed in accordance with the Medicare requirements related to care planning, provision of services, and discharge planning. The reviewers also identified any instances of poor quality care that they determined to be egregious. The instrument was developed in collaboration with the reviewers and tested on a sample of stays.[35] The reviewers conducted the medical review between April and September 2011.

Analysis

Care Planning and Provision of Services. To determine the extent to which SNFs developed care plans and provided services in accordance with care plans, we analyzed the data from the medical record review. We identified the stays in which the care plans: (1) did not address one or more RAPs (hereinafter referred to as "problem areas") and provided no explanation in the medical

[34] The companion study is *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

[35] We conducted a preliminary review of a separate sample of 10 stays to test the instrument and to ensure consistency among the reviewers.

records; (2) lacked measurable objectives and detailed timeframes, i.e., duration or frequency; or (3) were not completed by an interdisciplinary team.

For each stay, we determined whether care plans contained measurable objectives and detailed timeframes for the following eight categories of services: (1) scheduled toileting plans or bladder retraining programs, (2) parenteral IV or feeding tubes, (3) skin treatments, (4) speech therapy, (5) occupational therapy, (6) physical therapy, (7) respiratory therapy, and (8) restorative nursing services.

Next, we identified the stays in which the SNFs did not provide services in accordance with care plans. Using the same service categories, we determined whether the duration and frequency of services provided was consistent with the duration and frequency called for in the care plans. We did not include instances when frequency was not applicable, such as the use of a specialized mattress, or when the duration of a service was understood without additional documentation, such as the dressing of a wound until it has healed. We also did not include instances when the SNFs changed the duration or frequency of services and provided explanations in the medical records. For example, if the record indicated that services were missed because the beneficiary refused treatment or was ill, we considered the frequency of services provided to be consistent with the care plan.

Using our sample results, we estimated the percentage of all stays in the population that the care plans did not meet one or more Medicare requirements. We also estimated the percentage of all stays in the population in which the SNFs did not provide services in accordance with the care plans.

Discharge Planning. To determine the extent to which SNFs planned for each beneficiary's discharge, we identified each stay that did not have a summary of the stay and status at discharge and post-discharge plan of care. We based this analysis on stays for which the SNFs should have planned for the beneficiaries' discharge. Specifically, the analysis included 83 stays in which the beneficiaries were discharged to another institutional setting (e.g., another nursing facility or a hospital) or to the community (e.g., a group home or the beneficiaries' own homes).[36] Using our sample results, we estimated the percentage of all stays in

[36] This 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.

the subpopulation described above in which the SNFs did not meet discharge planning requirements.

Poor Quality Care. As part of the medical record review, we asked the reviewers to identify examples of poor care that that they determined to be egregious. We analyzed their responses and grouped them into common areas of concern.

Limitations

This report was based solely on a medical record review. It does not identify all instances of poor quality care. It highlights examples that reviewers determined were egregious on the basis of their review of the medical records. Reviewers did not systematically review the records for poor quality care provided during each stay.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For 37 percent of stays, SNFs did not meet care plan or service requirements

For 37 percent of stays, the SNFs did not develop care plans that met requirements or provide services in accordance with care plans. Medicare paid approximately $4.5 billion for these stays, which did not meet these quality-of-care requirements. See Table 1 for the percentage of stays in which SNFs did not meet care plan and service requirements. See Appendix C-1 for the point estimates and confidence intervals.

Table 1: Percentage of Stays in Which SNFs Did Not Meet Care Plan or Service Requirements, 2009

Requirements	Percentage of Stays in Which SNFs Did Not Meet Requirements	Medicare Payments for Stays in Which SNFs Did Not Meet Requirements
Care plan requirements	25.6%	$3.1 billion
Service requirements	15.4%	$2.0 billion
Total	**36.7%**	**$4.5 billion**

Source: Office of Inspector General medical record review, 2012.

Note: The rows do not sum to the total because some stays met neither the care plan requirements nor the service requirements.

For 26 percent of stays, SNFs did not develop care plans that met requirements

SNFs are required to develop care plans that address problem areas identified in beneficiaries' assessments, include measurable objectives and detailed timeframes, and are completed by an interdisciplinary team. These requirements help to ensure that beneficiaries' needs are addressed and that care plans provide clear, individualized instructions about the most appropriate care for each beneficiary. For 26 percent of stays, the SNFs' care plans did not meet at least one of the requirements. See Table 2 for the percentage of stays in which SNFs did not meet the specific requirements.

Table 2: Percentage of Stays in Which SNFs Did Not Meet Care Plan Requirements, 2009

Care Plan Requirements	Percentage of Stays in Which SNFs Did Not Meet Care Plan Requirements
Care plans address problem areas identified in the assessments	19.2%
Care plans have measurable objectives and detailed timeframes*	6.8%
Care plans are developed by an interdisciplinary team	2.1%
Total	**25.6%**

Source: Office of Inspector General medical record review, 2012.

Note: The rows do not sum to the total because some stays did not meet two or more care plan requirements.

* The requirement states that both measurable objectives and timeframes must be in the care plan. The 6.8 percent represents the stays in which either measurable objectives or timeframes were missing.

For 19 percent of stays, SNFs developed care plans that did not address one or more problem areas identified in the beneficiaries' assessments. For example, in one stay, the SNF made no plans to monitor a beneficiary's use of antipsychotic medication that had potentially severe adverse reactions. In another stay, the SNF did not address the psychosocial needs of a beneficiary who had anxiety and made repeated health complaints. On average, beneficiaries had seven problem areas identified in their assessments. Some of the more common areas included activities of daily living, pressure ulcers, nutrition, and falls. See Appendix C-2 for the point estimates and confidence intervals for all 18 problem areas.

For 7 percent of stays, the SNFs' care plans did not include measurable objectives or detailed timeframes. These objectives and timeframes are intended to ensure that SNFs provide appropriate care in duration and frequency and that they monitor progress. Additionally, for 2 percent of stays, an interdisciplinary team did not complete the care plans. In one case, only one individual completed the care plan, and this care plan was completed after the beneficiary was discharged from the facility.

The reviewers further observed that care plans were not always customized to the beneficiaries' needs. One reviewer noted that care plans often had generic interventions or approaches and that there was not always evidence that the care plans for problem areas were developed using the information collected in the assessments. Another reviewer agreed, noting that the records had "many perfect computer-generated care plans" that were not individualized or customized for the beneficiaries. One reviewer also noted that sometimes the

records had little to no documentation that the care plans were implemented. This reviewer noted that information on restorative nursing services, toileting programs, and preventive wound care was sometimes missing from the records.

For 15 percent of stays, SNFs did not provide services in accordance with care plans

For 15 percent of stays, SNFs failed to provide at least one service at the frequency or duration prescribed in the care plans. Reviewers found several examples in which SNFs provided more services than were indicated in the care plans; these examples commonly involved therapy. SNFs have an incentive to provide more therapy than indicated in the plan of care because the amount of therapy that SNFs provide to beneficiaries largely determines the amount that Medicare pays SNFs. In one example, the SNF provided therapy for 12 continuous days without an explanation for the need for that amount of therapy. In another example, the SNF continued providing therapy even though the beneficiary had met all therapy goals.

Reviewers also found examples in which SNFs provided fewer services than were indicated in the care plans. In one example, the beneficiary was scheduled to receive assistance with toileting at least three times a day; however, the record showed that this assistance was provided much less often. In another example, the beneficiary was scheduled to receive assistance with activities of daily living every day; however, these activities were performed for the first few days and then stopped without any explanation.

For 31 percent of stays, SNFs did not meet discharge planning requirements

SNFs must provide a plan for each beneficiary being discharged to another facility or to home. The plan must have a summary of the beneficiary's stay and status at discharge, as well as a post-discharge plan of care. These requirements help ensure that care is coordinated and that the beneficiary's needs are met after discharge. Not having this information can lead to inadequate care or even to serious medical errors and life-threatening situations.

For 31 percent of stays, the SNFs failed to meet at least one of the discharge planning requirements.[37] Medicare paid approximately $1.9 billion for these stays. See Table 3 for the percentage of stays in which SNFs did not meet

[37] The point estimate is 31 percent with a 95-percent confidence interval of 21 to 43 percent.

discharge planning requirements. See Appendix C-3 for the point estimates and confidence intervals.

Table 3: Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirements, 2009

Discharge Planning Requirement	Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirement
Summary of beneficiary's stay and status at discharge	16.0%
Post-discharge plan of care	23.3%
Total	**30.9%**

Source: Office of Inspector General medical record review, 2012.

Note: The rows do not sum to the total because some stays did not meet either requirement.

For 16 percent of stays, SNFs did not have summaries of the beneficiaries' stays or statuses at discharge. Such summaries ensure that the next care provider has the necessary information regarding the beneficiary's current and prior health, including any treatments received and the beneficiary's response to them. Additionally, for several of the stays for which SNFs had summaries, the reviewers noted that the summaries had only minimum information, such as the statement "Has done well." The reviewers also found a few discharge-status summaries that contained no clinical information; this information is essential to ensuring a safe transition for the beneficiary to another care setting. In one case, the discharge status contained only the statement "[D]ischarged in stable condition, vital signs." The summaries may have lacked clinical information because physicians were not always part of the teams that completed them. For example, the reviewers noted that sometimes the discharge statuses were written by therapists and included only information regarding the beneficiaries' functional levels and therapy goals.

For 23 percent of stays, SNFs did not have post-discharge plans of care. Such instructions are essential to ensuring that the beneficiary's needs are met after discharge. In one example, the beneficiary needed specific instructions about her medication; however, the medical record noted that this was not provided. The reviewers also noted several instances when the medical records indicated that staff provided only verbal instructions to the beneficiaries.

Medical reviewers found examples of poor quality care related to wound care, medication management, and therapy

The medical reviewers found a number of egregious examples of poor quality care that were related to wound care, medication management, and therapy.

Wound care

The medical reviewers identified three instances in which SNFs provided poor wound care that may have resulted in the beneficiaries' condition worsening. Wound care refers to the various treatments provided to heal wounds, which may include application of dressings to the wound and the removal of nonviable tissue. The following two examples illustrate the issues that the reviewers found.

- A beneficiary was admitted to a SNF with a pressure ulcer. During her stay, the beneficiary developed three other pressure ulcers. The SNF had difficulty tracking and treating each wound properly, which made healing more difficult. In addition, nursing notes regarding the treatment provided for each wound were confusing and inconsistent.
- Another beneficiary developed a heel ulcer during her stay. The SNF provided inadequate wound care and neglected to provide interventions aimed at relieving pressure on the heel. The ulcer worsened considerably over the course of 2 months.

Furthermore, one medical reviewer observed that several SNFs did not include detailed information about wounds in the medical records. The reviewer noted that SNFs may not want to call attention to any pressure ulcers acquired during a beneficiary's stay. SNFs are required to report such instances to CMS. CMS then includes this data in its Nursing Home Compare Web site, which provides information to the public about each nursing facility.[38]

[38] For more information on the data collected for Nursing Home Compare, see http://www.medicare.gov/NursingHomeCompare.

Medication Management

The medical reviewers identified five instances in which SNFs did not appropriately manage beneficiaries' medications. The following two examples illustrate such issues.

- A beneficiary with dementia was given an antipsychotic drug during her SNF stay. This drug has a "black-box warning" that it is not approved for patients with dementia-related psychosis and may result in severe or life-threatening risks.[39] The medical record indicated that SNF staff and the beneficiary's roommate saw that the beneficiary was more confused, was agitated, and was not sleeping well after using the drug. However, the SNF did not address these issues in any way.
- Another beneficiary was given an antipsychotic drug when she did not have a diagnosis for psychosis and her care plan did not indicate that she had a mood disorder. The physician noted that the beneficiary was confused while on the drug, but he still increased the dosage. A month later, the beneficiary's family complained that the physician and SNF staff were trying to sedate the beneficiary with the drug.

These examples illustrate some of the same issues found in a previous OIG study.[40] That study found that 95 percent of claims for atypical antipsychotic drugs for elderly nursing facility residents were for off-label use and/or the condition specified in the black-box warning.[41] Although physicians are not prohibited from prescribing drugs for off-label use or for conditions specified in the black-box warning, Medicare will pay only for drugs that are used for medically accepted indications. The study found that 50 percent of claims did not meet this criterion.

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[39] If drug manufacturers or the Food and Drug Administration (FDA) determines during the approval process or after a drug has been approved for marketing that the drug may produce severe or life-threatening risks, FDA requires that drug manufacturers include a boxed warning (also referred to as a "black-box warning") on the product's labeling to warn prescribers and consumers of these risks. See 21 CFR § 201.57(c)(1).

[40] OIG, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150, May 2011.

[41] "Off-label use" is the term used to describe the provision of a drug for an indication other than the one approved by FDA.

Therapy

The medical reviewers identified two instances in which SNFs provided inappropriately high levels of therapy to beneficiaries given their conditions. The following illustrate these issues.

- A beneficiary received hospice care for terminal lung cancer and bone metastasis prior to SNF admission.[42] During the beneficiary's SNF stay, the SNF provided her with physical therapy 5 days a week for 5 weeks. The medical record showed that the beneficiary participated in therapy at first, but at some point, she did not want to continue. However, the SNF continued the therapy at the same intensity for the remainder of her stay until she was discharged to home with hospice care.
- Another beneficiary had a dislocated hip and could not bear weight on that side. Even though the beneficiary should not have been ambulating, the SNF provided "ultrahigh" levels of physical therapy to the beneficiary for the entire stay.[43]

These examples are consistent with the findings from a previous OIG study.[44] That study found that SNFs billed for a higher payment category than was appropriate for 20 percent of all claims in 2009. For approximately half of these claims, SNFs billed for ultrahigh levels of therapy when they should have billed for lower levels of therapy or no therapy at all. For some of these claims, the reviewers determined that the amount of therapy indicated in the beneficiary's medical record was not reasonable and necessary. As noted earlier, the amount of therapy that the SNF provides to the beneficiary largely determines the amount that Medicare pays the SNF.

[42] Metastasis is the spread of cancer from one part of the body to another.

[43] Ultrahigh therapy is the highest level of therapy a beneficiary may receive under the SNF payment system. It is 720 minutes or more of therapy per week. Medicare generally pays the most for this level of therapy.

[44] OIG, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

CONCLUSION AND RECOMMENDATIONS

SNFs are required to provide care planning and discharge planning for beneficiaries. These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another. For 37 percent of stays, SNFs did not develop care plans that met requirements or provide services that were consistent with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Medicare paid approximately $5.1 billion for stays in which SNFs did not meet these quality-of-care requirements. Additionally, reviewers found a number of examples of poor quality care related to wound care, medication management, and therapy.

These findings raise concerns about what Medicare is paying for. They also demonstrate that CMS should do more to strengthen its oversight of SNFs to ensure that they perform appropriate care planning and discharge planning for beneficiaries.

We recommend that CMS:

Strengthen the Regulations on Care Planning and Discharge Planning

CMS should revise the regulations on care planning and discharge planning to reflect current standards of practice and to address the vulnerabilities identified in this report. For example, CMS should strengthen the requirement that services be provided in accordance with care plans. Specifically, it should require SNFs to document in the medical records the reasons why they did not provide services in accordance with the care plans, similar to the existing requirement for SNFs to document the reasons why they did not develop care plans to address identified problem areas. CMS should also add a requirement that discharge planning be conducted by an interdisciplinary team, including a physician.

Provide Guidance to SNFs To Improve Care Planning and Discharge Planning

CMS should provide guidance to SNFs about care planning and discharge planning to ensure that SNFs make improvements in these areas. The guidance should reiterate and expand on the requirements. For care planning, it should emphasize the importance of addressing the problem areas identified in the beneficiary's assessment. To ensure that all of the beneficiary's needs are met, the guidance should stress that the care plan must be customized to the beneficiary and include measurable objectives and timeframes. In addition, the care plan

should be based on communication among interdisciplinary team members, the beneficiary, and the beneficiary's family. CMS should also emphasize that the care plan should be treated not as a documentation exercise but rather as an integral step in meeting the beneficiary's needs.

For discharge planning, the guidance should state that the discharge summary needs to provide an adequate clinical picture of the beneficiary and detailed individualized care instructions to ensure that care is coordinated and that the beneficiary transitions safely from one care setting to another. CMS should clarify the type of information that should be included in the discharge summary and specify that an interdisciplinary team, including a physician, should develop the summary of the beneficiary's stay and status at discharge.

Increase Surveyor Efforts To Identify SNFs That Do Not Meet Care Planning and Discharge Planning Requirements and To Hold These SNFs Accountable

State surveyors are CMS's primary tool to verify that SNFs are meeting care planning and discharge planning requirements and to enforce these requirements. CMS should increase surveyor efforts to make SNFs more accountable. It should provide more detailed guidance to surveyors to improve the detection of noncompliance, particularly for discharge planning. Specifically, CMS should revise its interpretive guidelines in the *SOM* and train surveyors to ensure that they cite facilities that are not developing individualized care plans or are not developing specific discharge plans that involve an interdisciplinary team, including a physician.

In addition, CMS should increase the use of existing enforcement remedies when SNFs do not meet care planning and discharge planning requirements. CMS should determine when enforcement actions should be taken for SNFs that are out of compliance with these requirements and which actions are most appropriate, such as increased State monitoring, a directed plan of correction, or civil monetary penalties.

Link Payments to Meeting Quality-of-Care Requirements

CMS should develop and expand alternative methods beyond the State survey and certification process to promote compliance and make improvements in the areas of care planning and discharge planning. CMS should link SNF payments more closely to meeting the requirements. To do so, it could build upon lessons learned from existing pay-for-performance incentive programs that reward SNFs for quality and improvement in care. For example, CMS could incorporate quality

measures for care planning and discharge planning in its Skilled Nursing Facility Value-Based Purchasing program.

Follow Up on the SNFs That Failed To Meet Care Planning and Discharge Planning Requirements or That Provided Poor Quality Care

We will provide CMS with a list of SNFs that failed to meet care planning and discharge planning requirements or provided poor quality care. When one problem is found, it may indicate a wider problem in the facility. CMS should provide the list to State Survey and Certification agencies to prioritize these facilities for review and determine whether enforcement actions are needed.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all five of our recommendations. CMS concurred with our first recommendation and stated that it is conducting a comprehensive review of the requirements for participation for long term care facilities to ensure that the regulations are effective and these facilities provide quality care. In addition, it has reached out to several external stakeholder groups for public input on these issues.

CMS concurred with our second recommendation and stated that its contractors, the Quality Improvement Organizations, are enrolling nursing homes in the Nursing Home Quality Care Collaborative. This initiative uses a menu of actionable items to improve the overall quality of care being received by residents and their quality of life. One of the items focused on in this initiative is care planning. CMS has also assembled a workgroup to identify areas of the *SOM* that might better address the discharge planning requirements.

CMS concurred with our third recommendation and stated that it will consider ways to increase oversight of care planning and discharge planning issues in SNFs. With regard to increasing the use of existing enforcement remedies, CMS stated that it will review the current citations related to care planning and discharge planning, including the severity determinations and enforcement actions taken, and work to develop ways to improve its enforcement efforts.

CMS concurred with our fourth recommendation and stated that it will consider incorporating care planning and discharge planning in future nursing home demonstrations. Finally, CMS concurred with our fifth recommendation and stated that it will analyze the survey data and determine appropriate methods to strengthen enforcement of CMS requirements.

We support CMS's efforts to address these issues. For the full text of CMS's comments, see Appendix D.

APPENDIX A

List of the 18 Resident Assessment Protocols

Activities
Activities of daily living functional/rehabilitation potential
Behavior symptoms
Cognitive loss
Communication
Dehydration/fluid maintenance
Delirium
Dental care
Falls
Feeding tubes
Mood state
Nutritional status
Physical restraints
Pressure ulcers
Psychosocial well-being
Psychotropic drug use
Urinary incontinence and indwelling catheter
Visual function

APPENDIX B

Sample Design

We used this sample design to meet the objectives of this study and our companion study, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200. For this study, we analyzed stay-level data from strata 2 and 3, for a total of 190 stays.

Stratum	Stratum Description	Number of Stays in Population	Number of Stays in Sample
1	Length of stay less than 21 days in 2009 and 3 or fewer claims in 2009	1,264,073	55
2	Length of stay 21 or more days in 2009 and 3 or fewer claims in 2009	435,893	45
3	Stays with over 3 claims in 2009 (by default, length of stay is more than 21 days)	668,799	145
Total		**2,368,765**	**245**

Source: Office of Inspector General medical record review, 2012.

APPENDIX C

Point Estimates, Sample Sizes, and 95-Percent Confidence Intervals for All Estimates Presented in the Report

C-1: Estimates for All Stays

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval
Stays in which skilled nursing facilities (SNF) did not meet care plan or service requirements	190	36.7%	29.7%–44.5%
Payment for stays in which SNFs did not meet care plan or service requirements	190	$4.5 billion	$3.5 billion–$5.5 billion
Payment for stays in which SNFs did not meet care plan requirements	190	$3.1 billion	$2.1 billion–$4.0 billion
Payment for stays in which SNFs did not meet service requirements	190	$2.0 billion	$1.2 billion–$2.8 billion
Stays in which SNFs did not develop care plans that met requirements	190	25.6%	19.4%–32.9%
- Care plans did not address one or more problem areas identified in the assessments	190	19.2%	13.8%–26.0%
- Care plans did not include measurable objectives or detailed timeframes	190	6.8%	3.8%–12.2%
- Interdisciplinary teams did not complete the care plans	190	2.1%	0.7%–6.0%
The average number of problem areas per beneficiary	190	7.0	6.5–7.6
Stays in which SNFs did not provide services in accordance with care plans	190	15.4%	10.5%–22.2%
Payment for stays in which SNFs did not meet care plan requirements, service requirements, or discharge planning requirements	190	$5.1 billion	$4.1 billion–$6.2 billion

Source: Office of Inspector General medical record review, 2012.

C-2: Percentage of Stays in Which Beneficiaries Had Problem Areas (Resident Assessment Protocols) Identified in Their Assessments

Resident Assessment Protocol	Sample Size	Point Estimate	95-Percent Confidence Interval
Activities of daily living functional/rehabilitation potential	190	86.1%	80.5%–90.3%
Pressure ulcers	190	81.0%	74.7%–86.0%
Nutritional status	190	69.1%	61.9%–75.5%
Falls	190	61.4%	53.9%–68.5%
Dehydration/fluid maintenance	190	55.4%	47.7%–62.8%
Urinary incontinence and indwelling catheter	190	54.0%	46.3%–61.5%
Cognitive loss	190	53.1%	45.4%–60.6%
Psychotropic drug use	190	44.2%	36.8%–51.9%
Mood state	190	40.9%	33.6%–48.7%
Psychosocial well-being	190	40.4%	33.1%–48.1%
Communication	190	33.5%	26.8%–40.9%
Visual function	190	22.5%	16.8%–29.5%
Dental care	190	21.7%	16.0%–28.7%
Delirium	190	15.4%	10.5%–22.2%
Behavior symptoms	190	10.6%	6.7%–16.4%
Activities	190	8.0%	4.9%–12.8%
Feeding tubes	190	5.5%	3.0%–9.6%
Physical restraints	190	1.3%	0.3%–5.5%

Source: Office of Inspector General medical record review, 2012.

C-3: Estimates for Stays in Which the Beneficiaries Were Discharged

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval
Stays in which SNFs did not meet discharge planning requirements	83	30.9%	21.2%–42.6%
Payment for stays in which SNFs did not meet discharge planning requirements	83	$1.9 billion	$1.1 billion–$2.7 billion
Stays in which SNFs' discharge planning did not include summaries of the stays or statuses at discharge	83	16.0%	9.0%–26.9%
Stays in which SNFs' discharge planning did not include post-discharge plans of care	83	23.3%	15.0%–34.4%

Source: Office of Inspector General medical record review, 2012.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 17 2013

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements" OEI-02-09-00201

The Centers for Medicare & Medicaid Services (CMS) would like to thank the OIG for the opportunity to review and comment on the subject OIG draft report. CMS recognizes the importance and impact of effective care planning and discharge planning on the quality of life and care for nursing home residents. The OIG's objectives for this report are to determine the extent to which skilled nursing facilities (SNFs) met Medicare requirements for care planning and discharge planning, and describe instances of poor quality care provided by SNFs.

The CMS responses to the OIG recommendations are discussed below.

OIG Recommendation 1

The OIG recommends that CMS strengthen the regulations on care planning and discharge planning.

CMS Response

The CMS concurs with this recommendation. Care planning and discharge planning are important aspects of providing quality care. CMS is currently conducting a comprehensive review of the requirements for participation for long term care facilities to ensure that the regulations are effective and these facilities provide quality care. The applicable regulatory provisions in 42 CFR Part 483, Subpart B are being reviewed for possible areas of improvement to ensure the health and safety of long-term care residents. Our review of these regulations includes consideration of timeliness, resident-centeredness, and quality improvement. In addition, CMS has reached out to several external stakeholder groups for public input on their key concerns and suggestions on these issues. We appreciate this timely and informative OIG report and will consider the results and recommendations of this study as we conclude our regulations review process.

OIG Recommendation 2

The OIG recommends that CMS provide guidance to SNFs to improve care planning and discharge planning.

CMS Response

The CMS concurs with this recommendation. Quality Improvement Organizations (QIOs), in their capacity as contractors to the Federal government, facilitate continual improvement of health care services to Medicare beneficiaries. QIOs are currently enrolling nursing homes in the Nursing Home Quality Care Collaborative (NHQCC) as part of the 10th Statement of Work. This initiative utilizes a menu of actionable items derived from high performing nursing homes to improve the overall quality of care and quality of life being received by residents. One of the items focused on in this initiative is nursing home care planning. As the NHQCC unfolds across the next 18 months, so too will our understanding of what works well in nursing home care plan development.

In addition, CMS has assembled a workgroup to identify areas of the State Operations Manual that might better address the discharge planning requirements. OIG's recommendation will be helpful as the workgroup prioritizes its efforts to improve surveyor guidance.

OIG Recommendation 3

The OIG recommends that CMS increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable.

CMS Response

The CMS concurs with this recommendation. CMS agrees with the desirability of increasing surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements. Therefore, we will consider ways to increase oversight of care planning and discharge planning issues in SNFs. With regard to increasing the use of existing enforcement remedies, we will review the current citations related to care planning and discharge planning including the severity determinations and enforcement actions taken and work to develop ways to improve our enforcement efforts.

OIG Recommendation 4

The OIG recommends that CMS link payments to SNFs meeting quality of care requirements.

CMS Response

The CMS concurs with this recommendation. CMS will consider incorporating care planning and discharge planning in future nursing home demonstrations.

OIG Recommendation 5

The OIG recommends that CMS follow-up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care.

CMS Response

The CMS concurs with this recommendation. OIG recommends that CMS prioritize the facilities for review and determine whether enforcement actions are needed. The standard survey process requires surveyors to inspect each nursing home to evaluate them for compliance with CMS conditions of participation once every 9 – 15 months. We will analyze the survey data and determine appropriate methods to strengthen enforcement of CMS requirements.

We appreciate the opportunity to comment on this draft report, and we look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Kellis served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Judy Bartlett. Central office staff who provided support include Berivan Demir Neubert, Kevin Farber, Sandy Khoury, Christine Moritz, Sue Nonemaker, and Julie Taitsman.

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