Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE MEDICARE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES NEEDS TO BE REEVALUATED

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EXECUTIVE SUMMARY: THE MEDICARE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES NEEDS TO BE REEVALUATED
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG), the Medicare Payment Advisory Commission, and other entities have raised longstanding concerns regarding Medicare's skilled nursing facility (SNF) payment system. These concerns focus on SNF billing, the method of paying for therapy, and the extent to which Medicare payments exceed SNFs' costs. Medicare pays SNFs a daily rate for nursing, therapy, and other services. The daily rate for therapy is primarily based on the amount of therapy provided, regardless of the specific beneficiary characteristics or care needs.

Previously, OIG found that SNFs increasingly billed for the highest level of therapy even though key characteristics of SNF beneficiaries remained largely unchanged from 2006 to 2008. OIG also found that SNFs billed one-quarter of all 2009 claims in error—primarily by billing for higher levels of therapy than they provided or were reasonable or necessary—which resulted in $1.5 billion in inappropriate Medicare payments. This study provides further evidence that supports and quantifies these concerns.

HOW WE DID THIS STUDY

This study was based on several data sources, including Medicare Part A SNF claims, Medicare cost reports, and beneficiary assessments. We used Medicare cost reports to compare Medicare payments to SNFs' costs for therapy over a 10-year period. We used claims to determine the extent to which SNF billing and beneficiary characteristics changed from fiscal years (FYs) 2011 to 2013. Finally, we determined the extent to which changes in SNF billing affected Medicare payments.

WHAT WE FOUND

We found that Medicare payments for therapy greatly exceeded SNFs' costs for therapy. We also found that under the current payment system, SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. Increases in SNF billing—particularly for the highest level of therapy—resulted in $1.1 billion in Medicare payments in FYs 2012 and 2013.

WHAT WE RECOMMEND

The findings of this and prior OIG reports demonstrate the need for the Centers for Medicare & Medicaid Services (CMS) to reevaluate the Medicare SNF payment system. Payment reform could save Medicare billions of dollars and encourage SNFs to provide services that are better aligned with beneficiaries' care needs. We recommend that CMS: (1) evaluate the extent to which Medicare payment rates for therapy should be reduced, (2) change the method for paying for therapy, (3) adjust Medicare payments to eliminate any increases that are unrelated to beneficiary characteristics, and (4) strengthen oversight of SNF billing. CMS concurred with all four of our recommendations.

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OBJECTIVES

1. To compare Medicare payments to skilled nursing facility (SNF) costs for therapy.
2. To determine the extent to which SNF billing and key beneficiary characteristics changed from fiscal years (FYs) 2011 to 2013.
3. To determine the extent to which changes in SNF billing affected Medicare payments.

BACKGROUND

SNFs provide skilled nursing care, therapy, and other services to Medicare beneficiaries under the Part A benefit. In 2012, nearly 2 million Medicare beneficiaries received these services.[1]

The Office of Inspector General (OIG), the Medicare Payment Advisory Commission (MedPAC), the American Health Care Association (AHCA)—the largest association of long term and post-acute care providers—and other entities have raised longstanding concerns regarding Medicare's SNF payment system.

One concern about the SNF payment system is the extent to which Medicare payments exceed SNFs' costs. MedPAC has found that Medicare payments are substantially higher than SNFs' costs—specifically, that Medicare margins have been above 10 percent since 2000—and, each year during the last decade, has recommended that Congress decrease Medicare payments.[2] Excessive Medicare payment rates are wasteful to taxpayers and could encourage SNFs to provide more therapy than beneficiaries need.

Another concern about the SNF payment system is how Medicare pays for therapy. The current method is, according to CMS, "based primarily on the amount of therapy provided to a patient, regardless of the specific patient characteristics and care needs."[3] A payment system that pays more as the volume of services increases creates a financial incentive to provide more

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[1] Centers for Medicare & Medicaid Services (CMS), *The Medicare and Medicaid Statistical Supplement*, 2013 Edition, Table 6.4. Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html on March 19, 2014.

[2] See MedPAC, Report to Congress: Medicare Payment Policy, March 2015, ch. 8, pp. 195 and 203. Accessed at http://www.medpac.gov/-documents-/reports on May 14, 2015. Medicare margins are a standard method for comparing payments and costs.

[3] CMS, *SNF PPS Payment Model Research*, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html on May 4, 2015.

services than the beneficiary may need. The AHCA, for example, "recognizes [the] concern surrounding therapy utilization" and supports "shifting Medicare away from paying providers based solely on their volume of services."[4] In addition, OIG, MedPAC, and others have recommended changing the method of paying for therapy from one based primarily on volume to one based primarily on beneficiary characteristics.[5]

Concerns also exist about SNF billing under the current system. Notably, in December 2010, OIG found that SNFs increasingly billed for the highest level of therapy, even though key beneficiary characteristics remained largely unchanged.[6] OIG also found that SNFs billed one-quarter of all 2009 claims in error, resulting in $1.5 billion in inappropriate Medicare payments.[7] For the vast majority of these claims, SNFs billed for higher levels of therapy than they provided or were reasonable or necessary. Such billing can create quality of care concerns. For example, a beneficiary—who received hospice care before and after her SNF stay—received physical therapy 5 days a week for 5 weeks, even though her medical records indicated that she asked that the therapy be discontinued.[8]

In addition, OIG investigations have found problems with SNF billing. For example, a SNF chain agreed to a $3.75 million settlement over allegations of fraudulent billing for medically unnecessary therapy.[9] Another SNF chain paid $3.5 million to settle a case that involved allegations of

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[4] AHCA, AHCA Medicare Payment Reform Initiative: SNF-Only Bundled Payment Model (Preliminary). The latter was accessed at http://www.ahcancal.org/solutions/download/medicare_concept_issue_brief.pdf on March 12, 2014.

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

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

[7] Claims billed in error are upcoded or downcoded or do not meet Medicare coverage requirements. See OIG, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

[8] OIG, *Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements*, OEI-02-09-00201, February 2013.

[9] Department of Justice (DOJ), *Two Companies to Pay $3.75 Million for Allegedly Causing Submission of Claims for Unreasonable or Unnecessary Rehabilitation Therapy at Skilled Nursing Facilities*, September 5, 2014. Accessed at http://www.justice.gov/opa/pr/2014/September/14-civ-943.html on September 10, 2014.

medically unnecessary therapy and false reports of therapy being delivered.[10]

This report provides policymakers with key information regarding the SNF payment system and SNF billing under this system. This information is especially relevant now because the payments for emerging models—such as accountable care organizations and bundled payments—are based on current fee-for-service payments.[11] This report is a companion to another report that focuses on SNF billing for changes in therapy.[12]

The SNF Payment System

The Medicare Part A SNF benefit covers skilled nursing care, therapy services (i.e., physical, occupational, and speech therapy), and other services.[13] To qualify for the SNF benefit, the beneficiary must be admitted to the SNF within 30 days of an inpatient hospital stay that lasted at least 3 consecutive days.[14]

During a Part A stay, a SNF periodically assesses a beneficiary to classify him or her into a resource utilization group (RUG), which determines how much Medicare pays the SNF each day for the beneficiary's care.[15]

Types of RUGs. CMS groups the 66 RUGs into 8 categories. Two categories—Rehabilitation and Rehabilitation Plus Extensive Services—are for therapy RUGs; the remaining six categories are for nontherapy RUGs. Therapy RUGs are for beneficiaries who need physical therapy, speech therapy, or occupational therapy, typically to recover from an event such as a hip fracture or a stroke. Nontherapy RUGs are for beneficiaries who require skilled nursing care, but very little or no therapy.

The therapy RUGs are divided into five levels: ultra high, very high, high, medium, and low. The SNF categorizes a beneficiary into one of these

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[10] DOJ, *New York Catholic Nursing Chain to Pay $3.5 Million to Resolve Allegations Concerning Claims for Rehabilitation Therapy*, March 2, 2015. Accessed at http://www.justice.gov/usao-ma/pr/new-york-catholic-nursing-chain-pay-35-million-resolve-allegations-concerning-claims on March 13, 2015.

[11] See, for example, MedPAC and the Urban Institute, *The Need to Reform Medicare's Payments to Skilled Nursing Facilities Is as Strong as Ever*, January 2015, p 2.

[12] OIG, *Skilled Nursing Facility Billing for Changes in Therapy: Improvements Are Needed*, OEI-02-13-00611, June 2015.

[13] Social Security Act (SSA), §§ 1812(a)(2)(A) and 1861(i); 42 U.S.C. §§ 1395d(a)(2)(A) and 1395x(i).

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

[15] SNFs use an assessment known as the Minimum Data Set (MDS) to classify beneficiaries into RUGs. The MDS is part of CMS's Resident Assessment Instrument (RAI). CMS, *Long-Term Care Facility Resident Assessment Instrument User's Manual, ver. 3.0 (RAI Manual 3.0)*, May 2013, § 1.3.

levels primarily on the basis of the amount of therapy provided during a 7-day assessment period.[16] For example, if a beneficiary received 45 minutes of therapy during the assessment period, he or she is typically categorized into a low therapy RUG, whereas if a beneficiary received 720 minutes, he or she is typically categorized into an ultra high therapy RUG.

In addition, RUGs are generally divided by the amount of assistance a beneficiary needs with certain Activities of Daily Living (ADLs), such as eating. If a beneficiary needs high levels of assistance, he or she is categorized into a RUG with a high ADL score, whereas a beneficiary who needs less assistance is categorized into a RUG with a lower ADL score.

Medicare Payment Rates for RUGs. Payment rates for therapy RUGs are typically higher than for nontherapy RUGs. Payment rates typically increase as the level of therapy increases and as the ADL score increases. For example, the average daily payment rate for ultra high therapy RUGs was $620 in FY 2013, while the average rate for low therapy RUGs was $362. See Appendix A for the Medicare payment rate for each RUG in FY 2013.

For each RUG, the payment rate is the sum of three components: nursing, therapy, and room and board. Table 1 shows the base rate for each component in FY 2013. For example, SNFs are paid a base rate of $123 a day to cover the costs of providing therapy to a beneficiary. This rate is multiplied by a Therapy Index that varies with the level of therapy provided to the beneficiary.[17]

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[16] CMS, *RAI Manual 3.0*, § 6.6.

[17] In FY 2013, the Indexes were 0.28 for low therapy, 0.55 for medium therapy, 0.85 for high therapy, 1.28 for very high therapy, and 1.87 for ultra high therapy. See 77 Fed. Reg. 46214, 46220, Table 4 (August 2, 2012). The base rate is also multiplied by a geographic factor to account for wage differences.

Table 1: Base Rate for Each Component of Medicare Payments to SNFs, FY 2013

Component	Base Rate per Day*
Nursing	$164
Therapy**	$123
Room and board	$83

* These rates are for urban SNFs; rural SNFs have somewhat different rates.

** This is the base rate for therapy RUGs. The base rate for nontherapy RUGs is $16 and covers, for example, SNFs' costs for evaluating beneficiaries to determine whether they need therapy.

Source: 77 Fed. Reg. 46214, 46219, Table 2, (August 2, 2012).

Changes to Medicare Payment Rates. CMS updates the base rates each year using a market-basket index that reflects changes over time in the prices of goods and services.[18] In addition, CMS changed payment rates—by changing the Therapy or Nursing Indexes—when it made significant revisions to the payment system.[19] After each significant revision, CMS readjusted rates because SNF billing, particularly billing for therapy, was substantially higher than CMS expected.[20]

Case Mix Creep. The SSA gives CMS the authority to adjust base rates to address "case mix creep"—that is, an increase in overall Medicare payments that is due to changes in SNF billing that do not reflect changes in beneficiaries' characteristics.[21] If CMS determines that case mix creep occurred, it can reduce rates to recoup Medicare payments that resulted from case mix creep.

Although CMS has used a similar authority to adjust rates in the home health payment system, it has not done so for SNFs.[22] For home health, CMS has conducted data analyses of Medicare claims and beneficiary

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[18] SSA, §§ 1888(e)(4)(E) (ii)(IV), (5)(A), and (5)(B)(i). Beginning in FY 2012, the Patient Protection and Affordable Care Act, section 3401(b), required that the market-basket index be reduced annually to account for increases in provider productivity, such as through new technology. See SSA, § 1888(e)(5)(B)(ii).

[19] CMS made significant revisions in FY 2006, when it increased the number of RUGs from 44 to 53, and in FY 2011, when it increased the number of RUGs to 66. See 70 Fed. Reg. 45026, 45037-45040, Tables 4, 4a, 5, and 5a (August 4, 2005) and 75 Fed. Reg. 42886, 42894-42900, Tables 4A, 4B, 5A, and 5B (July 22, 2010).

[20] For the readjustment associated with the FY 2006 revision, see 74 Fed. Reg. 40288, 40298 (August 11, 2009) and 73 Fed. Reg. 46416, 46421-22 (August 8, 2008). For the readjustment associated with the FY 2011 revision, see 76 Fed. Reg. 48486, 48493 and 48500 (August 8, 2011).

[21] SSA, § 1888(e)(4)(F).

[22] 72 Fed. Reg. 49762, 49832 and 49843 (August 29, 2007) (using SSA, § 1895(b)(3)(B)(iv) to address home health case-mix creep).

assessments to determine the extent to which increases in Medicare payments were due to case mix creep. As a result, CMS decreased home health rates by 2.75 percent in 2008 through 2010 to account for case mix creep.[23]

METHODOLOGY

We based this study on an analysis of: 1) Medicare cost reports from SNFs covering a 10-year period; 2) paid Part A SNF claims from the National Claims History file; 3) Part A hospital claims from the hospital stays that qualified the beneficiaries for these SNF stays; and 4) MDS beneficiary assessments.[24] See Appendix B for more detailed information about the methodology.

Limitations

This study assesses SNF billing and beneficiary characteristics based on an analysis of all Medicare Part A claims. We did not determine the extent to which Medicare payments for specific SNF claims were appropriate, including whether services billed for were necessary.

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.

[23] *Ibid.*

[24] We excluded swing beds that are used for both hospital and SNF care.

FINDINGS

Medicare payments for therapy greatly exceed SNFs' costs for therapy

Differences between Medicare payments for therapy and SNFs' costs for therapy resulted in an average Medicare margin for therapy of 29 percent—that is, on average, SNFs received $29 more than their therapy costs for every $100 in Medicare payments for therapy.[25]

Medicare pays SNFs a daily rate for therapy that is primarily based on the level of therapy provided to the beneficiary. In FY 2012, Medicare paid SNFs an average of $187 a day to provide therapy to a beneficiary. However, according to data that SNFs provided on Medicare cost reports, SNFs' costs to provide therapy averaged $133 per day.

The 29 percent Medicare margin for therapy is twice as high as the 14 percent overall Medicare margin for SNF payments reported by MedPAC in FY 2012. Each year during the last decade, MedPAC has reported that the overall Medicare margin exceeded 10 percent and has recommended that Congress decrease Medicare payments.[26]

The difference between Medicare payments and SNFs' costs for therapy, combined with the current payment method, creates an incentive for SNFs to bill for higher levels of therapy than necessary

The difference between therapy payments and costs, combined with the current method of paying for therapy, creates a strong financial incentive for SNFs to bill for higher levels of therapy even when beneficiaries do not need such levels.[27] In FY 2012, with a Medicare margin of 29 percent, SNFs received an average of $66 a day more than their therapy costs when they billed for ultra high therapy for a beneficiary. In comparison, they received an average of $11 more than their therapy costs when they billed for low therapy. See Table 2.

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[25] Medicare margins are a standard method for comparing payments and costs. See, for example, MedPAC, *Report to Congress: Medicare Payment Policy*, March 2015, ch. 8, p. 195.

[26] *Ibid*. For over a decade, MedPAC has recommended that Congress eliminate the market-basket updates to SNF payment rates and, since 2012, has recommended decreasing the base rates.

[27] We did not determine the extent to which Medicare payments for specific SNF claims were appropriate, including whether services billed for were necessary.

Table 2: Average Payment and Cost for Therapy per Day per Beneficiary, by Level of Therapy, FY 2012

Level of Therapy	Average Payment Per Day	Average Cost Per Day	Difference Between Average Payment and Cost Per Day
Ultra high	$231	$165	$66
Very high	$156	$111	$45
High	$104	$74	$30
Medium	$67	$48	$19
Low	$37	$26	$11

Source: OIG analysis of SNF cost reports, 2015.

Medicare payments have greatly exceeded SNFs' costs for therapy for the past decade

Medicare payments for therapy rose faster than SNFs' costs for therapy from FYs 2002 to 2010. In FY 2002, the difference between payments and costs resulted in a Medicare margin for therapy of 25 percent. As shown in Table 3, the margin increased to 42 percent by FY 2010. In FY 2011, the margin decreased; however, it remained near 30 percent.

Table 3: Medicare Margin for Therapy, by Selected Fiscal Years

Fiscal Year	Medicare Margin for Therapy
2002	25%
2004	34%
2006	36%
2008	40%
2010	42%
2011	31%
2012	29%

Source: OIG analysis of SNF cost reports, 2015.

Two factors accounted for increasing payments for therapy. First, SNFs increasingly billed for higher levels of therapy. Second, as required by statute, CMS increased the base payment rate each year by the market-basket index, which is intended to reflect changes over time in the prices of goods and services. In FY 2011, overall payments for therapy decreased; however, they continued to greatly exceed SNFs' costs for therapy.[28]

SNFs also employed strategies to optimize revenues. Specifically, SNFs increasingly provided the minimum number of therapy minutes for the

[28] In FY 2011, CMS decreased the therapy payment rate by decreasing the Therapy Indexes. Prior to FY 2011, these Indexes ranged from 0.43 for low therapy to 2.25 for ultra high therapy. Beginning in FY 2011, the Indexes ranged from 0.28 to 1.87. Therapy payments are determined by multiplying the therapy base rate by the Therapy Index.

higher levels of therapy. This practice increased from FYs 2011 to 2013. For example, SNFs must provide therapy for 720 minutes or more during the 7-day assessment period to bill for ultra high therapy, and SNFs increasingly provided exactly 720 minutes. Notably, in FY 2011, SNFs provided exactly 720 minutes for 21 percent of ultra high therapy RUGs, which increased to 34 percent in FY 2013. See Table 4.

Table 4: Percentage of RUGs in Which SNFs Provided the Minimum Number of Required Therapy Minutes, by Level of Therapy and by Fiscal Year

Level of Therapy	Percentage of RUGs in Which SNFs Provided the Minimum Number of Required Therapy Minutes		
	FY 2011	FY 2012	FY 2013
Ultra high	21%	29%	34%
Very high	12%	18%	22%
High	10%	15%	18%
Medium	7%	9%	10%
Low	14%	13%	12%

Source: OIG analysis of MDS assessments, 2015.

SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same

From FYs 2011 to 2013, SNFs increasingly billed for ultra high therapy, even though key beneficiary characteristics remained largely the same. As shown in Table 5, SNFs increased their billing for ultra high therapy RUGs from 49 percent of therapy days in FY 2011 to 57 percent in FY 2013.

SNFs also increased their billing for other higher paying RUGs. During this same time period, SNFs increased their billing for therapy RUGs from 90 to 92 percent of days and their billing for high ADL RUGs from 34 to 36 percent. Finally, SNFs increased their billing for higher paying nontherapy RUGs from 54 to 60 percent of nontherapy days.

Table 5: Changes in SNF Billing from FYs 2011 to 2013

Type of Billing Change	FY 2011	FY 2012	FY 2013
Percentage of therapy days billed for ultra high therapy RUGs	49%	53%	57%
Percentage of days billed for therapy RUGs	90%	90%	92%
Percentage of days billed for high ADL RUGs	34%	36%	36%
Percentage of nontherapy days billed for higher paying RUG categories	54%	58%	60%

Source: OIG analysis of SNF claims data, 2015.

Increases in SNF billing were not due to changes in key beneficiary characteristics

During the same time that SNFs increased their billing, key beneficiary characteristics remained largely the same. From FYs 2011 to 2013, the average age of SNF beneficiaries stayed about the same—79.5 and 79.2 years, respectively. In addition, the top 20 reasons for the hospital stays that qualified beneficiaries for SNF stays were identical. The average length of the qualifying hospital stays changed minimally from 8.19 to 8.12 days. The severity levels of the hospital stays also changed little. Appendix C provides more detailed information about beneficiaries' characteristics in FYs 2011 and 2013.

Moreover, SNFs increasingly billed for ultra high therapy across each of these beneficiary characteristics. The percentage of days billed as ultra high therapy increased by at least 5 percentage points for each of the top 20 reasons for beneficiaries' qualifying hospital stays. For example, for beneficiaries who were in the hospital for cellulitis prior to going to the SNF, the percentage of days billed as ultra high therapy increased from 39 percent in FY 2011 to 49 percent in FY 2013. SNFs also increased their billing for ultra high therapy across other beneficiary characteristics, including age, and length and severity level of the qualifying hospital stay. Appendix D provides more detailed information about billing for ultra high therapy.

Increases in SNF billing—particularly for the highest level of therapy—resulted in $1.1 billion in Medicare payments in FYs 2012 and 2013

Medicare paid SNFs $53.1 billion in FYs 2012 and 2013; however, Medicare would have paid $52.0 billion if SNFs had not increased their billing for higher paying RUGs. As shown in Table 6, this increase in SNF

billing resulted in $1.1 billion in Medicare payments in FYs 2012 and 2013. Because the increases in SNF billing were not due to changes in key beneficiary characteristics, the increases in Medicare payments may be due to case mix creep. CMS can reduce rates to recoup Medicare payments that resulted from case mix creep.

Table 6: Medicare Payments Resulting From Increased Billing for Higher Paying RUGs, by Fiscal Year

Fiscal Year	Actual Medicare Payments (millions)	Medicare Payments Based on Billing From FY 2011* (millions)	Medicare Payments Resulting From Increased Billing Since FY 2011 (millions)
2012	$26,228	$26,026	$202
2013	$26,888	$26,004	$884
Totals	**$53,116**	**$52,030**	**$1,086**

* We calculated what Medicare would have paid in FYs 2012 and 2013 if SNFs had not increased billing for higher paying RUGs—i.e., if the distribution of RUGs in these years were the same as the distribution in FY 2011.

Source: OIG analysis of SNF claims data, 2015.

Increased billing for ultra high therapy accounted for the vast majority of the $1.1 billion in Medicare payments

This shift toward ultra high therapy accounted for nearly $900 million, or approximately 80 percent, of the $1.1 billion in increased Medicare payments. Other changes in SNF billing also contributed to the increased payments, but to a lesser extent than the shift to ultra high therapy. Appendix E provides more information about how changes in SNF billing affected Medicare payments.

CONCLUSION AND RECOMMENDATIONS

The findings of this report provide further evidence that longstanding concerns about the SNF payment system must be addressed. We found that Medicare payments for therapy greatly exceeded SNFs' costs for therapy. Combined with the current method of paying for therapy, this large difference between therapy payments and costs creates a strong financial incentive for SNFs to bill for higher levels of therapy than necessary. Under this system, SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. Increases in SNF billing—particularly for the highest level of therapy—resulted in $1.1 billion in Medicare payments in FYs 2012 and 2013.

The findings of this and prior OIG reports, which complement the work of MedPAC and others, demonstrate the need to reevaluate the Medicare SNF payment system. Payment reform could save Medicare billions of dollars and encourage SNFs to provide services that are better aligned with beneficiaries' care needs. A reevaluation of the SNF payment system is also important because the payments for emerging models—such as accountable care organizations and bundled payments—are based on current fee-for-service payments.

We recommend that CMS:

Evaluate the extent to which Medicare payment rates for therapy should be reduced

As this report shows, Medicare payments for therapy greatly exceed SNFs' costs and create an incentive for SNFs to bill for higher levels of therapy than beneficiaries need. To address this problem, CMS should reduce the base rate for therapy. We recognize that CMS may need additional statutory authority to make such a change. CMS should analyze how to set an appropriate new base rate—possibly using SNF cost reports—and take steps to develop a legislative proposal, if necessary, to do so. The proposal could also seek to eliminate the market-basket update.

Change the method of paying for therapy

As we have recommended previously, CMS should change the current method of paying for therapy. CMS pays for therapy primarily based on the amount of therapy provided during the assessment period, rather than on beneficiary characteristics or care needs. Under this system, SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same.

CMS should accelerate its efforts to develop and implement a new method of paying for therapy that relies on beneficiary characteristics or care needs. In both March 2007 and April 2014, CMS issued a report that reviewed

various payment methods. CMS should publicly provide a timeline for completing the development and implementation of a new method of paying for therapy. As CMS develops the new payment method, it will also need to develop controls to monitor SNF billing under the new system.

Adjust Medicare payments to eliminate the effect of case mix creep

CMS has the authority to adjust payment rates if it determines that overall payments to SNFs increased due to changes in billing that are unrelated to changes in beneficiaries' characteristics—that is, that are the result of case mix creep. This report adds to the growing evidence that case mix creep is occurring. CMS should quantify the amount of creep that has occurred and adjust payment rates to eliminate the effect of case mix creep.

Strengthen oversight of SNF billing

CMS should take other actions to minimize increases in SNF billing that do not reflect changes in beneficiary characteristics. These oversight activities should include increasing and expanding reviews of SNF claims and improving data analysis strategies. For example, CMS should develop strategies for identifying SNFs that have increased their billing for higher paying RUGs and determining whether these increases reflect changes in the characteristics of their beneficiaries.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations.

First, CMS concurred with our recommendation to evaluate the extent to which Medicare payment rates for therapy should be reduced. CMS stated that additional statutory authority would be required for CMS to address this recommendation. CMS further noted that the FY 2016 President's budget included a legislative proposal requiring a reduction to the market-basket updates for SNF payment rates beginning in FY 2016.

Second, CMS concurred with our recommendation to change the method of paying for therapy. CMS stated that it is conducting a project to study and evaluate SNF therapy payment options. It will use the results of this project to inform changes to the method of paying for therapy.

Third, CMS concurred with our recommendation to adjust Medicare payments to eliminate the effect of case mix creep. CMS stated that it will consider various approaches to adjust payments if it determines that changes in overall payments to SNFs were unrelated to beneficiaries' characteristics.

Finally, CMS concurred with our recommendation to strengthen oversight of SNF billing. CMS stated that it will work to monitor SNF billing and target SNFs that rarely bill for changes in therapy or frequently use therapy assessments incorrectly for education and claims review. It will also consider the feasibility of refining the Fraud Prevention System to support the monitoring of SNF billings.

For the full text of CMS's comments, see Appendix F.

APPENDIX A

Medicare Payment Rates per Day per RUG in FY 2013

RUG Category	RUG	Therapy Level	ADL Score	Payment Rate per Day*
Therapy RUGs				
Rehabilitation Plus Extensive Services	RUX	Ultra high	11 to 16**	$751
	RUL	Ultra high	2 to 10	$734
	RVX	Very high	11 to 16**	$668
	RVL	Very high	2 to 10	$599
	RHX	High	11 to 16**	$605
	RHL	High	2 to 10	$540
	RMX	Medium	11 to 16**	$555
	RML	Medium	2 to 10	$509
	RLX	Low	2 to 16	$488
Rehabilitation	RUC	Ultra high	11 to 16**	$569
	RUB	Ultra high	6 to 10	$569
	RUA	Ultra high	0 to 5	$476
	RVC	Very high	11 to 16**	$488
	RVB	Very high	6 to 10	$423
	RVA	Very high	0 to 5	$421
	RHC	High	11 to 16**	$425
	RHB	High	6 to 10	$383
	RHA	High	0 to 5	$337
	RMC	Medium	11 to 16**	$374
	RMB	Medium	6 to 10	$351
	RMA	Medium	0 to 5	$289
	RLB	Low	11 to 16**	$363
	RLA	Low	0 to 10	$234
Nontherapy RUGs				
Extensive Services	ES3		2 to 16	$685
	ES2		2 to 16	$536
	ES1		2 to 16	$479
Special Care High	HE2		15 to 16**	$463
	HE1		15 to 16**	$384
	HD2		11 to 14**	$433
	HD1		11 to 14**	$361
	HC2		6 to 10	$409
	HC1		6 to 10	$342
	HB2		2 to 5	$404
	HB1		2 to 5	$339

Medicare Payment Rates per Day per RUG in FY 2013 (continued)

RUG Category	RUG	Therapy Level	ADL Score	Payment Rate per Day*
Nontherapy RUGs (continued)				
Special Care Low	LE2		15 to 16**	$420
	LE1		15 to 16**	$352
	LD2		11 to 14**	$404
	LD1		11 to 14**	$339
	LC2		6 to 10	$355
	LC1		6 to 10	$299
	LB2		2 to 5	$337
	LB1		2 to 5	$286
Clinically Complex	CE2		15 to 16**	$375
	CE1		15 to 16**	$345
	CD2		11 to 14**	$355
	CD1		11 to 14**	$325
	CC2		6 to 10	$311
	CC1		6 to 10	$288
	CB2		2 to 5	$288
	CB1		2 to 5	$267
	CA2		0 to 1	$244
	CA1		0 to 1	$227
Behavioral Symptoms and Cognitive Performance	BB2		2 to 5	$258
	BB1		2 to 5	$247
	BA2		0 to 1	$214
	BA1		0 to 1	$204
Reduced Physical Function	PE2		15 to 16**	$345
	PE1		15 to 16**	$329
	PD2		11 to 14**	$325
	PD1		11 to 14**	$309
	PC2		6 to 10	$280
	PC1		6 to 10	$267
	PB2		2 to 5	$237
	PB1		2 to 5	$227
	PA2		0 to 1	$196
	PA1		0 to 1	$188

* These are the unadjusted urban rates.

** We consider these ADL scores to be high.

Source: 77 Fed. Reg. 46214, 46220–46221, Table 4 (August 2, 2012) and CMS, RAI Manual 3.0, § 6.

APPENDIX B
Detailed Methodology

Comparison of Medicare payments for therapy with SNFs' costs for therapy

We based this analysis on Medicare cost reports from SNFs. We obtained the cost reports for every other year from FYs 2002 to 2010 and for every year from FYs 2010 to 2012.[29] For each fiscal year, we used these reports to calculate therapy payments and costs.

To calculate therapy payments, for each SNF and for each therapy level, we multiplied: the number of days reported for the therapy level on the cost report, the Therapy Index, the base rate for therapy, and the SNF's geographic factor.[30] We then summed across the five therapy levels and across all SNFs to calculate total therapy payments for each fiscal year. Similarly, we determined SNFs' costs for therapy by summing across the therapy costs reported by each SNF for each fiscal year.[31]

We calculated the average therapy payment per day per beneficiary by dividing the total therapy payments by the total number of therapy days reported. We calculated the average therapy cost per day per beneficiary using the same method. To determine the extent to which therapy payments exceeded costs, we calculated the Medicare margin for therapy by subtracting total costs from total payments and then dividing by total payments.

Next, for FY 2012, we determined the extent to which the difference between the average daily payment and cost for therapy varied by therapy level. To do this, for each therapy level, we multiplied the average payment per day by the Medicare margin for therapy.[32]

Lastly, we examined the factors that affected Medicare payments for therapy during the 10-year period. We determined the extent to which SNFs increasingly billed for higher levels of therapy by calculating the

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[29] Medicare cost reports are publicly available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/Cost-Reports-by-Fiscal-Year.html. We analyzed reports from free-standing SNFs that had reporting periods of at least 10 months and no more than 13 months.

[30] These payments include beneficiary copayments.

[31] We did not include cost reports with outlier therapy costs per day using a standard method.

[32] While SNFs report payment information by therapy level on the cost report, they do not report costs by therapy level.

average Therapy Index billed by SNFs for each year.[33] In addition, we reviewed how CMS changed the base rate for therapy and the five Therapy Indexes over this time period.

Analysis of the therapy minutes provided by SNFs using MDS assessments

For each beneficiary assessment, the therapy level is primarily determined by the minutes of therapy provided during the 7-day assessment period.[34] Under the current payment system, SNFs can minimize their therapy costs, which optimizes their revenues, by providing the minimum number of minutes required for each of the five levels of therapy. For example, SNFs can provide exactly 500 minutes of therapy to beneficiaries in very high therapy RUGs. For FYs 2011 through 2013, for each therapy level, we calculated the percentage of RUGs for which the SNF provided the minimum number of required therapy minutes. For ultra high therapy, at least 720 minutes are required during the 7-day assessment period; for very high therapy, 500 minutes; for high therapy, 325 minutes; for medium therapy, 150 minutes; and for low therapy, 45 minutes.

Analysis of changes in SNF billing from FYs 2011 to 2013 using SNF claims

We determined the extent to which SNFs shifted from lower to higher paying RUGs, or vice versa, from FYs 2011 to 2013. Specifically, we determined the extent to which SNFs shifted their billing:

- from nontherapy to therapy RUGs;
- from lower levels of therapy RUGs to ultra high therapy RUGs;
- from lower paying nontherapy RUG categories to higher paying RUG categories;[35] and
- from lower ADL RUGs to high ADL RUGs.

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[33] For this calculation, we used the five Therapy Indexes that were in place prior to FY 2011.

[34] SNFs separately report the minutes associated with each mode of therapy—individual, concurrent, and group therapy. Beginning in FY 2011, SNFs were required to divide concurrent therapy minutes among beneficiaries when determining each beneficiary's therapy level; beginning in FY 2012, SNFs were also required to divide group therapy minutes. So, in FY 2012, for example, the total minutes used to determine the therapy level included all minutes in individual therapy, half of the minutes in concurrent therapy, and one-quarter of the minutes in group therapy. See CMS, *RAI Manual 3.0*, § 6.

[35] The three higher paying nontherapy categories are Extensive Services, Special Care High, and Special Care Low. The three lower paying categories are Clinically Complex, Reduced Physical Function, and Behavioral Symptoms & Cognitive Performance.

For each of these types of billing changes, we determined the percentage of days billed in FYs 2011 to 2013. For example, we determined how the percentage of therapy days billed as ultra high therapy changed during these 3 years.

Analysis of key beneficiary characteristics using SNF and hospital claims data

We determined whether SNF billing changes were associated with changes in key beneficiary characteristics. To do this analysis, we used claims data to determine the following beneficiary characteristics: 1) the beneficiary's age, 2) the length of the hospital stay that qualified the beneficiary for the SNF stay, 3) the reason for the qualifying hospital stay, and 4) the severity level of the hospital stay.[36]

We chose beneficiary characteristics related to the qualifying hospital stay because SNF services must be for the same condition that the beneficiary was treated for in the hospital.[37] In addition, some of the alternative methods for improving the SNF payment system that are being considered by CMS rely on information from the beneficiary's hospital stay.[38]

For each of these beneficiary characteristics, we determined how the distribution of SNF stays changed from FYs 2011 to 2013.[39] For example, we determined the percentage of SNF stays associated with each of the top 20 reasons for the qualifying hospital stay. In addition, we determined how the percentage of days billed as ultra high therapy changed across these beneficiary characteristics.

Analysis of the extent to which changes in SNF billing affected Medicare payments

Using the Part A SNF claims, we first determined total Medicare payments for FYs 2012 and 2013. Next, we determined the extent to which changes in SNF billing that occurred since FY 2011 affected Medicare payments.

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[36] The reason for the hospital stay and the severity level were derived from the Medicare severity Diagnosis Related Group (MS-DRG) on the hospital claim. For example, the reason associated with MS-DRG 470 is major joint replacement of the lower extremity and the severity level is low because this MS-DRG is for beneficiaries without any major secondary conditions.

[37] 42 CFR § 409.31. 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.

[38] See, for example, Acumen, *SNF Therapy Payment Models Base Year Final Summary Report*, April 2014, which Acumen completed under contract with CMS.

[39] We identified SNF stays from claims using SNF and beneficiary identifiers and admission dates. We matched these SNF stays to hospital claims using the qualifying hospital dates on the SNF claim and the beneficiary identifier.

To do this, we calculated what Medicare would have paid in FYs 2012 and 2013 if the distribution of RUGs in these years was the same as the distribution in FY 2011—i.e., if SNFs had not increased or decreased billing for higher paying RUGs.[40]

In addition, we determined the effect on Medicare payments of each of the four types of billing changes described above. For each type of billing change, we estimated what Medicare would have paid in FYs 2012 and 2013 if the change had not occurred.

[40] For this analysis, we calculated Medicare payments from claim line items, rather than claims. For less than half of 1 percent of claims, we adjusted the payments associated with the line items to account for minor discrepancies between the information on the claims and on the line items.

APPENDIX C

Changes in Key Beneficiary Characteristics From FYs 2011 to 2013

Table C.1: Percentage of SNF Stays, by Age Group and by Fiscal Year

Beneficiaries' Ages at Admission	Percentage of SNF Stays		
	FY 2011	FY 2013	Percentage-Point Difference*
Age < 65	9.5%	10.0%	0.5%
65 ≤ Age < 70	8.7%	9.7%	1.0%
70 ≤ Age < 75	11.3%	11.9%	0.6%
75 ≤ Age < 80	15.1%	15.0%	-0.2%
80 ≤ Age < 85	20.0%	18.8%	-1.2%
85 ≤ Age < 90	20.2%	19.3%	-0.9%
90 ≤ Age < 95	11.5%	11.7%	0.2%
Age ≥ 95	3.7%	3.7%	0.0%
Totals*	**100.0%**	**100.0%**	

* Totals and percentage-point differences may vary due to rounding.

Source: OIG analysis of Part A SNF claims, 2015.

Table C.2: Percentage of SNF Stays, by Average Length of Qualifying Hospital Stay and by Fiscal Year

Average Length of Beneficiaries' Qualifying Hospital Stays	Percentage of SNF Stays		
	FY 2011	FY 2013	Percentage-Point Difference*
Less than 3 days	1.2%	1.0%	-0.2%
3 days	19.8%	20.6%	0.8%
4 days	14.5%	14.4%	0.0%
5 days	11.4%	11.3%	0.0%
6 or 7 days	16.5%	16.3%	-0.2%
8 or 9 days	9.8%	9.5%	-0.2%
10 to 19 days	17.1%	16.9%	-0.2%
20 days or more	6.6%	6.4%	-0.1%
Unknown**	3.2%	3.5%	0.3%
Totals*	**100.0%**	**100.0%**	

* Totals and percentage-point differences may vary due to rounding.

** In these cases, we were unable to identify the qualifying hospital stay.

Source: OIG analysis of Part A SNF and hospital claims, 2015.

Table C.3: Percentage of SNF Stays, by Reason for Qualifying Hospital Stay and by Fiscal Year

Top 20 Reasons for Beneficiaries' Qualifying Hospital Stays	Percentage of SNF Stays		
	FY 2011	FY 2013	Percentage-Point Difference*
Major joint replacement of lower extremity	7.3%	7.6%	0.3%
Septicemia	5.0%	6.0%	0.9%
Heart failure and shock	4.1%	4.0%	-0.1%
Other hip and femur procedures	4.0%	4.1%	0.1%
Simple pneumonia and pleurisy	3.9%	3.9%	0.0%
Kidney and urinary tract infections	3.9%	3.6%	-0.3%
Renal failure	2.9%	3.1%	0.2%
Intracranial hemorrhage or cerebral infarction	2.7%	2.8%	0.0%
Rehabilitation	2.7%	2.9%	0.2%
Chronic obstructive pulmonary disease	2.3%	2.2%	-0.1%
Respiratory infections and inflammations	2.1%	1.9%	-0.2%
Nutritional disorders	2.0%	1.7%	-0.3%
Degenerative nervous system disorders	1.5%	1.3%	-0.2%
Gastrointestinal hemorrhage	1.5%	1.5%	0.0%
Cellulitis	1.4%	1.4%	0.0%
Medical back problems	1.4%	1.2%	-0.1%
Irregular heartbeat	1.4%	1.4%	0.0%
Acute myocardial infarction	1.3%	1.2%	-0.1%
Digestive disorders	1.3%	1.2%	-0.1%
Psychoses	1.2%	1.2%	0.0%
Other	46.0%	45.9%	-0.1%
Totals*	**100.0%**	**100.0%**	

* Totals and percentage-point differences may vary due to rounding. The rows are sorted in descending order by the percentage of SNF stays in FY 2013.

Source: OIG analysis of Part A SNF and hospital claims, 2015.

Table C.4: Percentage of SNF Stays, by Severity Level of Qualifying Hospital Stay and by Fiscal Year

Severity Level of Qualifying Hospital Stay	Percentage of SNF Stays		
	FY 2011	FY 2013	Percentage-Point Difference*
Low	31.4%	29.2%	-2.1%
Medium	23.8%	23.3%	-0.5%
High	34.0%	36.2%	2.2%
Not applicable or unknown**	10.8%	11.2%	0.4%
Totals*	**100.0%**	**100.0%**	

* Totals and percentage-point differences may vary due to rounding.

** In these cases, we were unable to identify the qualifying hospital stay or the qualifying hospital stay was not associated with a severity level.

Source: OIG analysis of Part A SNF and hospital claims, 2015.

APPENDIX D

Increases in the Use of Ultra High Therapy From FYs 2011 to 2013, by Key Beneficiary Characteristic

Table D.1: Use of Ultra High Therapy, by Age Group and by Fiscal Year

Beneficiaries' Ages at Admission	Percentage of SNF Days Billed as Ultra High Therapy		
	FY 2011	FY 2013	Percentage-Point Difference*
Age < 65	38%	45%	7%
65 ≤ Age < 70	45%	53%	8%
70 ≤ Age < 75	45%	54%	8%
75 ≤ Age < 80	46%	54%	8%
80 ≤ Age < 85	46%	54%	8%
85 ≤ Age < 90	46%	54%	8%
90 ≤ Age < 95	44%	52%	8%
Age ≥ 95	39%	47%	8%

* Percentage-point differences may vary due to rounding.

Source: OIG analysis of Part A SNF claims, 2015.

Table D.2: Use of Ultra High Therapy, by Average Length of Qualifying Hospital Stay and by Fiscal Year

Average Length of Qualifying Hospital Stay	Percentage of SNF Days Billed as Ultra High Therapy		
	FY 2011	FY 2013	Percentage-Point Difference*
Less than 3 days	39%	47%	7%
3 days	47%	56%	9%
4 days	45%	53%	8%
5 days	44%	52%	8%
6 or 7 days	43%	51%	8%
8 or 9 days	42%	50%	8%
10 to 19 days	44%	52%	8%
20 days or more	46%	52%	6%
Unknown	45%	52%	7%

* Percentage-point differences may vary due to rounding.

Source: OIG analysis of Part A SNF and hospital claims, 2015.

Table D.3: Use of Ultra High Therapy, by Reason for Qualifying Hospital Stay and by Fiscal Year

Top 20 Reasons for Qualifying Hospital Stay	Percentage of SNF Days Billed as Ultra High Therapy		
	FY 2011	FY 2013	Percentage-Point Difference*
Major joint replacement of lower extremity	59%	68%	9%
Septicemia	36%	43%	8%
Heart failure and shock	41%	49%	8%
Other hip and femur procedures	49%	57%	8%
Simple pneumonia and pleurisy	38%	46%	8%
Kidney and urinary tract infections	41%	49%	8%
Renal failure	41%	50%	9%
Intracranial hemorrhage or cerebral infarction	61%	66%	5%
Rehabilitation	64%	70%	6%
Chronic obstructive pulmonary disease	40%	48%	9%
Respiratory infections and inflammations	37%	44%	6%
Nutritional disorders	42%	50%	8%
Degenerative nervous system disorders	44%	50%	6%
Gastrointestinal hemorrhage	38%	47%	9%
Cellulitis	39%	49%	9%
Medical back problems	49%	58%	9%
Irregular heartbeat	43%	52%	9%
Acute myocardial infarction	41%	49%	8%
Digestive disorders	41%	50%	9%
Psychoses	39%	45%	7%
Other	43%	51%	8%

* Percentage-point differences may vary due to rounding. The rows are sorted in descending order by the percentage of SNF stays in FY 2013.

Source: OIG analysis of Part A SNF and hospital claims, 2015.

Table D.4: Use of Ultra High Therapy, by Severity Level of Qualifying Hospital Stay and by Fiscal Year

Severity Level of Qualifying Hospital Stay	Percentage of SNF Days Billed as Ultra High Therapy		
	FY 2011	FY 2013	Percentage-Point Difference*
Low	48%	56%	9%
Medium	44%	52%	9%
High	43%	51%	8%
Not applicable or unknown	43%	50%	7%

* Percentage-point differences may vary due to rounding.

Source: OIG analysis of Part A SNF and hospital claims, 2015.

APPENDIX E

Estimates of Medicare Payments in FYs 2012 and 2013 Resulting From Changes in SNF Billing

Type of Billing Change	Estimated Increased Medicare Payments Resulting From Changes in Billing Since FY 2011 (millions)
Increased billing for ultra high therapy RUGs, rather than lower levels of therapy RUGs	$879
Increased billing for therapy RUGs, rather than nontherapy RUGs	$127
Increased billing for high ADL RUGs, rather than lower ADL RUGs	$63
Increased billing for higher paying nontherapy RUGs, rather than lower paying nontherapy RUGs	$51
Total*	**$1,121**

* This sums to $1,121 million, rather than $1,086 million (from Table 6), because these are estimates. Our methodology measured each billing change separately; it did not take into account that these billing changes can occur simultaneously.

Source: OIG analysis of SNF claims data, 2015.

APPENDIX F
Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

To: Daniel R. Levinson
Inspector General
Office of Inspector General

From: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: The Medicare Payment System For Skilled Nursing Facilities Needs To Be Reevaluated (OEI-02-13-00610)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on the Medicare payment system for skilled nursing facilities (SNFs). CMS is committed to making sure that the Skilled Nursing Facility (SNF) payment model provides appropriate payments for services provided.

SNFs provide care to beneficiaries who need daily skilled care given by, or under the supervision of, skilled nursing or therapy staff. Currently, Medicare pays for services provided by SNFs under the Medicare Part A benefit on a per diem basis through the SNF Prospective Payment System (PPS). This payment methodology was designed to prospectively reimburse SNFs based on the relative amount of resources needed to treat beneficiaries.

The SNF PPS was expected to control the costs of administering the Medicare Part A SNF benefit. However, the number of Medicare Part A payment days continues to rise, and Medicare payments often exceed SNFs' costs. A potential cause of this cost issue is that the Medicare Part A therapy payment under the SNF PPS is based primarily on the amount of therapy provided to the beneficiary regardless of patient condition, which implicitly provides a financial payment incentive for facilities to provide as much therapy to a resident as that resident can tolerate, regardless of the impact of providing this level of therapy on producing positive patient outcomes.

CMS is working to identify potential alternatives to the existing methodology used to pay for services under the SNF PPS. In an effort to establish a comprehensive approach to SNF payment reform, CMS has initiated the SNF PPS Payment Model Research project. In the first phase of the project, we reviewed past research studies and policy issues related to SNF PPS therapy and options for improving or replacing the current system of paying for SNF therapy services. We are currently using the findings from that research as a guide to identify potential models suitable for further analysis for the entire SNF PPS system.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS evaluate the extent to which Medicare payment rates for therapy should be reduced.

CMS Response

CMS concurs with this recommendation. As recognized by the OIG, additional statutory authority would be required in order for CMS to address this recommendation. In addition, the OIG states that such a legislative proposal could possibly include an elimination of the market-basket update. CMS notes that the FY 2016 President's budget included a legislative proposal requiring a reduction to the market basket updates for SNF payment rates beginning in FY 2016.

OIG Recommendation

The OIG recommends that CMS change the current method of paying for therapy.

CMS Response

CMS concurs with this recommendation. CMS is currently conducting a project, the SNF PPS Payment Model Research project, to study and evaluate SNF therapy payment options. CMS will use results of this project to inform changes to the current method of paying for therapy.

OIG Recommendation

The OIG recommends that CMS adjust Medicare payments to eliminate the effect of case mix creep.

CMS Response

CMS concurs with this recommendation. CMS currently has the authority to adjust payment rates if it determines that overall payments to SNFs have changed across the SNF payment system that are unrelated to beneficiaries' characteristics. CMS will consider various approaches to adjust payments once such a determination is made.

OIG Recommendation

The OIG recommends that CMS strengthen the oversight of SNF billing.

CMS Response

CMS concurs with this recommendation. CMS will work to monitor SNF billing for and target SNFs that rarely bill for changes in therapy or frequently use therapy assessments incorrectly for education and claims review. CMS is committed to building reliable models in the Fraud

Prevention System that can detect and generate alerts for suspicious billing behavior and will consider the feasibility of refining these models to support the monitoring of SNF billings.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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 Bartlett served as team leader for this study, and Rachel Bryan served as lead analyst. We would also like to acknowledge the contributions of other Office of Evaluation and Inspections regional office staff, including Michael Rubin and Marissa Baron. Other Office of Evaluation and Inspections staff from the Baltimore regional office who supported the study include Berivan Demir Neubert. Other OIG staff who provided support include Clarence Arnold, Heather Barton, Evan Godfrey, and James Korn.

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