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Administrator
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FROM: /S/
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SUBJECT: Early Alert Memorandum Report: *Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011*, OEI-02-09-00204

This memorandum report presents our results to date regarding skilled nursing facilities (SNF) billing in fiscal year (FY) 2011. Specifically, this report describes the extent to which billing by SNFs changed from the last half of FY 2010 to the first half of FY 2011. This memorandum report is a followup to an earlier Office of Inspector General (OIG) report.[1] In that report, OIG found that Medicare payments to SNFs increased from 2006 to 2008, even though beneficiary characteristics remained largely unchanged. Specifically, payments to SNFs for the highest level of therapy increased by nearly 90 percent from 2006 to 2008, rising from $5.7 billion to $10.7 billion. Billing for high levels of assistance with ADLs also increased.

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) made a number of changes to the SNF payment system that became effective at the beginning of FY 2011. In particular, CMS changed how SNFs bill for concurrent therapy. CMS expected this change to decrease billing for higher levels of therapy. Because CMS did not intend to decrease overall payments to SNFs, it increased the payment rates for therapy. CMS also changed how SNFs bill for extensive services, such as tracheostomy care, and for assistance with beneficiaries' activities of daily living (ADL).

Although CMS intended the FY 2011 changes to be budget neutral, Medicare payments increased by $2.1 billion, or 16 percent, from the last half of FY 2010 to the first half of FY 2011. Contrary to CMS's expectations, in the first half of FY 2011, SNFs billed for higher levels of therapy and for very little concurrent therapy. These unanticipated billing patterns contributed to the overall increase in payments. At the same time, several

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

of CMS's changes reduced billing for certain higher-paying groups. Between the last half of FY 2010 and the first half of FY 2011, billing decreased slightly for therapy overall. Billing for extensive services and for high levels of assistance with ADLs also decreased.

The data indicate that CMS should adjust payment rates to address the significant increases in payments to SNFs. The data also show that CMS should make changes to how SNFs account for group therapy. Lastly, the data highlight the need for further changes to make Medicare payments more consistent with beneficiaries' care and resource needs.

We plan to conduct a full review of SNF billing at the end of FY 2011 and may issue formal recommendations to CMS at that time. However, based on the data in this report, CMS should take immediate action. CMS has proposed a number of changes to the SNF payment system and will issue a final rule for FY 2012. CMS should use this opportunity to address the issues identified in this memorandum report.

BACKGROUND

The Part A SNF benefit covers skilled nursing care, rehabilitation services (i.e., physical, occupational, and speech therapy), and other services for up to 100 days during any spell of illness.[2] To qualify, 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.[3]

Medicare pays SNFs under a prospective payment system. During a Part A stay, SNFs classify beneficiaries into groups based on their care and resource needs. These groups are called resource utilization groups (RUG). SNFs use an assessment known as the Minimum Data Set (MDS) to classify beneficiaries into RUGs.[4] The MDS assesses the beneficiary's clinical condition, functional status, and expected use of services. SNFs must conduct these assessments on or about the 5th, 14th, 30th, 60th, and 90th days of a Part A stay, as well on certain other occasions to account for changes in the beneficiary's care needs.[5] Accordingly, if a beneficiary has a 100-day Part A stay, he or she will have at least five assessments. For each assessment, the beneficiary is categorized into a RUG. A beneficiary may be categorized into different RUGs during his or her stay.

[2] Social Security Act, §§ 1812(a)(2)(A) and 1861(h); 42 U.S.C. §§ 1395d(a)(2)(A) and 1395x(h).
[3] 42 CFR §§ 409.30 and 409.31.
[4] 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),* Sept. 2010, §§ 1.2 and 1.3.
[5] 42 CFR § 413.343(b) and CMS, *RAI Manual 3.0,* § 2.8. CMS requires other comprehensive resident assessments at certain times as a condition of participation, which may be combined with MDS payment assessments when the timeframes coincide. See 42 CFR § 483.20 and *RAI Manual 3.0,* §§ 2.6 and 2.11.

Types of RUGs

Each RUG has a different Medicare per diem payment rate. Beginning in FY 2011, CMS increased the number of RUGs from 53 to 66. Medicare groups these 66 RUGs into eight distinct categories. Two categories—Rehabilitation and Rehabilitation Plus Extensive Services—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. In this report, we refer to the RUGs in the two therapy categories as therapy RUGs.

The remaining six categories are for beneficiaries who require very little or no therapy. We refer to the RUGs in these six categories as nontherapy RUGs. These categories are Extensive Services, Special Care High, Special Care Low, Clinically Complex, Reduced Physical Function, and Behavioral Symptoms and Cognitive Performance. See Appendix A for information about all RUGs in FY 2010 and FY 2011.

Medicare Payments for Therapy

Medicare payment rates for therapy RUGs are more than 1½ times higher, on average, than the rates for nontherapy RUGs.[6] Additionally, within the therapy RUGs, Medicare generally pays more for higher levels of therapy.

The therapy RUGs are divided into five levels of therapy: ultra high, very high, high, medium, and low. The SNF categorizes a beneficiary into one of the five therapy levels based primarily on the number of minutes of therapy provided during a 7-day assessment period.[7] For example, if the beneficiary received 45 minutes of therapy during the assessment period, he or she is categorized into a low therapy RUG, whereas if the beneficiary received 720 minutes, he or she is categorized into an ultra high therapy RUG. Medicare generally pays the most for ultra high therapy. In FY 2011, the average per diem rate for the ultra high therapy RUGs is $699, compared to $430 for low therapy RUGs.

Beneficiaries in a Part A stay can receive three different types of therapy:

- individual, in which the therapist works with only one beneficiary;
- concurrent, in which the therapist works with two beneficiaries at the same time using different treatments; and
- group, in which the therapist works with two to four beneficiaries at the same time using similar treatments.

Beginning in FY 2011, SNFs were required to divide concurrent therapy minutes among beneficiaries when determining each beneficiary's RUG.[8] For example, when two

[6] OIG analysis of FYs 2010 and 2011 unadjusted per diem urban rates. There is an urban and a rural payment rate for each RUG. The urban payment rates are generally lower than the rural rates for therapy RUGs. See 74 Fed. Reg. 40288, 40298–40300 (Aug. 11, 2009) and 75 Fed. Reg. 42886, 42894–42895, 42897–42899 (Jul. 22, 2010).

[7] CMS, *RAI Manual 3.0*, § 6.6. In addition to the minutes of therapy provided, SNFs must use other criteria to categorize a beneficiary into a therapy RUG, such as how often certain nursing services are provided.

[8] 74 Fed. Reg. 40288, 40315–40319 (Aug. 11, 2009) and CMS, *RAI Manual 3.0*, § 6.6 and ch. 3, § O0400.

beneficiaries receive 60 minutes of therapy concurrently, the SNF counts 30 minutes when determining each beneficiary's RUG.[9] In contrast, CMS did not require SNFs to divide group therapy minutes among beneficiaries.[10] For example, when one therapist provides group therapy to four beneficiaries for 60 minutes, the SNF counts all 60 minutes when determining each beneficiary's RUG.

As a result of the new requirement to divide concurrent therapy minutes among beneficiaries, CMS expected a decrease in SNF billing for higher levels of therapy in FY 2011.[11] CMS did not intend the changes implemented in FY 2011 to decrease overall payments to SNFs.[12] As a result, CMS increased the per diem payment rate for each level of therapy beginning in FY 2011. For example, CMS increased the average per diem rate for ultra high therapy RUGs from $528 in FY 2010 to $699 in FY 2011, a 32-percent increase. See Table 1 for the average per diem rates for each level of therapy.

Table 1: Average Amount That Medicare Pays SNFs per Diem for Each Level of Therapy, FYs 2010 and 2011

Level of Therapy	Number of Therapy Minutes Provided During Assessment Period	Average per Diem Payment FY 2010	Average per Diem Payment FY 2011	Percentage Increase From FY 2010 to FY 2011
Low	45 to 149	$288	$430	49%
Medium	150 to 324	$369	$488	32%
High	325 to 499	$364	$532	46%
Very high	500 to 719	$418	$594	42%
Ultra high	720 or more	$528	$699	32%

Source: OIG analysis of unadjusted per diem urban rates for FYs 2010 and 2011. See 74 Fed. Reg. 40288, 40298–40299 (Aug. 11, 2009) and 75 Fed. Reg. 42886, 42894–42895 (Jul. 22, 2010).

Medicare Payments for Extensive Services

Extensive services include tracheostomy care, the use of a ventilator or respirator, and infection isolation. Two categories of RUGs include extensive services: Rehabilitation Plus Extensive Services, which includes therapy; and Extensive Services, which does not include therapy. Beginning in FY 2011, CMS substantially narrowed the definition of extensive services.[13] It made this change because it found that many of the beneficiaries

[9] Effective FY 2011, SNFs were also required to report how many minutes of each type of therapy were provided to each beneficiary. In contrast, prior to FY 2011, SNFs only reported the total number of therapy minutes provided to each beneficiary. Compare CMS, *RAI Manual 3.0*, ch. 3, § O0400 with CMS, *Long-Term Care Facility Resident Assessment Instrument User's Manual 2.0 (RAI Manual 2.0)*, Dec. 2002, revised Dec. 2008, ch. 3, § P1.b.

[10] During both FYs 2010 and 2011, CMS limited group therapy to 25 percent of the total therapy provided to each beneficiary. See CMS, *RAI Manual* 3.0, § 6.6, and *RAI Manual 2.0*, ch. 3, § P2.b.

[11] For example, in FY 2010, if a beneficiary received 320 minutes of individual therapy and 400 minutes of concurrent therapy, this beneficiary was categorized into an ultra high therapy RUG (320 + 400 = 720 minutes). In contrast, in FY 2011, this same beneficiary is categorized into a very high therapy RUG (320 + 400/2 = 520 minutes).

[12] 74 Fed. Reg. 40288, 40338–40339 (Aug. 11, 2009).

[13] Compare CMS, *RAI Manual 3.0*, § 6.6 with *RAI Manual 2.0*, § 6.6.

previously classified as needing extensive services required fewer resources than expected.[14]

Medicare Payments for Assistance With ADLs

RUGs are further divided by the amount of assistance a beneficiary needs with certain ADLs.[15] As part of the assessment, SNFs assign each beneficiary an ADL score based on how much assistance he or she needs with certain ADLs, such as eating. If a beneficiary needs high levels of assistance, he or she is categorized into a RUG with high ADL scores, whereas a beneficiary who needs less assistance is categorized into a RUG with lower ADL scores.[16] Medicare pays higher rates for RUGs with high ADL scores than for RUGs with lower ADL scores. In FY 2011, CMS changed both how the ADL score was calculated and the range of ADL scores associated with each RUG.[17]

Other Changes to the SNF Payment System

CMS made several other changes to the SNF payment system. Prior to FY 2011, during a beneficiary's first assessment, SNFs were allowed to place the beneficiary in a therapy RUG based on scheduled (but not yet provided) therapy. Beginning in FY 2011, CMS no longer allowed this, explaining that studies indicated that SNFs were often overpaid because beneficiaries did not always receive the level of therapy that was scheduled. Instead, in FY 2011, CMS introduced an optional start-of-therapy assessment, which allows SNFs to recalculate a beneficiary's RUG if therapy was started later during the stay.[18] Additionally, prior to FY 2011, CMS allowed SNFs to wait 8 to 10 days to conduct an end-of-therapy assessment after all therapy was discontinued. Beginning in FY 2011, CMS required SNFs to conduct this assessment within 1 to 3 days.[19]

METHODOLOGY

We based this study on information from: (1) all paid Part A SNF claims from the last half of FY 2010 through the first half of FY 2011 and (2) MDS beneficiary assessment data from the same period.[20]

We first identified the universe of paid Part A SNF claims from the last half of FY 2010 (April 1 to September 30, 2010) and the first half of FY 2011 (October 1, 2010, to

[14] 74 Fed. Reg. 22208, 22230–22231 (May 12, 2009).

[15] The one exception is the Extensive Services category. The RUGs in this category are not divided by the amount of assistance a beneficiary needs with ADLs.

[16] Each RUG is associated with a range of ADL scores. Within each category, we refer to the RUGs with the highest range of ADL scores as RUGs with high ADL scores. For example, for the Clinically Complex category, we consider the two RUGs with ADL scores ranging from 15 to 16 to be RUGs with high ADL scores.

[17] Compare CMS, *RAI Manual 3.0*, § 6.6 with *RAI Manual 2.0*, § 6.6.

[18] 74 Fed. Reg. 40288, 40346–40349 (Aug. 11, 2009), 74 Fed. Reg. 22208, 22244–22246 (May 12, 2009), and CMS, *RAI Manual 3.0*, § 2.8.

[19] While SNFs are required to recalculate the RUG after all therapy is discontinued, they are not required to recalculate the RUG when the beneficiary's level of therapy changes substantially.

[20] The CMS claims data were obtained from the Services Tracking Analysis and Reporting System. These data included all claims with processing dates before June 1, 2011.

March 31, 2011).[21] For each 6-month period, we calculated the total amount billed—both for therapy and nontherapy RUGs.

Next, we compared the distributions of the RUGs for each period.[22] Specifically, we determined the percentages of RUGs billed for each level of therapy for both periods. For this analysis, we combined the data from the two therapy categories—Rehabilitation and Rehabilitation Plus Extensive Services—to determine how often SNFs billed for each of the different therapy levels: ultra high, very high, high, medium, and low.

Next, for first half of FY 2011, we used MDS data to determine the extent to which SNFs billed for each type of therapy: concurrent, group, and individual.[23] Because SNFs did not have to report this information prior to FY 2011, we compared these data to CMS's expected use of each type of therapy. CMS based its expectations on the Staff Time and Resource Intensity Verification (STRIVE) study, which found that about three-quarters of therapy was provided individually, one-quarter was provided concurrently, and less than 1 percent was provided in a group setting.[24]

Lastly, we determined the percentage of RUGs billed for extensive services. We did this analysis separately for extensive services with and without therapy. We also analyzed how often SNFs billed for RUGs with high ADL scores. We compared this information for the two periods to determine whether there were any differences.

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.

RESULTS

Medicare Payments to SNFs Increased by $2.1 Billion From the Last Half of FY 2010 to the First Half of FY 2011

CMS made several changes to how Medicare paid SNFs for Part A stays in FY 2011. While CMS intended these changes to be budget neutral, overall payments to SNFs instead increased significantly. As shown in Table 2, payments to SNFs rose from $12.7 billion during the last half of FY 2010 to $14.8 billion during the first half of FY 2011, an increase of 16 percent. The total increase of $2.1 billion was primarily due to payments for therapy RUGs, which rose by $1.8 billion. In contrast, payments for nontherapy RUGs increased by $0.2 billion.

[21] In this report, we refer to claim line items as claims.
[22] We based our analysis on the RUGs that SNFs submitted on the claims. A RUG from a beneficiary's assessment may span two claims. In this report, we count this as one RUG.
[23] For example, to determine the use of concurrent therapy, we summed the minutes of concurrent therapy reported by SNFs for all beneficiaries and divided by the total number of minutes reported for all therapy.
[24] The STRIVE study was conducted by the Iowa Foundation for Medical Care under contract with CMS. Data were collected in 2006 and 2007. See https://www.qtso.com/strive.html. Accessed on May 2, 2011.

Table 2: Change in Medicare Payments From the Last Half of FY 2010 to the First Half of FY 2011

Type of RUG	Total Medicare Payments		Difference in Payments*
	Last Half of FY 2010	First Half of FY 2011	
Therapy	$12.2 billion	$14.0 billion	$1.8 billion
Nontherapy	$0.6 billion	$0.8 billion	$0.2 billion
Total*	**$12.7 billion**	**$14.8 billion**	**$2.1 billion**

* Payments may not subtract to the difference and sum to the total because of rounding.
Source: OIG analysis of Part A SNF claims, 2011.

SNF billing for higher-paying therapy RUGs increased, which CMS did not anticipate. Medicare pays more for RUGs in which the beneficiary receives higher levels of therapy. CMS expected that the changes implemented in FY 2011 would result in a decrease in SNF billing for higher levels of therapy. However, contrary to what CMS expected, billing for higher levels of therapy actually increased in the first half of FY 2011, compared to the last half of FY 2010.

As shown in Table 3, billing for ultra high therapy increased by almost 2 percentage points and billing for high and very high therapy each increased by about 4 percentage points. At the same time, billing for medium therapy decreased by nearly 10 percentage points. Notably, billing for the three highest levels of therapy increased from the first to the second quarter of FY 2011.

Table 3: Change in Billing For Each Level of Therapy From the Last Half of FY 2010 to the First Half of FY 2011

Level of Therapy	Last Half of FY 2010	First Half of FY 2011	Percentage Point Change*
Low	0.2%	0.2%	0.1
Medium	20.6%	11.1%	-9.5
High	9.2%	13.1%	3.9
Very high	26.2%	30.2%	4.1
Ultra high	43.8%	45.4%	1.5
Total	**100%**	**100%**	

* Percentage differences do not subtract to percentage point change because of rounding.
Source: OIG analysis of Part A SNF claims, 2011.

SNFs billed for less concurrent therapy than CMS expected. CMS changed how SNFs must account for therapy provided concurrently. Beginning in FY 2011, SNFs were required to divide concurrent therapy minutes among beneficiaries. As a result of this new requirement, CMS expected a decrease in the number of therapy minutes billed per beneficiary and a decrease in the levels of therapy billed. Instead, SNFs billed for far less

concurrent therapy in FY 2011 than CMS expected and the anticipated shift to lower levels of therapy did not occur.

As shown in Table 4, when CMS determined the reimbursement rates for SNFs during FY 2011, it assumed that SNFs' use of concurrent therapy would be approximately 25 percent of all therapy. However, during the first half of FY 2011, less than 1 percent of all therapy minutes were for concurrent therapy. Furthermore, SNFs' use of concurrent therapy decreased each month, from 1.4 percent in October 2010 to 0.7 percent in March 2011.

Table 4: The Use of Each Type of Therapy, as Expected by CMS and as Billed During the First Half of FY 2011

Type of Therapy	Expected by CMS*	First Half of FY 2011	Percentage Point Difference
Concurrent	25.3%	0.9%	-24.4
Group	0.5%	7.7%	7.2
Individual	74.1%	91.4%	17.3
Total	**100%****	**100%**	

* CMS's expectations are based on the STRIVE study.

** Percentages do not sum to total because of rounding.

Source: OIG analysis of MDS data, 2011.

SNFs billed for more group and individual therapy than CMS expected. While the use of concurrent therapy was much lower than expected, the use of both group and individual therapy was much higher than expected in the first half of FY 2011. CMS expected group therapy to account for less than 1 percent of all therapy. However, during the first half of FY 2011, SNF billing for group therapy accounted for nearly 8 percent of all therapy. Lastly, CMS expected individual therapy to amount to about three-quarters of therapy; however, in the first half of FY 2011, individual therapy was about 91 percent of all therapy.

Although Medicare Payments to SNFs Increased Overall, Several of CMS's Changes Reduced Billing for Certain Higher-Paying RUGs

Overall, billing for therapy RUGs decreased slightly from the last half of FY 2010 to the first half of FY 2011. Medicare pays SNFs more than 1½ times as much for therapy RUGs, on average, as it does for nontherapy RUGs. Billing for therapy RUGs decreased from 89 percent of all RUGs during the last half of FY 2010 to 86 percent during the first half of FY 2011.

Two changes in FY 2011 likely contributed to this shift toward nontherapy RUGs. First, in FY 2011, SNFs were no longer allowed to bill for therapy RUGs based on scheduled (but not yet provided) therapy. Second, in FY 2011, SNFs were required to recalculate a

beneficiary's RUG within 1 to 3 days after all therapy was discontinued, rather than 8 to 10 days. As a result, SNFs' use of these end-of-therapy assessments increased from 1.7 percent during the last half of FY 2010 to 2.8 percent during the first half of FY 2011.

Billing for extensive services decreased substantially from the last half of FY 2010 to the first half of FY 2011. Medicare pays more for RUGs in which the beneficiary requires extensive services than it does for RUGs in which the beneficiary does not require extensive services. In FY 2011, CMS substantially narrowed the definition of extensive services, which likely decreased billing for these RUGs.

As shown in Table 5, SNFs significantly reduced their billing for extensive services. Billing for therapy RUGs with extensive services decreased from nearly 42 percent of all RUGs during the last half of FY 2010 to less than 3 percent of all RUGs during the first half of FY 2011. Additionally, billing for nontherapy RUGs with extensive services decreased from about 4 percent to less than 1 percent of all RUGs.

Table 5: Change in Billing for RUGs That Include Extensive Services From the Last Half of FY 2010 to the First Half of FY 2011

Type of RUG	Last Half of FY 2010	First Half of FY 2011
Therapy RUGs		
With Extensive Services	41.7%	2.7%
Without Extensive Services	47.3%	83.3%
Nontherapy RUGs		
With Extensive Services	4.2%	0.7%
Without Extensive Services	6.9%	13.3%
Total	**100%**	**100%**

Source: OIG analysis of Part A SNF claims, 2011.

Billing for RUGs with high ADL scores decreased from the last half of FY 2010 to the first half of FY 2011. In general, Medicare pays more for RUGs with high ADL scores than for RUGs with lower ADL scores. In FY 2011, CMS changed how the ADL score was calculated and the range of ADL scores associated with each RUG; these changes likely contributed to SNFs' decreased use of RUGs with high ADL scores.

Billing for therapy RUGs with high ADL scores decreased from 35 percent during the last half of FY 2010 to 30 percent during the first half of FY 2011. At the same time, beneficiaries' need for assistance with ADLs did not change, on average. The average ADL score was 13 during the last half of FY 2010 and, applying the FY 2010 rules, remained 13 during the first half of FY 2011.

Current Timeframes for When SNFs May Calculate a Beneficiary's RUG May Lead to Inaccuracies

SNFs must calculate a beneficiary's RUG on or about the 5th, 14th, 30th, 60th, and 90th day of a Part A stay, as well as when changes in the beneficiary's care needs occur. SNFs gather information about the beneficiary during an assessment period to determine the beneficiary's RUG. CMS specifies timeframes for the last day of assessment periods. For example, SNFs must set the last day of the assessment period sometime between the 11th and the 19th day of a stay for the beneficiary's second assessment.

Currently, a beneficiary's assessment periods can overlap substantially. During the first half of FY 2011, 43 percent of RUGs had a 7-day assessment period that overlapped with another RUG's assessment period by at least 3 days. This was an increase of 4 percentage points from the last half of FY 2010. This overlap typically occurred when SNFs chose the 8th day of the stay as the end of the beneficiary's first assessment, and then chose the 11th day as the end of the second assessment. In these cases, the two assessment periods overlapped by 4 days. When SNFs use overlapping assessment periods, the same information is used to calculate two different RUGs. This may lead to inaccuracies in the assessment of beneficiaries' changing needs and the corresponding RUGs.

CONCLUSION

In FY 2011, CMS made a number of changes to the SNF payment system. In particular, CMS changed how SNFs bill for concurrent therapy. CMS expected this change to decrease billing for higher levels of therapy. Because CMS did not intend to decrease overall payments to SNFs, it increased the payment rates for therapy. CMS also changed how SNFs bill for extensive services and for assistance with ADLs.

Although CMS intended the FY 2011 changes to be budget neutral, Medicare payments increased by $2.1 billion, or 16 percent, from the last half of FY 2010 to the first half of FY 2011. Contrary to CMS's expectations, in the first half of FY 2011, SNFs billed for higher levels of therapy and for very little concurrent therapy. These unanticipated billing patterns contributed to the increase in payments. At the same time, several of CMS's changes reduced billing for certain higher-paying RUGs. Between the last half of FY 2010 and the first half of FY 2011, billing decreased slightly for therapy overall. Billing for extensive services and for RUGs with high ADL scores also decreased.

These data indicate that CMS should adjust payment rates to address the significant increases in payments to SNFs. Given the current trends, Medicare will pay over $4 billion more to SNFs in FY 2011 than in FY 2010. In addition, the data show that CMS should make changes to how SNFs account for group therapy. Currently, SNFs have a financial incentive to choose group therapy over individual or concurrent therapy. By better aligning Medicare payments to SNFs' expenditures for each type of therapy, SNFs will more likely choose the type of therapy that best meets the beneficiary's needs.

Lastly, the data highlight the need for further changes to make RUGs and Medicare payments more consistent with beneficiaries' care and resource needs. These changes could include requiring SNFs to recalculate a beneficiary's RUG whenever his or her level of therapy changes substantially, as well as reducing the overlap that occurs in assessment periods.

We plan to conduct a full review of SNF billing at the end of FY 2011 and may issue formal recommendations to CMS at that time. However, based on the data in this report, CMS should take immediate action. CMS has proposed a number of changes to the SNF payment system and will issue a final rule for FY 2012.[25] CMS should use this opportunity to address the issues identified in this memorandum report.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-09-00204 in all correspondence.

[25] 76 Fed. Reg. 26364, 26364–26429 (May 6, 2011).

APPENDIX A

Therapy RUGs							
RUG Category	**RUG Code**		**Therapy Level**	**Range of ADL Scores**		**Per Diem Rate**	
	FY 2010	**FY 2011**		**FY 2010**	**FY 2011**	**FY 2010**	**FY 2011**
Rehabilitation Plus Extensive Services	RUX	RUX	Ultra high	16 to 18	11 to 16	$617	$869
	RUL	RUL	Ultra high	7 to 15	2 to 10	$546	$847
	RVX	RVX	Very high	16 to 18	11 to 16	$468	$787
	RVL	RVL	Very high	7 to 15	2 to 10	$437	$698
	RHX	RHX	High	13 to 18	11 to 16	$396	$723
	RHL	RHL	High	7 to 12	2 to 10	$386	$638
	RMX	RMX	Medium	15 to 18	11 to 16	$449	$668
	RML	RML	Medium	7 to 14	2 to 10	$413	$611
	RLX	RLX	Low	7 to 18	2 to 16	$319	$594
Rehabilitation	RUC	RUC	Ultra high	16 to 18	11 to 16	$529	$634
	RUB	RUB	Ultra high	9 to 15	6 to 10	$485	$634
	RUA	RUA	Ultra high	4 to 8	0 to 5	$463	$513
	RVC	RVC	Very high	16 to 18	11 to 16	$421	$552
	RVB	RVB	Very high	9 to 15	6 to 10	$401	$468
	RVA	RVA	Very high	4 to 8	0 to 5	$364	$466
	RHC	RHC	High	13 to 18	11 to 16	$365	$488
	RHB	RHB	High	8 to 12	6 to 10	$349	$434
	RHA	RHA	High	4 to 7	0 to 5	$326	$376
	RMC	RMC	Medium	15 to 18	11 to 16	$335	$435
	RMB	RMB	Medium	8 to 14	6 to 10	$326	$403
	RMA	RMA	Medium	4 to 7	0 to 5	$320	$324
	RLB	RLB	Low	14 to 18	11 to 16	$294	$431
	RLA	RLA	Low	4 to 13	0 to 10	$252	$264

APPENDIX A (Continued)

Nontherapy RUGs						
RUG Category	**RUG Code**		**Range of ADL Scores**		**Per Diem Rate**	
	FY 2010	**FY 2011**	**FY 2010**	**FY 2011**	**FY 2010**	**FY 2011**
Extensive Services	SE3	ES3	7 to 18	2 to 16	$361	$661
	SE2	ES2	7 to 18	2 to 16	$309	$518
	SE1	ES1	7 to 18	2 to 16	$276	$463
Special Care	SSC		17 to 18		$272	
	SSB		15 to 16		$258	
	SSA		4 to 14		$253	
Special Care High		HE2		15 to 16		$447
		HE1		15 to 16		$371
		HD2		11 to 14		$418
		HD1		11 to 14		$349
		HC2		6 to 10		$394
		HC1		6 to 10		$330
		HB2		2 to 5		$390
		HB1		2 to 5		$327
Special Care Low		LE2		15 to 16		$406
		LE1		15 to 16		$339
		LD2		11 to 14		$390
		LD1		11 to 14		$327
		LC2		6 to 10		$342
		LC1		6 to 10		$289
		LB2		2 to 5		$325
		LB1		2 to 5		$276
Clinically Complex	CC2	CE2	17 to 18	15 to 16	$270	$361
	CC1	CE1	17 to 18	15 to 16	$248	$333
	CB2	CD2	12 to 16	11 to 14	$236	$342
	CB1	CD1	12 to 16	11 to 14	$225	$314
	CA2	CC2	4 to 11	6 to 10	$223	$300
	CA1	CC1	4 to 11	6 to 10	$211	$278
		CB2		2 to 5		$278
		CB1		2 to 5		$257
		CA2		0 to 1		$235
		CA1		0 to 1		$219

APPENDIX A (Continued)

Nontherapy RUGs (continued)						
RUG Category	**RUG Code**		**Range of ADL Scores**		**Per Diem Rate**	
	FY 2010	**FY 2011**	**FY 2010**	**FY 2011**	**FY 2010**	**FY 2011**
Impaired Cognition	IB2		6 to 10		$202	
	IB1		6 to 10		$199	
	IA2		4 to 5		$183	
	IA1		4 to 5		$177	
Behavior Problems (RUG-III) Behavioral Symptoms and Cognitive Performance (RUG IV)	BB2	BB2	6 to 10	2 to 5	$200	$249
	BB1	BB1	6 to 10	2 to 5	$196	$238
	BA2	BA2	4 to 5	0 to 1	$182	$207
	BA1	BA1	4 to 5	0 to 1	$169	$197
Reduced Physical Function	PE2	PE2	16 to 18	15 to 16	$217	$333
	PE1	PE1	16 to 18	15 to 16	$214	$317
	PD2	PD2	11 to 15	11 to 14	$206	$314
	PD1	PD1	11 to 15	11 to 14	$203	$298
	PC2	PC2	9 to 10	6 to 10	$197	$270
	PC1	PC1	9 to 10	6 to 10	$196	$257
	PB2	PB2	6 to 8	2 to 5	$175	$229
	PB1	PB1	6 to 8	2 to 5	$172	$219
	PA2	PA2	4 to 5	0 to 1	$171	$189
	PA1	PA1	4 to 5	0 to 1	$166	$181

Source: OIG analysis of unadjusted per diem urban rates for FYs 2010 and 2011. See 74 Fed. Reg. 40288, 40298–40299 (Aug. 11, 2009) and 75 Fed. Reg. 42886, 42894–42895 (Jul. 22, 2010).