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Complete Healthcare Compliance Manual 2024
Post-Acute Care: Skilled Nursing Facilities

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What Are Skilled Nursing Facilities?

Skilled nursing facilities (SNFs) offer services to Medicare beneficiaries if daily skilled care or rehabilitation services are ordered by a physician and performed by, or under the supervision of, professional or technical personnel. The services must be for an ongoing condition for which the beneficiary also received inpatient hospital services or for a new condition that arose during the SNF care for that ongoing condition.[3]

In order to qualify for SNF services, the beneficiary must have been hospitalized for at least three consecutive days (not counting the day of discharge).[4] The beneficiary must be transferred to a SNF within 30 days after discharge from the hospital, unless the condition of the beneficiary makes it medically inappropriate for admission after discharge.[5]

When these requirements are met, the beneficiary may receive up to 100 days of SNF care. The services may be provided in a Medicare-certified SNF, a distinct SNF located within a hospital, or a critical access hospital with swing bed approval.

While SNFs allow Medicare beneficiaries to access skilled long-term care services, Medicaid beneficiaries may receive skilled care in a nursing facility (NF). NFs are Medicaid-certified long-term care facilities where the beneficiary receives care under their state Medicaid program. While many of the qualifications for services are similar to a SNF, all states have income and asset requirements in order to qualify for NF skilled care. For this article, "nursing homes" refers to SNFs for Medicare and NFs for Medicaid.

Enforcement and Regulation

Critical focus areas for enforcement include fines; satisfying the rigorous operational and care mandates in the federal regulations; consistently maintaining high levels of infection control practices; billing; emergency preparedness; vendor relationships and referrals; and Coronavirus Aid, Relief, and Economic Security (CARES) Act provider relief fund use and reporting.

Nursing homes are among the most regulated providers of healthcare. Nursing homes must comply with the Requirements of Participation (ROPs) found at 42 C.F.R. § 483. The ROPs which were significantly revised in 2018 focus on patient-centered care. Most notably, the ROPs mandated that all nursing homes have a compliance program, making them the first providers of healthcare required to have a compliance program. The Centers for Medicare & Medicaid Services (CMS) is expected to issue interpretive guidance on the compliance program, which will appear as guidance to surveyors in "Appendix PP" of the CMS State Operations Manual.

CMS has the responsibility for ensuring compliance with the ROPs through surveys conducted by the state survey agencies. The state survey agencies conduct annual surveys of nursing homes at least once every 18 months. The state survey agencies also conduct abbreviated surveys of nursing homes when there is a complaint allegation. Federal surveyors have the ability to conduct surveys in order to verify the state survey agencies are following

federal survey protocols. Federal surveyors will sometimes assist the state survey agencies if the care at the nursing home warrants their assistance.

Failure to comply with the ROPs can subject nursing homes to significant penalties, including per-day civil money penalties. Other remedies available to CMS are denials of payment for new or all admissions, installing a temporary manager, and directed plans of correction. CMS also has the authority to terminate nursing homes from the Medicare and/or Medicaid programs.

The COVID-19 pandemic caused CMS to focus on violations of the infection control ROP due to the high number of COVID-19 outbreaks in nursing homes. Nursing homes need to pay special attention to their infection control programs. CMS expects nursing homes to have an infection control program that creates "a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement."[6] CMS will continue to focus on compliance with the infection control ROPs, which has led to several six-figure civil monetary penalties in recent years.

Recent healthcare fraud schemes involving nursing homes have been announced by the U.S. Department of Justice (DOJ). One DOJ announcement included an extensive healthcare fraud conspiracy involving a network of assisted living facilities and SNFs, in which the owner bribed physicians to admit patients into the facilities. The owner then cycled the patients through the facilities where they often failed to receive appropriate medical services or received medically unnecessary services billed to Medicare and Medicaid.[7]

Nursing homes are at an increased audit risk under the Patient-Driven Payment Model (PDPM) as CMS has committed to closely monitor therapy service utilization, payment, and quality trends in the course of billing under PDPM.[8] It is extremely important for providers to understand that, while therapy is not the reimbursement driver under PDPM as it was under the SNF Prospective Payment System (PPS), providers are still required to provide all therapy necessary if the resident requires therapy under the Medicare SNF benefit. Other PDPM billing-specific risk areas to consider include Interim Payment Assessment (IPA), upcoding, and care design driven by patient goals.

In 2016, CMS updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including residents of nursing homes. Updates included requirements that nursing homes have expanded sprinkler systems and smoke detector coverage; an emergency preparedness plan that is reviewed, explained to staff through training, tested, and updated at least annually; and provisions for sheltering in place and evacuation. Recent U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) reviews and surveys have found that nursing homes participating in Medicare or Medicaid programs consistently failed to comply with CMS and state requirements for life safety and emergency preparedness.

In addition to the regulatory authority CMS has over nursing homes, most states also license nursing homes. States that license nursing homes will generally refer to the nursing home as a nursing home, long-term care facility, or health facility. States will regulate nursing homes pursuant to licensure regulations separate from the ROPs. In some states, the licensure regulations defer to the ROPs or are similar to the ROPs. In other states, the licensure regulations impose requirements that have no connection to the ROPs. Nursing homes must pay close attention to state licensure regulations. If a nursing home loses its state license, it is also automatically terminated from the Medicare and/or Medicaid program.