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MISSOURI QUALITY INITIATIVE FOR NURSING HOMES (MOQI)

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PHYSICIAN REIMBURSEMENT AND REDUCING NURSING HOME RESIDENT HOSPITALIZATIONS

There has been an increasing scrutiny on potentially unavoidable hospitalizations in nursing home residents as the concept of value-based medicine (VBM) has developed. While VBM is often viewed as mainly concerned with reducing costs, it actually has equal concern for providing the best care for persons. Residents can experience substantial harm during hospitalizations including iatrogenic illness, functional decline, stress, disorientation and lengthened recuperations. Currently only hospitals are penalized for potentially avoidable hospitalizations, although this will be expanded to nursing facilities. Estimates of unnecessary transfers from nursing homes to emergency rooms and hospitals run as high as 60% of all cases. In 2011, nursing homes transferred one quarter of their Medicare residents annually to hospitals for inpatient admissions, and Medicare spent \$14.3 billion on these hospitalizations. For comparison Medicare spent \$32 billion on SNF stays in 2011, and all nursing home physician services cost about \$1 billion dollars. Most hospitalized residents (68 percent) transferred from nursing homes to hospitals only once, twenty percent transferred two times, 7 percent transferred three times, and 5 percent transferred four or more times. The average hospitalized nursing home resident cost a third more than the average Medicare beneficiary. Billions of dollars could potentially be saved annually and resident harm minimized if systems could be optimized to promote early recognition of change in condition, provide needed services in the nursing home and minimize unneeded transfers.

The Missouri Quality Initiative for Nursing Homes (MOQI) is working to reduce such unnecessary hospitalizations. Many factors influence hospitalization rates beside clinical status of long term care residents, including adequacy of communication systems, preferences of resident and family, training and number of nursing staff, availability and preference of practitioners, and payment / economic factors. Medicare through the MOQI project has expressed interest in addressing all these factors to help provide better value based medicine for nursing home residents. The physician who understands how these systems work will be posed for success as payment systems change.

The most common diagnosis associated with nursing home admissions (and percent of all admits) includes septicemia (13.4%), pneumonia (7%), congestive heart failure (5.8%), UTI (5.3%), aspiration pneumonia (4%), and acute renal failure (3.9%). These 44% of all admits can all be substantially impacted by improved systems for disease management in the nursing home. In a separate analysis specifically looking for avoidable hospitalization diagnosis and percent occurrence, the most common causes were pneumonia (30.5%), congestive heart failure (16.8%), dehydration (12.9%) and UTI (11.7%). Potential cost savings are huge – septicemia of hospitalized nursing home residents cost Medicare \$3 billion dollars, and all types of pneumonia cost almost \$1.5 billion dollars. Costs of treating these conditions in the nursing home are not well estimated, but



undoubtedly far less than the average Medicare Part A hospital reimbursement of over \$17,000 for septicemia and about \$10,000 for all pneumonia types.

The Office of the Inspector General (OIG) has recently reported several factors which affect the home's propensity to hospitalize patients, including Five Star Rating, size of the home, staffing ratios, survey findings, financial status and geographic location. Several underlying factors seem to be common, including communication systems and involvement of health professionals. Because of these differences in hospitalization rates the OIG has suggested, and CMS has concurred, with the development of a quality measure that describes the nursing home hospitalization rates. This quality measure may not only be valuable tools for quality improvement, referring healthcare systems and consumers, but may be one of several factors influencing physician payment.

Physician performance will soon be economically influenced by the undue expense of costly medical practices, which can result in hospitalizations. Under the current law, starting in 2015 for larger groups and by 2017 for all physicians, a value based modifier system will be utilized which will assign all Medicare A and B expenses to each practitioner responsible for such costs. This cost basis for each practitioner will then be compared to peers and stratified to arrive at incentives for low cost physicians and penalties for high cost physicians. Since the highest costs occur under Medicare Part A, there will be substantial interest for the physician to aggressively address potentially avoidable hospitalizations. The current system envisions differential payments of about 4%, but a proposed congressional bill (Medicare Patient Access and Quality Improvement Act of 2013) that in part is designed to "fix" the SGR problem envisions a slightly different Value Based Program that has incentives of up to 10% for best performing physicians. Both the current law and the proposed bill allow physicians to avoid such value based programs and the attendant incentive- penalties, but only if some form of risk-based alternative program is used such as an ACO. These systems may have different exact fiscal incentives, but nonetheless there will be rewards for physicians who can avoid unnecessary hospitalizations.

Under the current fee for service system it is financially advantageous to hospitalize nursing home patients. As an example, in the unlikely scenario of a physician making three visits over 5 days to treat pneumonia in the nursing home, billing at maximal levels only results in a total reimbursement of \$270 (\$90 a day, logistic issues, fewer support staff plus many calls). In the hospital a typical five day stay would net about \$500 (\$100 a day, few logistic issues, abundant support staff and fewer calls). The nursing home is similarly fiscally inclined to transfer ill patients out of the facility rather than encounter the lack of reimbursement for the extra staff and logistic needs. Medicare is considering trialing payment mechanisms to combat these tendencies. For specific conditions that could result in avoidable hospitalizations (such as pneumonia or dehydration) both the facility and the physician may receive additional payments to treat the condition in the home, which reflects the extra time spent in effectively managing the condition. There are many efforts to pay for care planning codes whereby the physician is reimbursed for time spent discussing care options, goals of care, prognosis and advance directives. Such conversations have been shown to reduce excess medical costs and hospitalizations.

Hospitalizations for frail nursing home patients will always be inevitable, but ensuring that only the right person goes there at the right time under the right circumstances is critical to ensuring the best care for the patient at the least cost to the system. The status quo cannot continue unchecked, and the physician who learns how to clinically practice the best medicine and understands how systems work to provide optimal care will win for themselves and their patients. Working with the MOQI project will teach the physician these principles for future success.

Sincerely,

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Office of the Inspector General, DHSS, Medicare Nursing Home Resident Hospitalization Rates Merit Additional

Monitoring OEI-06-11-00040, November 2013.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents,
<http://innovation.cms.gov/initiatives/rahnfr/>.