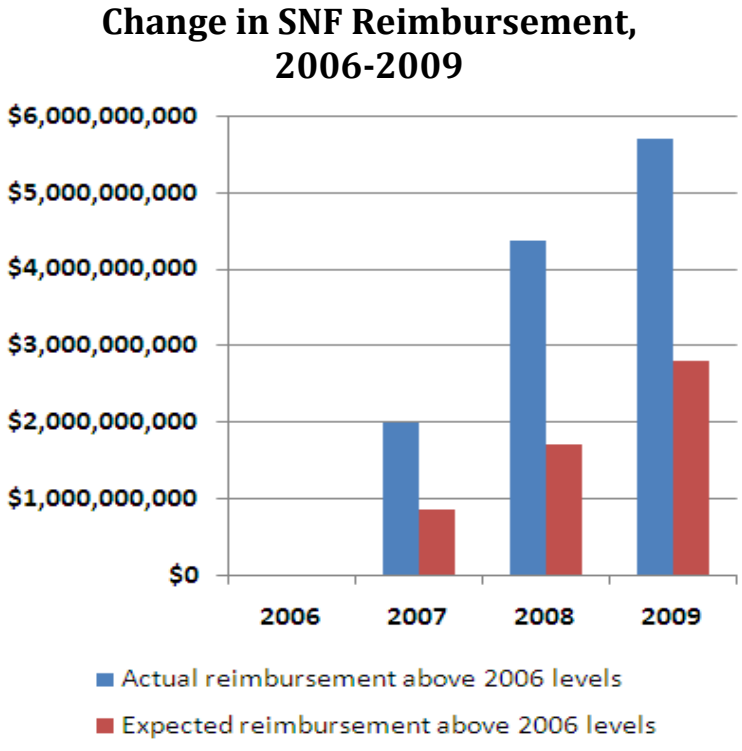
Medicare Reimbursement to Skilled Nursing Facilities, 2006-2009

Executive Summary

This SEIU Healthcare report extends and enhances the key findings of the December 2010 report by the Office of the inspector General (OIG) in the Department of Health and Human Services entitled *Questionable Billing by Skilled Nursing Facilities.* Our report finds that between 2006 and 2009, Medicare paid Skilled Nursing Facilities (SNFs) a cumulative total of $5.4 billion more than expected based on 2006 reported acuities. In 2009 alone, Medicare payments were $2.8 billion more than they would have been if 2009 nursing home residents had the same reported acuity as they had in 2006, on average. This change in reported acuities, manifested by SNFs billing for higher-paying Resource Utilization Groups (RUGs), occurred despite little change in SNF resident ages and the diagnoses that residents received at the hospital where they were treated prior to post-acute care at a SNF.

The report also drills down into the excess $2.8 billion in Medicare expenditures in 2009, listing the top 15 nursing home operators who received the additional funds. Our top 15 list looked at operators who were in the highest 5% of all SNF operators, ranked by actual-versus-expected Medicare payment amounts. Of these, we focused on the 15 operators with the largest payments above expected. In total, 9.2% of the entire $2.8 billion went to a single nursing home operator, Manor Care. The second highest-ranking operator was North American Health Care (NAHC), earning $40.6 million above expected in 2009. In total, the top 15 operators received $446.6 million of the $2.8 billion in potentially excess 2009 Medicare reimbursements to SNFs.



This analysis by SEIU Healthcare extends and enhances the findings of the OIG report by:

1. Updating key results of the OIG's findings with 2009 Medicare payments to SNFs
2. Quantifying the portion of the increase that can be attributed solely to SNFs billing for higher-paying RUGs
3. Listing potential excess reimbursement by SNF operator, for the top 15 operators
4. Augmenting OIG's analysis demonstrating that while RUG billing by SNFs has skyrocketed, the clinical characteristics of patients admitted to SNFs are essentially unchanged over the period

Overview

In December 2010 the Office of the Inspector General in the Department of Health and Human Services (OIG) released a report entitled *Questionable Billing by Skilled Nursing Facilities.* This report examined skyrocketing Medicare reimbursements to Skilled Nursing Facilities (SNFs) between 2006 and 2008.[1] Medicare pays SNFs on a prospective basis, classifying patients into groups based upon care and resource needs. These categories are termed Resource Utilization Groups (RUGs), and in general patients assigned by SNFs into higher-reimbursing RUGs require greater amounts of therapy and/or more assistance with the "activities of daily living" (ADLs).

From 2006 – 2008, OIG found that total Medicare payments to SNFs rose over 18%, from $23.8 billion to $28.1 billion. OIG's analysis determined that much of this increase was due to higher claimed therapy utilization and higher reported activities of daily living (ADL) scores. However, the most surprising part of OIG's analysis was that this large increase in payments was potentially not attributable to sicker patients in need of more therapy and care:

> **From 2006 to 2008, SNFs increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged.** From 2006 to 2008, the percentage of RUGs for ultra high therapy increased from 17 to 28 percent. The percentage of RUGs with high ADL scores increased from 30 percent in 2006 to 34 percent in 2008. Even though SNFs significantly increased their billing for these higher paying RUGs, beneficiaries' ages and diagnoses at admission were largely unchanged from 2006 to 2008.[2]

Why should the Centers for Medicare and Medicaid Services (CMS) reimburse SNFs for more complex care in 2008, as compared to 2006, when there is little difference between the populations treated at SNFs in those two years? In OIG's words, "these findings raise concerns about the potentially inappropriate use of higher paying RUGs . . . The findings also indicate that the current payment system provides incentives to SNFs to bill for ultra high therapy and for high levels of assistance when these levels of care may not be needed."[3]

The OIG report raises the possibility that billions of Medicare dollars are being misappropriated by nursing home operators, through "questionable billing." This report builds on OIG's work as outlined above, beginning with a look at 2009 Medicare bills.

[1] Department of Health and Human Services, Office of Inspector General, *Questionable Billing by Skilled Nursing Facilities* OEI-02-09-202.
[2] *Ibid.* page ii, emphasis in the original.
[3] *Ibid.* page iii.

Medicare Reimbursement to SNFs, 2006 – 2009

Total reimbursement to SNFs continued to rise dramatically in 2009, up $5.7 billion from $24.1 billion[4] in 2006 to nearly $30 billion in 2009. This 23.6% increase in just three years occurred in a period of only modest gains in utilization days (2.3%), and overall legislated rate increases of around 10.1% over the three year period 2006 - 2009.[5]

The payment increases are summarized in the table below. The portion of the payment increases due solely to the utilization of higher paying RUGs as a result of reported changes in patient acuity is included in the rightmost column. Highlights:

- Of the $5.7 billion increase from 2006 to 2009, nearly half ($2.82 billion) was due solely to the utilization of higher paying RUGs
- In the three-year period 2007-2009, Medicare paid SNFs a cumulative total of $5.4 billion more than expected, based on 2006 RUG utilization

Table 1: National Summary of SNF Reimbursements, 2006-2009

Year (CY)	Days	Total Reimbursement	Change in reimbursement since 2006	Portion of change due to payment rate changes and total days of care	Portion of increased reimbursement due solely to utilization of higher paying RUGs
2006	66,206,662	$24,105,461,682			
2007	67,137,980	$26,101,504,901	$1,996,043,219	$1,127,558,532	$868,484,687
2008	68,835,780	$28,483,886,795	$4,378,425,112	$2,656,944,841	$1,721,480,271
2009	67,752,639	$29,806,231,293	$5,700,769,610	$2,880,466,412	$2,820,303,198

[4] Note: The dataset available to us varies slightly from the data available to the OIG. Our numbers are derived from the 2006-2009 Medicare Limited Data Set Standard Analytical Files for Skilled Nursing Facilities (SNF LDS SAF). See https://www.cms.gov/IdentifiableDataFiles/02_StandardAnalyticalFiles.asp for more documentation.

[5] Market basket increases for federal fiscal years 2007, 2008, and 2009 were 3.1%, 3.3% and 3.4%, respectively. Regarding increases in utilization days, OIG flagged increasing length of stay as a potential area of abuse: "these billing patterns indicate that certain SNFs may be . . . keeping beneficiaries in Part A [i.e. Medicare reimbursed] stays longer than necessary. *Ibid*, page ii.

The Top 15 Operators, 2009

Nursing home operators' overall impact on the Medicare program has two components: (1) the *total magnitude* of the cost to Medicare, and (2) the *relative magnitude* of the cost to Medicare, given the size of the operator. To generate our list we looked at the top 5% of operators based on relative magnitude, and defined the Top 15 as the 15 operators in that group who received the largest potential excess reimbursements in 2009. A detailed explanation is provided in the Methodology; see, "Methodology notes for identifying the Top 15 providers," below.

Table 2: The Top 15 Operators, 2009

Operator	Days	Actual Reimbursement	Expected Reimbursement	Reimbursement Above Expected	Actual / Expected
Manor Care	2,782,704	1,362,538,600	1,103,600,690	258,937,910	123%
North American Health Care	253,936	160,875,178	120,250,061	40,625,117	134%
Ensign	296,700	160,531,305	129,791,680	30,739,624	124%
Avery Eisenreich	158,962	100,067,252	74,568,278	25,498,974	134%
Gulf Coast Health Care	240,644	110,467,529	89,298,836	21,168,693	124%
Sun-Mar	91,345	51,845,565	41,415,885	10,429,681	125%
Greystone	80,073	41,035,463	31,163,843	9,871,620	132%
DOS	74,893	39,384,168	30,419,215	8,964,953	129%
Theresea Khawly	64,446	38,325,062	30,327,672	7,997,390	126%
Altercare	71,875	34,289,073	27,090,707	7,198,366	127%
Opis	72,116	33,369,633	26,637,211	6,732,421	125%
Whitehall Boca	36,632	20,344,451	14,452,503	5,891,949	141%
Emmanuel David	48,594	26,813,108	21,727,238	5,085,870	123%
Compass Health	31,706	18,748,891	14,864,699	3,884,192	126%
Salter Healthcare Services	26,441	14,995,546	11,409,933	3,585,612	131%
Top 15 Totals	4,331,067	2,213,630,824	1,767,018,453	446,612,371	125%
National Totals	67,752,639	$29,806,231,293	$26,985,928,094	$2,820,303,198	110%
Top 15 Systems as Percent of National	6.4%	7.4%	6.5%	15.8%	

In 2009, 15.8% of potentially excess SNF reimbursements were concentrated among the top 15 high-impact operators. Over the same period, this group of 15 operators was responsible for just 6.4% of all Medicare SNF days.

In other words, a disproportionate share of the excess $2.8 billion in national SNF reimbursement in 2009 went to this group of 15 operators – by a factor of nearly 250%.[6]

In the following section we seek to assess:

(1) Whether patient clinical characteristics changed, nationally, from 2006 to 2009

(2) Whether patient clinical characteristics are different between the top 15 operators and their peers

In figures graphically comparing clinical characteristics between the top operators and their peers, we grouped 14 of the Top 15 providers together, showing Manor Care separately because of the unique magnitude of its potential impact on the Medicare program; Manor Care alone is responsible for more than half the potential excess reimbursement paid to the Top 15 operators combined, and 9.2% of the national excess.

Acuity: Comparing hospital care to corresponding SNF resident acuity for the top operators

The OIG report showed that, at the national level, SNF resident characteristics did not change significantly between 2006 and 2008. Whether patients were treated in 2006 or 2008, or at for-profit, not-for-profit and government-operated SNFs, key beneficiary characteristics showed little variation.[7] Faced with this dramatic disjuncture between static SNF resident acuity and rapidly increasing therapy utilization, OIG entitled its report "*Questionable Billing,"* reflecting the fact that clinical differences between patient populations over time were not a driving force behind skyrocketing bills presented to Medicare by skilled nursing facilities.

Building on the OIG's examination of variations in SNF billing practices between 2006 and 2008, and within different categories of ownership, our Top 15 list draws from a subset of SNF operators in the top 5% of all operators, ranked by actual-versus-expected daily costs of care. We did not distinguish between ownership types in generating the list, but simply ranked SNF operators in this outlier group by their total impact on Medicare.

Our report also expands on the OIG's work with a deeper look into patient clinical characteristics. In its report, the OIG measured resident characteristics via two variables: patient age and patient diagnosis upon SNF admission. Our research confirms for 2009 what OIG found for 2006 – 2008: that the patient characteristics between the most recent year for which data are available (2009) and 2006 did not differ

[6] I.e., 15.8% / 6.4%
[7] Ibid, page 12.

substantially on a national level, or for the Top 15 operators. Indeed, a review of average resident ages shows that the average age decreased modestly over the period (refer to Table 3 below). In addition to age, we examined patient diagnoses.

Rather than rely on SNF-reported diagnoses, we linked SNF stays to their qualifying hospital stays to determine whether those top-paid operators have a different case-mix from their peers.[8] All Medicare SNF patients have a hospital stay preceding their admission to the SNF, since Medicare-eligible SNF stays must be preceded by a minimum three-day hospital stay. We linked the hospital claims database to the SNF database through a unique patient identifier field included in each dataset, the year and quarter of the hospital discharge and the SNF admission, and the discharge destination reported by the hospital. In sum, this allowed us to match approximately 73% of all SNF residents to their qualifying hospital stay.[9]

We then examined the corresponding hospital stays to determine whether the patients at a particular operator differed from the national average. Specifically, we analyzed each Diagnostic Related Group (DRG) that represented at least 0.25% of hospital stays leading to a Medicare nursing home stay. In the hospital patient classification system, DRGs are the analog of the SNF RUG classification system; patients in the same DRG typically have relatively homogeneous clinical characteristics and utilize similar hospital resources.

Because the DRG system changed dramatically over the time period studied, we used the Primary Diagnosis rather than the DRG to assess whether the national mix of patients treated at SNFs changed from year to year.

Comparing these clinical characteristics over time helps us answer questions about whether the increased acuity reported by SNFs results from changes in SNF billing and utilization, or actual changes in the case mix. We found that, indeed, patients had similar characteristics from 2006 to 2009:

- Average ages are similar (Table 3, below)
- Patients had very similar Primary Diagnosis at the hospital prior to entering a SNF for post-acute care (Table 4, below).

However, even though national patient characteristics were little changed from 2006 to 2009, we also wanted to find out whether patients at the Top 15 operators were different from patients at other SNFs. Comparing the hospital-reported clinical characteristics of patients treated at the Top 15 SNF operators to the same characteristics of patients treated at other operators helped us answer questions about whether the Top 15 operators are treating more complex patients than their peers. Again, we found

[8] In its recommendation to CMS to reform Medicare payments to SNFs, OIG implicitly supports this methodology by recommending that determining SNF payment levels CMS should consider "beneficiary hospital diagnosis and other information from the hospital stay to better predict the beneficiary's therapy needs." *Ibid*. page iii.

[9] Note: for the DRG matched-claim analysis we limited this analysis to the three available quarters of data for Federal Fiscal Year 2009 because the DRG system changes at the change of the Federal Fiscal Year. For the Primary Diagnosis matched-analysis we used entire calendar years. The 36 most common Primary Diagnoses did not change during the period 2006-2009.

that patients treated at the Top 15 operators in 2009 had similar clinical characteristics to national averages:

- Patient ages ranged from slightly below to slightly above the mean (Table 3)

- Patients also were grouped into very similar Diagnosis Related Groups (DRGs) during their hospital stay, whether or not they were treated at a Top 15 SNF (Figure 5)

Lastly, we compared the RUGs reported by SNFs within each hospital-reported DRG and Primary Diagnosis code and found that:

- The dramatic increase in billing for higher-paying RUGs reported by SNFs nationally from 2006 to 2009 was not due to changes in the types of patients seen at SNFs. On the contrary, each of the most common hospital diagnoses leading to a SNF stay witnessed this dramatic increase in RUG payments

- Analogously, the difference in billing for higher-paying RUGs between the Top 15 SNF operators and the national average SNF operators does not appear to be due to differences between respective patient populations. Instead, compared to the national average facility, the Top 15 SNF operators billed for higher-paying RUGs within each and every hospital-reported DRG leading to a SNF stay

Further analysis and discussion is provided along with the figures and tables below.

Table 3: Analysis of SNF Resident Age by Year, 2006 - 2009

Nursing Home Operator	Average Resident Age				Number of Residents			
	2006	2007	2008	2009	2006	2007	2008	2009
Salter Healthcare Services	82.6	82.1	82.8	82.7	639	856	974	1,097
Whitehall Boca	82.1	81.8	81.8	81.4	922	1,008	1,124	1,197
Theresea Khawly	79.7	80.0	80.5	80.6	2,111	2,139	2,146	1,896
Compass Health	82.2	81.1	81.3	80.5	986	977	1,039	1,140
Opis	79.6	80.0	80.2	80.1	1,994	2,052	2,031	1,927
NATIONAL	**79.1**	**79.0**	**79.0**	**78.8**	**2,017,565**	**2,014,728**	**2,035,840**	**1,980,999**
Altercare	79.2	79.7	79.1	78.7	1,863	1,896	1,753	2,064
DOS	78.1	78.0	78.6	78.2	1,760	1,714	1,921	1,813
Sun-Mar	79.2	78.7	79.3	77.9	1,464	1,641	1,747	1,882
Gulf Coast Health Care	77.3	77.5	77.8	77.8	4,840	4,860	4,716	5,049
North American Health Care	78.2	78.1	78.0	77.8	4,743	4,963	5,466	6,041
Manor Care	78.4	78.1	78.1	77.6	75,938	76,774	75,387	71,299
Greystone	75.9	77.0	76.5	76.4	2,379	2,454	2,500	2,632
Avery Eisenreich	76.7	76.7	76.5	76.2	3,944	3,855	3,988	3,744
Ensign	76.7	76.5	76.5	76.2	7,571	7,971	8,773	8,925
Emmanuel David	76.9	75.8	74.8	75.5	1,152	1,214	1,256	1,281

Table 4: Analysis of National SNF Residents by Hospital Diagnosis, 2006 - 2009

Primary Diagnosis from Hospital Stay Preceding Matched SNF Stay		Percent of All Stays for Year				Percent of Stays within this Hospital Primary Diagnosis that get ultra-high rehab utilization in SNF			
ICD-9	Description	2006	2007	2008	2009	2006	2007	2008	2009
486	PNEUMONIA, ORGANISM NOS	4.7%	4.3%	4.1%	3.8%	10%	14%	19%	25%
71536	LOC OSTEOARTH NOS-L/LEG	3.3%	3.5%	3.5%	3.7%	28%	36%	43%	52%
5990	URIN TRACT INFECTION NOS	3.3%	3.4%	3.5%	3.7%	11%	16%	22%	28%
V5789	REHABILITATION PROC NEC	2.3%	2.9%	3.0%	3.2%	29%	37%	46%	54%
82021	INTERTROCHANTERIC FX-CL	3.0%	3.0%	2.9%	3.0%	17%	23%	30%	38%
0389	SEPTICEMIA NOS	2.0%	2.2%	2.5%	2.8%	10%	13%	19%	24%
43491	CRBL ART OCL NOS W INFRC	2.6%	2.3%	2.2%	2.2%	26%	31%	38%	45%
5849	ACUTE RENAL FAILURE NOS	2.0%	2.2%	2.3%	2.1%	11%	16%	22%	29%
49121	OBS CHR BRONC W(AC) EXAC	1.3%	1.3%	1.7%	1.6%	10%	14%	19%	26%
4280	CHF NOS	3.9%	3.4%	2.1%	1.6%	11%	15%	21%	27%
71535	LOC OSTEOARTH NOS-PELVIS	1.4%	1.4%	1.5%	1.6%	25%	33%	41%	49%
5070	FOOD/VOMIT PNEUMONITIS	1.6%	1.6%	1.7%	1.6%	11%	15%	20%	26%
8208	FX NECK OF FEMUR NOS-CL	1.4%	1.4%	1.4%	1.4%	19%	24%	32%	40%
82009	FX FEMUR INTRCAPS NEC-CL	1.6%	1.5%	1.5%	1.4%	19%	25%	33%	41%
41071	SUBENDO INFARCT, INITIAL	1.4%	1.4%	1.4%	1.4%	12%	18%	22%	30%
71596	OSTEOARTHROS NOS-L/LEG	1.2%	1.1%	1.1%	1.2%	26%	33%	42%	50%
6826	CELLULITIS OF LEG	1.0%	1.0%	1.1%	1.1%	10%	15%	22%	28%
3310	ALZHEIMER'S DISEASE	1.2%	1.2%	1.2%	1.1%	11%	15%	21%	27%
27651	DEHYDRATION	1.4%	1.4%	1.2%	1.1%	12%	17%	23%	31%
51881	ACUTE RESPIRATRY FAILURE	1.4%	1.4%	1.3%	1.0%	12%	16%	22%	29%
42731	ATRIAL FIBRILLATION	0.8%	0.8%	0.9%	1.0%	13%	17%	25%	31%
8082	FRACTURE OF PUBIS-CLOSED	0.8%	0.8%	0.9%	0.9%	16%	22%	30%	40%
7802	SYNCOPE AND COLLAPSE	0.8%	0.8%	0.8%	0.8%	16%	22%	30%	39%
41401	CRNRY ATHRSCL NATVE VSSL	0.9%	0.8%	0.8%	0.8%	13%	18%	25%	32%
42823	AC ON CHR SYST HRT FAIL	0.0%	0.1%	0.4%	0.7%	13%	15%	21%	27%
73313	PATH FX VERTEBRAE	0.7%	0.7%	0.6%	0.6%	12%	18%	25%	32%
42833	AC ON CHR DIAST HRT FAIL	0.1%	0.1%	0.3%	0.6%	13%	15%	20%	28%
03842	E COLI SEPTICEMIA	0.5%	0.5%	0.5%	0.5%	11%	14%	20%	26%
00845	INT INF CLSTRDIUM DFCILE	0.4%	0.5%	0.6%	0.5%	12%	17%	23%	29%
4359	TRANS CEREB ISCHEMIA NOS	0.6%	0.5%	0.5%	0.5%	19%	26%	34%	41%
5789	GASTROINTEST HEMORR NOS	0.5%	0.5%	0.5%	0.5%	9%	12%	17%	24%
71595	OSTEOARTHROS NOS-PELVIS	0.5%	0.5%	0.5%	0.5%	25%	31%	40%	48%
8054	FX LUMBAR VERTEBRA-CLOSE	0.4%	0.4%	0.5%	0.5%	14%	21%	29%	37%
2761	HYPOSMOLALITY	0.5%	0.5%	0.4%	0.5%	13%	18%	26%	34%
25080	DMII OTH NT ST UNCNTRLD	0.5%	0.5%	0.5%	0.5%	11%	16%	22%	29%
72402	SPINAL STENOSIS-LUMBAR	0.5%	0.5%	0.4%	0.5%	16%	21%	29%	36%
All Other	n/a	49.4%	49.3%	49.8%	49.8%	13%	18%	24%	31%

Table 4 (above) shows that, in every year 2006-2009, patients had very similar Primary Diagnosis at the hospital, prior to entering a SNF for post-acute care. Table 4 also shows that following hospital care for each of the most common Primary Diagnoses, the corresponding percentage of SNF patients requiring ultra-high therapy utilization rose dramatically.

The diagnosis codes listed are the 36 most common Primary Diagnoses for hospital patient, prior to a SNF stay. These 36 codes account for around 50% of nursing home stays in each year, 2006-2009.

Results for the remaining 50% of stays (encompassing 6,757 different Primary Diagnosis codes) are aggregated into a single line, labeled “All Other.”

For each of the 36 most-common hospital Primary Diagnoses, the table lists:

- The percentage of SNF stays associated with each
- The percentage of stays leading to ultra-high therapy utilization upon admission to a SNF

Observations

- There was little change in the percentage of SNF stays associated with each of the 36 most common hospital diagnoses
- A dramatic shift occurred in the percentage of patients who utilized ultra-high therapy at the SNF

For example, in each year from 2006 to 2009, approximately 1% of patients became SNF residents following a hospital stay for which the Primary Diagnosis was 682.6, "Cellulitis and abscess of leg except foot."[10] This rate remained steady throughout the period. But at the same time, the percentage of these patients utilizing ultra-high therapy services rose steadily from 10% in 2006 to 28% in 2009 -- overall, a 280% increase.

[10] In the table, the standard, abbreviated form of the ICD-9 code and description are provided: 6826, CELLULITIS OF LEG

Figure 5: Hospital DRG Stay preceding SNF Stay for each DRG: Manor Care, Next 14 Operators and National Average

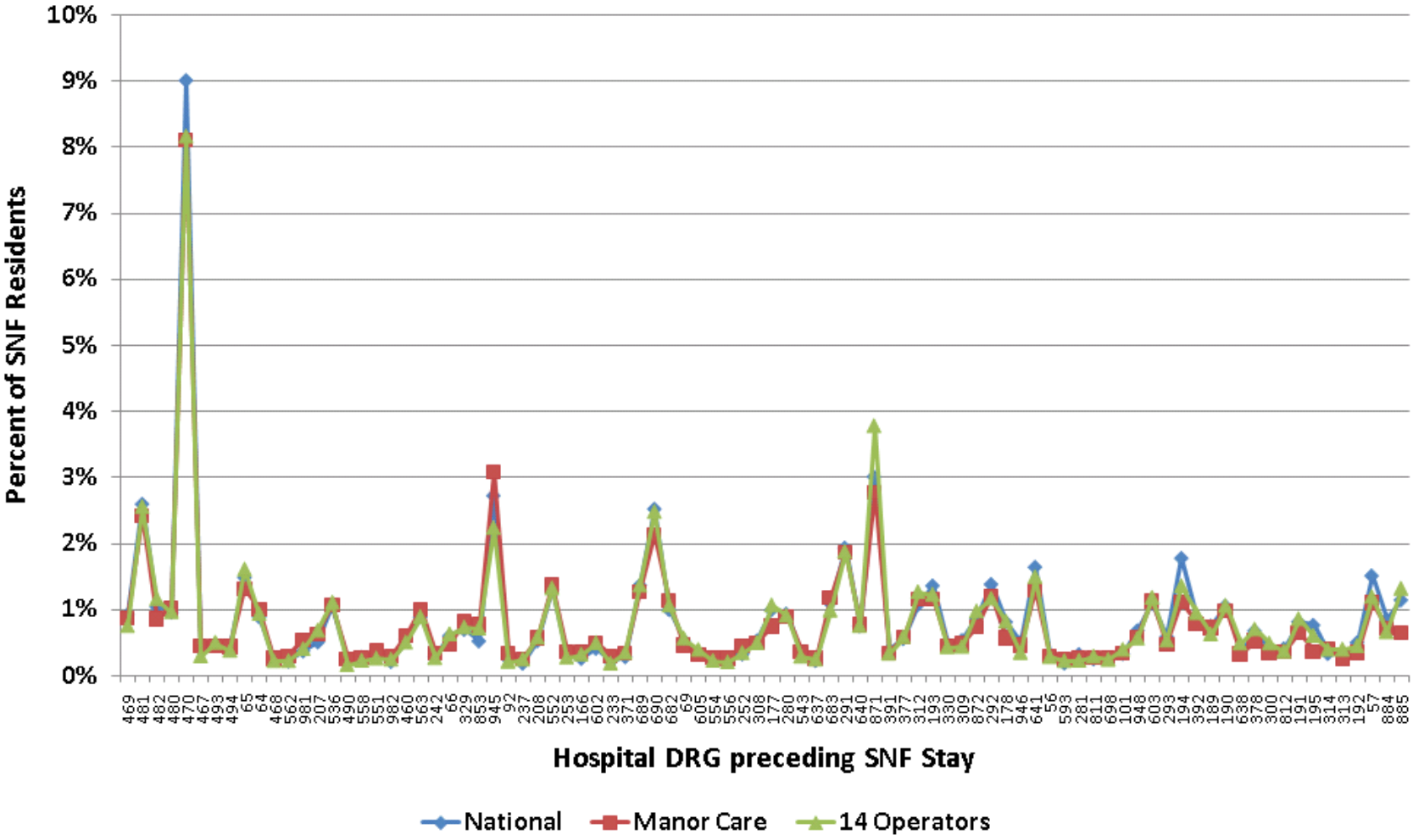


Figure 5 (above) shows the percentage of SNF residents whose qualifying hospital stay was classified in each DRG. The hospital DRGs are sorted in order of the average associated SNF RUG payment, with hospital stays typically leading to the highest-paying mix of SNF RUGs on the left, and the lowest paying mix of SNF RUGs associated with hospital stays classified in DRGs on the right.

Here payment is measured by the average per diem amount SNFs received for treating patients for the first day of a SNF admission, with geographic and other reimbursement adjustment factors removed. DRGs associated with less than 0.25% of nursing home stays are not included in this figure. The percent of residents not included in the figure nationally, at Manor Care, and for the other 14 operators: 26.6%, 29.9%, 27.9%, respectively.

Figure 5 strongly suggests that the Top 15 SNF operators do not have higher acuity patients than national averages. That is because, if the Top 15 SNFs were attracting higher-acuity residents, we would expect to see more residents coming from DRGs associated with higher-paying RUGs. In other words, in Figure 5 we would expect to see more residents coming from DRGs on the higher-acuity side (the left), and fewer residents coming from the lower-acuity side (the right). However, Manor Care and the 14 smaller operators' DRG frequencies line up very closely with national averages.

Following that demonstration, Figure 6 will show that patients admitted to SNFs after hospital stays in each and every DRG were treated by the Top 15 SNF operators at a standard payment amount per day significantly higher than the national average.

Figure 6: Standard Payment Amount per Day for each DRG: National vs. Manor Care vs. Next 14 Top Operators

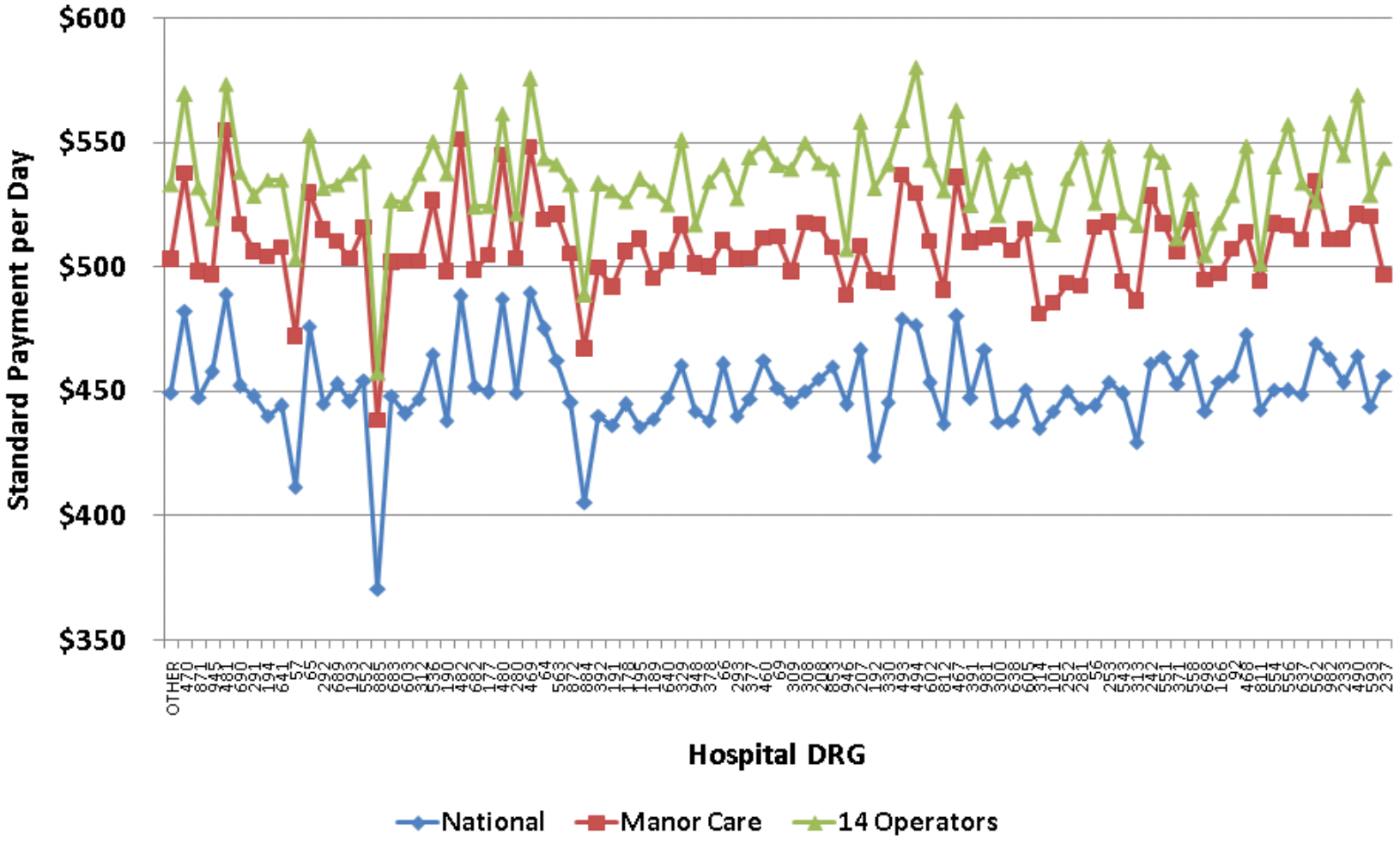


Figure 6 (above) shows that regardless of the hospital DRG preceding their stay, Manor Care and the next 14 of the Top 15 SNF operators bill using markedly better-paying RUGs than average. Geographic and other reimbursement adjustment factors have been removed from the payment amounts for apples-to-apples comparison. DRGs are sorted in order of frequency, from the most common DRG leading to a SNF stay, to the least common. The "Other" category is included, aggregating DRGs that have a small number of associated SNF stays.

Acuity – Recap

The data strongly suggests that the clinical characteristics of patients receiving post-acute care did not change much between 2006 and 2009. Therefore, the dramatic increase in the utilization of higher paying RUGS appears to be driven by non-clinical factors.

The Top 15 SNF operators driving these trends in 2009 did not generally appear to differ from their peers in the case-mix of patients coming from hospitals, nor in the average age of those patients. Despite seeing a typical mix of patients, these operators appear to bill Medicare for similar patients, but using better-paying RUGs than their peers.

Conclusion

Building on the OIG's work in its *Questionable Billing* report, SEIU Healthcare estimated the potential overpayments to SNFs at $5.4 billion for 2007-2009 combined. More than half of the excess, $2.8 billion, was paid out in 2009 alone. We also identified the top 15 providers responsible for the questionable billing. Lastly, we found that the escalating RUG payment levels billed by SNFs from 2006 – 2009 do not appear to be accompanied by corresponding changes in average patient age, or in patients' clinical characteristics. Rather, clinical data about acute care hospital patients who are treated in a SNF following their hospital stay show very similar patient populations in each year from 2006 to 2009. In short, our findings agree with the OIG's assertion that, "(e)ven though SNFs significantly increased their billing for these higher paying RUGs, beneficiaries' ages and diagnoses at admission were largely unchanged from 2006 to 2008."[11]

SEIU Healthcare applauds the OIG's *Questionable Billing* report, as well as previous efforts by the agency to identify potential waste, fraud and abuse.[12] We look forward to the two announced, forthcoming studies by OIG, which will determine the extent to which SNF claims meet Medicare requirements, as well as the degree to which SNFs meet Federal requirements governing quality of care.[13] It is our hope that this report will contribute to the work of regulators, advocates and other stakeholders seeking to focus enforcement efforts and payment reform initiatives on areas where their attention can have the greatest positive impact on improving the Medicare program on behalf of seniors and the American public.

[11] *Ibid.* page ii

[12] See especially OIG, *A Review of Nursing Facility Resource Utilization Groups*, OEI-02-02-00830, February 2006, which found that 26 percent of claims submitted by SNFs in FY 2002 were not supported by the medical record, representing $542 million in potential overpayments.

[13] OIG, *Medicare Part A Payments to Skilled Nursing Facilities*, OEI-02-09-00200 and *Medicare Requirements for Quality of Care in Skilled Nursing Facilities*, OEI-02-09-201, forthcoming.

Methodology Notes

Medicare Reimbursement to SNFs, 2006 – 2009

Data source: 2006-2009 Medicare LDS Standard Analytical Files for Skilled Nursing Facilities

Included: SNF claims from 2006-2009 having RUGs days billed to Medicare[14]; all SNFs having at least 50 stays[15] in the year were included.

Details:

- ClaimThroughDate between 2006Q1 and 2009Q4
- Claims must have a Revenue Center line representing a bill for at least 1 day in a valid RUG, where the calculated daily reimbursement rate is non-zero
- PPS Indicator must indicate that the claim was a Medicare PPS claim

For each SNF, we calculated:

- **APA**: the Actual Payment Amount (includes geographic rate adjustments)
- **Days**: the Days of care provided
- **SPA**: the Standard Payment Amount, defined as the total RUG payments that would have been made to the SNF at reimbursement rates standardized at Medicare's payment rate to a SNF in an urban area with geographic wage index of 1.0
- **eSPA**: Expected Standard Payment Amount , defined as what the **SPA** would have been, were RUG days distributed at national, 2006 frequencies
- **eAPA**: Same as eSPA, but restores the geographic adjustments[16]

National and operator-level aggregates were calculated by summing over these values. Nationally, the key findings that result are obtained by observing:

- The APA and Days for each year
- The change in APA from 2006 to later years – this is, "Change in reimbursement since 2006"
- The change in eAPA from 2006 to later years – the difference between this and the actual change in APA gives us "Portion of increased reimbursement due solely to changes in reported acuity"
- The remainder of the "Change in reimbursements since 2006" is labeled, "Portion of change due to payment rate changes and total days of care"

Salient operator-specific aggregates were calculated similarly.

[14] Technical details for analysts seeking to replicate: ClaimThroughDate of 2006Q1-2009Q4; Claims have non-zero RUG days and non-zero corresponding charges. PPS Indicator indicates PPS claim.

[15] By number of admissions. The 50-stay cutoff matches the OIG's methodology, though the OIG's dataset is richer, and our methodology and resulting numbers differ slightly as a result.

[16] Geographic adjustment approximated at the provider level, employing the aggregate ratio of each provider's APA to its SPA. I.e., eAPA was approximated as (APA/SPA) x eSPA.

Methodology notes for identifying the Top 15 providers

To focus on operators that were paid at well-above expected rates, we sorted operators by the ratio of Actual Reimbursement to Expected Reimbursement. We then honed in on operators in the 95th percentile and above. We defined Expected Reimbursement as what would have been paid to each operator in 2009 had the operator categorized patients into each RUG at the same frequency as SNF residents were classified into the same RUG in 2006. The 2006 RUG frequencies employed were simply the percentage of all SNF days classified into each RUG, nationally, in 2006.

To create the Top 15 list we included only operators in the 95th percentile or above, for Actual / Expected. Among that top 5%, the 15 operators with the greatest total dollar impact on Medicare are listed below. The dollar impact was defined as the potential excess reimbursement: Actual – Expected reimbursement.

Average Patient Age

Each SNF resident was counted once per year and quarter, and the number of residents represents the sum of the number of unique residents treated at each SNF in each quarter of the year. Resident ages were drawn from the Medicare Denominator file.

About SNF Ownership by Operators

SNF ownership is based on the SNFs presently owned by each operator according to SEIU's internal nursing home database. The paucity of public disclosure on nursing home ownership, as well as intricate ownership structures, leads to the potential for minor omissions or other inaccuracies. In addition, recently acquired SNFs are grouped under their current operator for previous periods when they might have been controlled by other operators. This improves comparisons over time, as any given facility will typically be categorized in the same group each year. However, it also means that the operator listed may not be the operator who was responsible for the facility at the time a given RUG payment was billed to Medicare.