



CMS lost \$84M in two years for ineligible nursing home stays

By Susan Jaffe | February 20, 2019

The CMS pays millions of dollars a year to nursing homes for taking care of older adults who don't qualify for coverage, according to an investigation by HHS' inspector general.

The IG's [report](#), released Wednesday, includes steps the CMS should take to fix the problem; but in a written response, CMS Administrator Seema Verma rejected some key recommendations.

Based on a review of nursing home payments from 2013 through 2015, the IG found that the CMS paid nursing homes an estimated \$84 million for patients whose records did not contain the required three-day hospital admission. Although that's a relatively small amount



compared to the \$85.9 billion the CMS paid nursing homes during the same period, IG investigators said such improper payments are accumulating year after year. The IG discovered the problem by comparing hospital and nursing home payment data.

"Our report indicates that this is still happening," said Stephen Slamar, a supervisory auditor at the IG's office. "There are incidents where beneficiaries are getting nursing home care

billed to Medicare and paid by Medicare, but they did not meet the three-day qualification."

To receive Medicare's nursing home coverage, beneficiaries must first spend three consecutive days as an admitted hospital patient within 30 days of entering a nursing home. The day they leave the hospital as well as time spent receiving observation care, which is an outpatient service, doesn't count toward the three-day minimum.

Congress passed a law in 2015 requiring hospitals to tell patients within 24 hours of their arrival (excluding time in the emergency room) when they are being held for observation care and have not been admitted. But that classification can change during their hospital stay and patients don't always know the correct number of days they spent as admitted patients.

"This report reinforces what our providers have known for years," said Clif Porter, senior vice president for government relations, at the American Health Care Association, a nursing facility trade group. "There are significant barriers to Medicare beneficiaries accessing post-acute care services using their Medicare benefits."

To address the problem, investigators suggested that the CMS require hospitals to provide a written notice to patients before they are discharged indicating the number of days they were admitted. The IG also recommended that the CMS require nursing homes to obtain a copy of that notice from the patient or the hospital.

"Without a coordinated notification mechanism among hospitals, beneficiaries, and skilled-nursing facilities, the CMS will continue to improperly pay millions of dollars annually for SNF care when the 3-day rule is not met," the report concludes.

The American Hospital Association is reviewing the IG's report and had no comment on it yet, a spokeswoman said.

The observation care notice is sufficient, Verma said in a written response included in the report. "The CMS has also taken action to prevent improper Medicare payments by educating health care providers on proper billing," she also noted.

The IG also found that the improper payments couldn't be recovered from the nursing homes because their Medicare bill contains whatever number of days the hospital says the patient was admitted. Under Medicare law, when the provider of

services is not responsible for the billing error, the patient who received those services is responsible for reimbursing Medicare. Instead of seeking repayment from patients, the IG noted that the CMS had advised providers to submit accurate billing information.

In cases where patients don't have the necessary three-day hospital admission, the IG recommended that the CMS should require nursing homes to tell beneficiaries in a written notice that Medicare is likely to deny payment. Nursing homes must give beneficiaries an "advance beneficiary notice" before they receive services Medicare may not cover, but the IG said providers are not required to give such a notice when Medicare is expected to deny payment because patients don't have the three-day hospital admission.

"Currently, beneficiaries and skilled-nursing facilities often do not have sufficient or correct information to make an informed decision to receive or provide care that would be covered by Medicare," Regional Inspector General Sheri Fulcher said.

Susan Jaffe is a freelance writer.