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Financial Incentives in the Long-Term Care Context: A First Look at Relevant Information

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Executive Summary

This report examines financial incentives surrounding long-term care, particularly in the skilled nursing facility (SNF) setting, focusing especially on how these incentives might influence the transfer of nursing home residents to inpatient hospital or emergency department settings for additional care. It also briefly considers factors relevant to hospice care and care provided in the assisted living facility (ALF) setting.

Among the paper's major findings and conclusions are the following;

- Differences in Medicare payment and coverage for physician evaluation and management services provided in different settings (hospital, nursing home, and ALF) appear unlikely, by themselves, to play a significant role in influencing the transfer of nursing home patients to hospital settings. However, the Medicare contractors that adjudicate physician claims may be more likely to question the provision of frequent or daily visits to a nursing home or ALF resident compared to a hospitalized patient. This risk together with physician uncertainty about how to code, and document the medical necessity of, physician visits in long-term care settings may have a bearing on decisions to transfer nursing home and ALF residents to the hospital.

- The current Medicare SNF payment policy (under which payment is made on a fixed, per diem basis, adjusted for certain factors), the related consolidated billing requirement (under which a SNF is financially responsible for nearly all items and services that its residents receive during a Medicare-covered SNF stay), and exclusions from that requirement (notably for emergency services and ambulance trips to hospitals) make it easy to understand why a SNF would have incentives to see residents with some acute condition transferred to the hospital rather than remain in the SNF.

- Separate "bed-hold" and "reserved-bed" revenue streams might provide a modest, added incentive for transferring nursing home residents to the hospital with the expectation that they will ultimately return to the nursing home. Under the first, a nursing home receives payments from residents in return for holding a specific bed in the facility while the resident is away receiving inpatient hospital care. Under the second, a nursing home receives payments from hospitals seeking guaranteed or priority placement of their discharged patients.

- The fact that a SNF's own medical director might also serve as the attending physician for many of the facility's residents (thereby being directly responsible for decisions to transfer some SNF residents to the hospital), means there is at least the appearance of a potential conflict of interest in the medical director's discharge of his or her two roles (as facility medical director and as attending physician). Further, a facility's medical director could also be the decision maker with respect to the transfer of patients whose attending physician cannot be contacted in an emergency, and a facility's own nursing staff also has the option of immediately transferring a patient to the hospital under certain circumstances.

- Financial incentives associated with the provision of hospice care to nursing home residents (affecting both the nursing home and the hospice) may lead to arrangements not necessarily in

the best interests of the patients and/or the public programs paying for nursing home and hospice care. In fact, it appears there is a significant risk that the affected nursing home residents are not necessarily getting full value for the payments made on their behalf under the Medicare and/or Medicaid programs.

- A host of other considerations, such as fear of malpractice litigation if a nursing home resident is not transferred to a hospital and dies or suffers serious complications or lack of necessary technology in the nursing home setting, also likely have a bearing on decisions to transfer nursing home residents to a hospital.

- The recently enacted health reform legislation mandated a number of policy changes, demonstrations, and other initiatives relating to nursing home and hospice care. These provisions demonstrate Congressional recognition that Medicare and Medicaid policies relating to nursing home and hospice care are far from perfect and require modification. Nevertheless, it is far from clear that the mandated changes will significantly alter the incentives influencing the transfer of long-term care facility residents to a hospital (rather than appropriately caring for them in the long-term care facility itself), or those affecting the provision of hospice care to nursing home residents.

Introduction

The Medicare Payment Advisory Commission (MedPAC) recently called attention to the fact that potentially avoidable rehospitalizations of skilled nursing facility (SNF) patients have "steadily increased (indicating poor quality)."[1] More specifically, in 2007, the mean risk-adjusted SNF rate for the five potentially avoidable rehospitalization conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) was 18.5 percent, compared with 13.7 percent in 2000. At the same time, the Commission recommended that the Congress eliminate the update to Medicare payment rates for SNF services for fiscal year 2011, due in large part to a finding of high average Medicare margins for freestanding SNFs (16.5 percent in 2008), although nursing home representatives argue that generous Medicare payments are needed to offset the effect of much lower Medicaid payments.

This report examines financial incentives surrounding long-term care, particularly in the SNF setting, focusing especially on how these incentives might influence the transfer of SNF and nursing facility (NF) residents to the inpatient hospital setting (or a hospital emergency department) for additional care. A SNF is a long-term care facility providing skilled care, which can be covered under Medicare. The term NF technically refers to facilities providing non-skilled (custodial) care, commonly covered under Medicaid, but which may also paid for by private long-term care insurance or from residents' own funds (the term may also sometimes substitute for the more generic term nursing home). This paper, which examines issues affecting both SNF and NF residents, begins by examining incentives that might influence physician behavior, and then discusses the potential implications of current Medicare SNF payment policies. The paper goes on to review other SNF and NF revenue streams and the roles of the SNF or NF medical director. It then briefly considers factors relevant to the hospice and assisted living facility (ALF) settings. It concludes by summarizing pertinent policy changes arising from recently enacted health reform legislation.

As described in more detail below, the paper finds that decisions to transfer the resident of a SNF, NF, or ALF to a hospital for further care might be influenced by one or more factors other than purely clinical considerations. In addition, financial incentives associated with the provision of hospice care to SNF or NF residents may lead to arrangements not necessarily in the best interests of the patients involved and/or the public programs paying for the care.

Physician Incentives

Under federal regulations (42 CFR section 483.40), each resident of a SNF participating in Medicare and each resident of an NF participating in Medicaid must remain under the care of a physician and, except as noted below, each resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist. In addition, at the option of the relevant state, any required physician task in an NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. Further, SNFs and NFs must ensure that the medical

[1] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, March 2010.

care of each resident is supervised by a physician and that another physician supervises the medical care of residents when their attending physician is unavailable. In fact, these facilities must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

Medicare Physician Payment Differentials. An obvious question is whether Medicare policies with respect to the payment and coverage of physician evaluation and management (E&M) services provided to patients in SNFs, NFs, ALFs, and hospitals might have a bearing on physician decisions to transfer SNF, NF, and ALF residents to a hospital for further care. One possibility is that Medicare physician payment differentials for E&M services provided in different settings might help explain why physicians might prefer to transfer long-term care facility residents to a hospital rather than attempt to manage them in a long-term care setting. Assessing these payment differentials is complicated by differences in how the services are described and coded, including differences in the number of levels of service in the different settings.

Descriptor codes for E&M services can vary based on the setting of the E&M service (hospital vs. NF visits), whether the service relates to a patient new or not new to the physician (the latter known as an established patient), and whether the service is the first during a particular episode of care or a subsequent visit. Further, for any setting, there are multiple levels of E&M service (usually three to five) that vary based on three key components: history, examination, and medical decision making. For example, for initial NF visits, the highest level visit (Level III) would be expected to involve a comprehensive history, a comprehensive examination of the patient, and medical decision making of high complexity. Further, in furnishing this service, a physician would typically be expected to spend 45 minutes at the bedside and on the patient's facility floor or unit. Suffice it to say that in reporting E&M services, a physician must select from an array of Current Procedural Terminology (CPT) codes and descriptors maintained by the American Medical Association and his or her selection must be based on a determination of which code most accurately describes the service actually provided.

Table 1 compares the April 1, 2010 average Medicare payments for different levels of initial hospital and initial NF care and for domiciliary care services provided to new patients residing in an ALF (the CPT codes for domiciliary, rest home, or custodial care services are used to report E&M services in an ALF). The table also shows the typical time (in minutes) that a physician would be expected to spend in providing the different types and levels of service. Please note, however, that time is only one of the criteria that distinguish between visit levels. Nevertheless, time does provide a simple, though crude means for comparing payments to anticipated levels of physician work.

Table 1
Medicare Payments for Selected Initial/New Patient E&M Services

Level	Initial Hospital	Typical Physician Time	Initial Nursing Facility	Typical Physician Time	Assisted Living, New Patient	Typical Physician Time
I	$95.26	30	$85.16	25	$54.49	20
II	$129.18	50	$119.44	35	$79.39	30
III	$189.80	70	$152.64	45	$133.15	45
IV	N/A	N/A	N/A	N/A	$173.57	60
V	N/A	N/A	N/A	N/A	$203.52	75

Similarly, Table 2 compares average Medicare payment amounts for subsequent hospital and subsequent NF care and for domiciliary care services provided to established patients residing in an ALF.

Table 2
Medicare Payments for Selected Subsequent/Established Patient E&M Services

Level	Subsequent Hospital	Typical Physician Time	Subsequent Nursing Facility	Typical Physician Time	Assisted Living, Established Patient	Typical Physician Time
I	$35.25	15	$40.78	10	$57.01	15
II	$68.92	25	$62.79	15	$88.77	25
III	$98.87	35	$82.99	25	$124.85	40
IV	N/A	N/A	$122.69	35	$179.34	60
V	N/A	N/A	N/A	N/A	N/A	N/A

In reviewing the above tables, it is important to understand that Medicare payments for physicians' services are based on an assessment of the relative resources involved in providing those services, specifically focusing on physician work (time and intensity), practice expenses, and professional liability insurance costs. For each of these resource categories, relative value units are assigned to a service. Further, the relative values for many physicians' services, including most E&M services, have been revised over time through a process known as the five-year review of relative values. Thus, while there is certainly room for quibbling about the accuracy of current relative values, it is also true that an attempt has been made to adopt values that accurately reflect differences in the resources required to furnish different services. Thus, if payment for one service is greater than or less than that for another, the rebuttable presumption is that the two services differ in terms of typical resource inputs.

Of course, in assessing the potential incentives arising from Medicare payment differentials, it is important to acknowledge that travel time to a facility is typically ignored in setting payment rates. In addition, the number of patients seen on the same day in a given facility obviously would have a bearing on the degree to which a physician's time is spent efficiently. For example, travel to a hospital to see a single patient would certainly have different implications for the physician in question than traveling to an NF to see five or more patients. ***In any event, in light of the relatively modest payment differentials noted in the above tables, it seems unlikely that Medicare payment differentials alone would provide very strong incentives for physicians to prefer caring for their SNF, NF or ALF patients in a hospital setting rather than in a long-term care facility setting.***

Medicare Contractor Oversight. Of course, Medicare payment differentials are not the only consideration in assessing possible incentives for a physician to transfer a patient from a SNF, NF or ALF setting to a hospital. Another relevant matter is whether the medical necessity of furnishing multiple (e.g., daily) visits to a patient might be less likely to be challenged by Medicare contractors in one setting versus another. In this regard, there are certainly anecdotal reports of Medicare contractors or Quality Improvement Organizations (QIOs) either making it difficult for physicians to be paid for SNF or NF visits occurring more frequently than once per month or discouraging them from seeing nursing home patients more often than once every 30 days.

With respect to the medical necessity issue, Section 30.6 of Chapter 12 of the Medicare Claims Processing Manual does not impose any specific limits on the number of visits that can be furnished to patients residing in SNF, NF, ALF, or hospital settings. Repeatedly, the manual instead emphasizes that each visit must be reasonable and medically necessary and documented in the medical record. For example, Section 30.6.13 of the Manual states that "[p]ayment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record." Note, too, that federal regulations specify, for example, that a nursing home patient must be seen by a physician at least once (not only once) every 30 days for the first 90 days.

A search of the public Web sites of three Medicare contractors (Trailblazer, First Coast and Noridian) found no evidence that such contractors had adopted arbitrary limits on the number of visits that could be provided to nursing home patients. Nevertheless, the existence of such limits has been noted in the past. For example, a 2001 Institute of Medicine (IOM) report recommended removal of "[a]rbitrary limits set by fiscal intermediaries on the number of [nursing home] visits" and the IOM committee added that Medicare and Medicaid regulations for physicians' services in nursing homes should clearly allow the number and type of services provided to be based on residents' medical needs and the severity of their illness.[2]

A close review of the current (9th) Statement of Work for QIOs also found no evidence that these organizations were being tasked with discouraging physician visits to nursing home patients or even being urged to monitor the frequency of physician visits to such patients. In fact, that Statement of Work makes provision for both a "Nursing Homes in Need" (NHIN) program and an optional Care Transitions program. Under the NHIN program, technical assistance is being provided to a limited number of nursing homes (one per year per state) from August 1, 2008 through July 31, 2011 by QIOs, who must conduct an on-site assessment of each home to identify underlying causes of poor quality of care, prepare a root-cause analysis based on those findings, and develop an action plan to address the home's problems. CMS monitors improvement in two quality of care measures to determine the effect of QIO assistance during the initiative—the percentage of long-term residents of a facility who were either physically restrained or were high risk and had pressure ulcers. CMS also monitors QIO performance by evaluating nursing home satisfaction.[3] Under the Care Transitions project, QIOs in 14 states are working to coordinate care and promote seamless transitions across settings, including from the hospital to home, skilled nursing care, or home health care, and to reduce unnecessary readmissions to hospitals. In the time available for this project, attempts were made to obtain CMS staff feedback regarding QIO roles in nursing homes (especially to determine whether allegations that at least one QIO is discouraging physician visits to nursing facility patients might be true) but these were unsuccessful.

The above notwithstanding, there is undoubtedly a greater likelihood that the Medicare contractors that adjudicate physician claims would question the provision of frequent or daily visits to a SNF or NF patient or to an individual residing in an ALF compared to a hospitalized patient, since the presumption would be that a patient admitted to a hospital was sufficiently ill to require daily visits by the physician responsible for his or her care. While Medicare policy has sometimes been motivated by concerns about inadequate physician involvement in the care of NF patients, there has also been a long history of concern about the potential for physicians to provide unnecessary visits to such patients. For example,

[2] Institute of Medicine, *Improving the Quality of Long-Term Care*, 2001, p. 201.
[3] Government Accountability Office, "Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened," March 2010.

a special fraud alert issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services in May 1996,[4] called attention to the issue of "gang visits" by one or more medical professionals, where large numbers of residents are seen in a single day. The alert went on to note that in such cases, the practitioner "may be providing medically unnecessary services, or the level of service provided may not be of a sufficient duration or scope consistent with the service billed to Medicare or Medicaid." Similarly, the alert warned that frequent and recurring "routine visits" by the same medical professional "may indicate the provider is billing for services that are not medically necessary." Finally, the alert called attention to the problem of questionable documentation for medical necessity of professional services furnished in the NF setting, adding that practitioners "who are billing inappropriately may also enter, or fail to enter, important information on medical charts."

In addition, the Medicare Claims Processing Manual, at section 30.6.13(G) of Chapter 12, states that claims "for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits." The manual goes on to emphasize that the medical record "must be personally documented by the physician or qualified NPP [non-physician practitioner] who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient."

Physician Practices in Nursing Homes. In 2005, the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services released a report reviewing the available literature on physician practices in nursing homes.[5] As part of this work, a 10-member technical advisory group (TAG), consisting of six physicians, two nurses, one geriatric nurse practitioner, and one nursing home administrator, was also convened. With respect to reimbursement, the report notes physicians' "concern that their nursing home claims will be denied" and adds that Medicare contractors "commonly disallow visits between the required 30-day or 60-day intervals as routine <u>when not well documented</u>" [emphasis added]. TAG members also:

> …identified a need to address the misperceptions and fears of coding and billing for nursing home physicians. Several participants reported very low denial rates once billing codes and documentation for visits were carefully examined for accuracy. In particular, one participant estimated that physicians could expect to achieve denial rates less than 1% with attention to billing practices. **Participants agreed that the source of physician denials and subsequent perception that reimbursement for nursing home work is poor is more likely due to misunderstanding or lack of adequate education about correct billing and coding procedures than the actual reimbursement rates.** However, with little training or education in nursing home care, physicians are not likely to feel comfortable in their billing practices for nursing home care [emphasis added].

The ASPE report also acknowledges other potential motivations for physician decisions to transfer an NF patient to the hospital:

[4] Office of the Inspector General, Special Fraud Alert, "Fraud and Abuse in the Provision of Services in Nursing Facilities," OIG 96-18, May 1996.
[5] Levy, Cari et al., "Literature Review and Synthesis of Physician Practices in Nursing Homes," Prepared for Office of Disability, Again and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, October 17, 2005.

- Lengthy travel time to a nursing home, creating incentives for physicians to request that a resident with some acute problem be sent to the hospital or emergency department;
- Conflicts between the demands of a busy physician office practice and a distant nursing home's call to attend to a patient with some acute problem;
- Inadequate training to provide care in nursing homes;
- Fear of malpractice litigation for not hospitalizing a patient who subsequently dies in the nursing home; and
- Technology available in nursing homes being "below the standard needed to effectively treat a patient for an acute event."

Unfortunately, it is beyond the scope of this paper to do justice to these other potentially relevant factors.

An Individual Physician's Role(s) Across Care Settings. Lastly, any incentives relating to differential payment and coverage of E&M services provided in different settings would really only be relevant if the same physician were providing services across the various settings. As noted in detail below, this is frequently not the case today.

In this regard, the 2005 ASPE report cited earlier:

- Notes the trend in physician specialization in the delivery of care, acknowledges that the "hospitalist" specialty "has emerged specializing in the delivery of care in the hospital environment," and goes on to add that increasing specialization "in one site of care reduces the number of physicians who are following patients from the office to the hospital and then to the nursing home setting;"
- Points out the distinction between NFs with closed staffing models (under which physicians salaried or employed by an NF care for the facility's residents) and those with open staffing models (where community physicians care for the residents);
- Notes that the TAG suggested that some physicians are beginning to specialize in nursing home care in a manner similar to physicians who specialize in hospitals as their sites of care, and also identified "a lack of continuity of physicians between the hospital and nursing home" as one potential barrier to training physicians in the care of nursing home residents;
- States that the majority of physicians who care for nursing home residents have traditionally been community physicians with both an office and hospital-based practice as opposed to practicing in one of these settings exclusively, but then acknowledges data suggesting that "once patients are admitted to nursing homes, they are unlikely to be followed by their physicians who had been treating them in office practices;"
- Finds that nursing home medical directors often provide direct care to nursing home residents with one study indicating that about two-thirds of medical directors serve as the attending physician for some residents and, on average, care for 43 percent of patients in their facilities; and
- Notes that some Medicare managed care plans employ or use physicians who devote 100 percent of their practices to the care of nursing home residents. Moreover, only 3 of 21 managed care programs with nursing-home based physicians reported that the physicians followed their residents into the hospital when they needed acute care, with most such physicians having "dedicated nursing home practices with no competing clinical duties."

In a similar vein, a 2010 practice guideline on "Transitions of Care in the Long-Term Care Continuum" developed by the American Medical Directors Association (AMDA), the national professional organization representing medical directors, attending physicians, and other practitioners who care for patients in the long-term care setting, notes that a patient may be hospitalized under the care of a hospitalist and subsequently admitted to a SNF under the care of a SNF specialist, a physician who limits his or her practice to SNFs, and that a single clinician "rarely provides continuous care for a patient across care settings." This guideline also notes that financial incentives to promote transitional care, collaboration across sites, and accountability are lacking.

Hospitalists practice full-time within an institutional setting and do not have an office-based practice. At the same time, "[i]n the face of declining reimbursement rates that have failed to keep pace with rising practice costs, many primary care physicians have shifted focus to office-based practice where they can work more efficiently."[6] In fact, through the Community Tracking Study (CTS), the Center for Studying Health System Change has been able to document the rapid growth in the number of hospitalists practicing in the twelve metropolitan areas covered by the CTS, and as the hospitalist model has gained acceptance, "a sizable percentage of community-based physicians…no longer deliver any inpatient care" [emphasis added].[7]

Taking all of the above into account, it seems unlikely that differences in Medicare payment and coverage for physician E&M services provided in different settings, by themselves, play a significant role in influencing the transfer of nursing facility patients to the hospital inpatient setting.

SNF Payments

Another area worth exploring is whether Medicare payment policies related to SNF care might have a bearing on the transfer of Medicare beneficiaries from SNFs to hospitals. All SNF Part A inpatient services are paid under a prospective payment system (PPS), under which daily base rates are adjusted for case mix using a system known as Resource Utilization Groups (RUGs), with the RUG-III classification system now in place having 53 groups (a RUG-IV system, originally slated for implementation effective fiscal year 2011 has 66 groups). Assignment to a RUG is based on a number of considerations, such as the patient's need for certain services, the presence of certain conditions, and an index based on the patient's ability to perform independently four activities of daily living.[8]

Under the consolidated billing requirement, a SNF must submit all Medicare claims for all the services that its residents receive under Part A, except for certain excluded services. As noted in section 10.1 of Chapter 6 of the Medicare Claims Processing Manual, a beneficiary's status as a SNF patient for consolidated billing purposes ends if the beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (or as a resident to another SNF), if the beneficiary dies, or if the beneficiary is formally discharged from the SNF (which can include being moved to a Medicare non-certified area within the same institution). Further, for services subject to consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside

[6] Society for Hospital Medicine, "Hospitalists: Leading the Way to More Effective, Higher Quality Care," accessed at www.hospitalmedicine.org.
[7] Pham, Hoangmai et al., "Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care," *Health Affairs* 27(5):1315-1327, September/October 2008.
[8] See Medicare Payment Advisory Commission, "Skilled Nursing Facility Services Payment System," Revised October 2009, for other SNF payment basics.

entity (such as a supplier) under an "arrangement." Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing.

Services excluded from SNF consolidated billing include most physicians' services, emergency services, and ambulance trips relating to the transport of a Medicare beneficiary from the SNF to a Medicare participating hospital or a critical access hospital for an inpatient admission. On the other hand, ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility are included in SNF consolidated billing and may not be billed separately. ***Given current Medicare SNF payment policy, the related consolidated billing requirement, and exclusions from that requirement (notably emergency services and ambulance trips to hospitals), it is easy to see why a SNF would have incentives to see SNF residents with some acute condition transferred to the hospital rather than remain in the SNF.***
In fact, MedPAC has argued that "[t]he shortcomings of the current SNF PPS are extensive and create inequities for beneficiaries and providers."[9] For example, MedPAC believes that the current Medicare SNF payment methodology "underpays for medically complex care," and has recommended separate payment for nontherapy ancillary services (expensive antibiotics, ventilator care, and intravenous medications), and addition of an outlier policy "for SNF stays with exceptionally high ancillary costs."

Lessons from Prior Research. One relatively recent study concluded that treating residents of nursing homes with pneumonia and other lower respiratory tract infections using a clinical pathway or algorithm developed by the researchers "can result in comparable clinical outcomes, while reducing hospitalizations and health care costs."[10] However, the authors of this study argued that "[p]rospective payment and flat-rate systems of Medicaid reimbursements to nursing homes represent financial disincentives to have residents treated on-site in the nursing home" and that nursing homes "would need to receive supplemental funding to implement the pathway…[which] could be used to hire appropriately trained nurses, such as nurse practitioners."

A demonstration conducted several years ago, the EverCare Demonstration, showed transfers of nursing home residents to hospital emergency departments and hospital admissions from nursing homes could be reduced. The demonstration involved a capitated package of Medicare-covered services with more intensive primary care provided by nurse practitioners, who worked in cooperation with the residents' primary care physicians. Under this demonstration, nursing homes also were able to receive additional payment for Intensive Service Days, a policy intended to allow them to handle patients who might otherwise need to be hospitalized. Patients in the demonstration were seen more by their physicians than either of two control groups (86.72 visits per 100 enrollees per month vs. 70.49 and 66.54, $p<0.001$), indicating that the involvement of nurse practitioners in the care of demonstration patients did not displace physician visits. Interestingly, however, there was no indication that this model was able to reduce the incidence of events that traditionally required hospitalization. Further, an independent evaluation of this demonstration concluded that payments made for individuals enrolled in

[9] Hackbarth, Glenn M., Chairman, Medicare Payment Advisory Commission, Letter to Charlene Frizzera, Acting Administrator, Centers for Medicare & Medicaid Services, February 2, 2009.
[10] Loeb, Mark, et al., "Effect of a Clinical Pathway to Reduce Hospitalizations in Nursing Home Residents With Pneumonia: A Randomized Controlled Trial," Journal of the American Medical Association 295(21):2503-2510, June 7, 2006.

the demonstration project were about 30 percent higher than if they remained in fee-for-service Medicare.[11]

Another study concluded that managed care programs for nursing home residents provide more primary care and have the potential to reduce emergency department and hospital use compared with fee-for-service care but that not all such programs have been associated with decreased emergency department and hospital utilization, "perhaps because of differences in structure or implementation problems."[12]

Other Nursing Facility Revenue Streams

SNFs and NFs also have the potential to receive payments other than those made under the Medicare and Medicaid programs. For example, NFs may receive payments from residents in return for holding a specific bed in the facility while the resident is away receiving inpatient hospital care or is otherwise in a therapeutic leave status.

Bed Holds. Section 483.12 of federal regulations (42 CFR) addresses patients' admission, transfer and discharge rights with respect to NF care. It specifies facilities' obligation to provide notice of their bed-hold policy, including the duration of the bed-hold policy under the Medicaid State plan, if any, during which the resident is permitted to return and resume residence in the NF. These regulations also specify that a facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medicaid NF services.

With respect to bed-holds and the resident's right to return to the nursing home after being discharged from the home for hospitalization or therapeutic leaves, requirements are determined in part by the State's policy on how long payment will be made to hold a bed for a resident after discharge, and these vary. For example, in California, residents or representatives must decide whether to hold their bed within 24 hours of notification of transfer, and the bed must be held for up to seven days. In Iowa, the decision to hold the bed must be made within 48 hours of transfer notification. In Wisconsin, the period for a bed-hold is up to 15 days.[13] A fact sheet applicable to Michigan makes the following important points regarding the bed-hold situation in that state: All nursing home residents have the right to pay a fee to reserve their specific bed and each nursing home must provide the resident, family member or legal representative the facility's written bed-hold policy. There is no limit on how much a home can charge to reserve the resident's place at the home. However, all homes must readmit upon discharge from the hospital, even when payment to reserve the bed is not made (unless the resident requires care that is not available to any other resident in the facility), and the facility's obligation to readmit the resident to the next available bed continues indefinitely.[14]

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[11] Kane, Robert L, Gail Keckhafer and John Robst, "Evaluation of the Evercare Demonstration Program: Final Report," May 2002, Revised August 2002.
[12] Reuben, DB et al., "Primary care of long-stay nursing home residents: approaches of three health maintenance organizations," Journal of the American Geriatrics Society 47(2):131-138, February 1999.
[13] NH Regulations Plus, accessed at www.sph.umn.edu/hpm/nhregsPlus/category_face_pages/resident_rights_admission_transfer_discharge.htm.
[14] Citizens for Better Care, "Factsheet: Readmission to a Nursing Home Following a Hospital Stay," accessed at www.cbcmi.org/publications/readmission.htm.

Reserved Bed Arrangements. In addition to receiving payments relating to bed-holds, NFs may also receive payments from hospitals seeking guaranteed or priority placement of their discharged patients, under reserved bed arrangements. The OIG has noted that these arrangements "could be problematic if one purpose of the remuneration is to induce referrals of Federal health care program business from the nursing facility to the hospital." The OIG goes on to give examples of reserved bed payments that "may give rise to an inference that the arrangement is connected to referrals." These include payments that result in double-dipping (e.g., sham payments for beds that are actually occupied or for which the facility is otherwise receiving payment), and excessive payments (e.g., those exceeding the facility's actual costs of holding a bed).[15]

These separate bed-hold and reserved-bed revenue streams might provide a modest, added incentive for transferring nursing home residents to the hospital with the expectation that they will ultimately return to the SNF or NF.

The Roles of the Nursing Facility Medical Director

Another topic that deserves exploration is the range of potential roles played by SNF and NF medical directors. Section 483.75(e)(3) of federal regulations (42 CFR) specifies that a SNF or NF must designate a physician to serve as medical director. This individual is responsible for implementation of resident care policies and the coordination of medical care in the facility. A recent job posting for a nursing home medical director position in Philadelphia, PA, gives as job description the following:

> "The Medical Director as member of the nursing home management team is responsible for ensuring the adequacy and appropriateness of medical care at the Nursing Home. Responsible for direct primary medical care for residents, oversight of the clinical aspects of the care provided, and direct clinical supervision of the medical staff. Also provides medical direction including but not limited to: program development, quality oversight, care utilization, and strategic planning" (The posting provided no salary or other remuneration information relating to the advertised position).[16]

A recent survey of NF medical directors (part of a broader survey of professionals involved in NF care)[17] provides interesting information but must be treated with extreme caution, since the response rate was only 2.4 percent and no information is provided about the number of medical directors responding.[18] Survey findings relevant to this report include the following:

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[15] Office of the Inspector General, "OIG Supplemental Compliance Program Guidance for Nursing Facilities," *Federal Register*, September 30, 2008, pp. 56845.
[16] American Medical Directors Association, www.amda.com/careers/jobDetails.cfm?jobID=250.
[17] Simonson W., ed., *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals*, Sanofi-Aventis Managed Care Digest Series, 2009.
[18] The survey was conducted in April and May of 2009, more than 14,000 nursing facility medical directors, pharmacists active in practice with the elderly, nursing facility directors of nursing and geriatric nurse practitioners were surveyed, the total number of responses was 726, with response rates of 2.4 percent for medical directors, 5.2 percent for nurse practitioners, 5.6 percent for directors of nursing and 14.5 percent for pharmacists.

- Responding medical directors spend an average of 41 percent of their time in the nursing home, 8 percent in hospital, 5 percent in the ALF setting, 40 percent in office-based practice, 2 percent in home care, and 5 percent in other activities.
- The majority of medical directors (59 percent) serve one facility, 21 percent serve two, and 17 percent serve in three or more.
- 94 percent of medical directors also serve as an attending physician in one or more nursing facilities, and 45 percent said they serve as attending physician for 60 percent or more of the residents in their facilities.
- 63 percent of medical directors said they serve as attending physician for 100 or fewer residents, while 12 percent said they serve more than 200 residents.
- 35 percent of medical directors said they also serve as a medical director/advisor in one or more ALFs.

The typical nursing home medical director serves in that capacity on a contractual basis with the facility. There appears to be little or no public data on what physicians are paid by nursing homes for serving as medical director. And assessing such payment levels is complicated by variations in time actually spent by nursing home medical directors, the number of nursing home residents, the degree of physician involvement, etc. One estimate provided informally by a knowledgeable NF medical director was a probable range of $75 to $150 per hour for time actually worked. Medicare does not pay nursing home medical directors for the administrative services they provide to a SNF; these services would be considered included in the prospective payment made to the SNF and intended to cover all the services provided to a Medicare beneficiary in a Medicare Part A-covered stay. Of course, as noted earlier, a nursing home medical director could also function as an individual resident's attending physician and be paid separately by Medicare or other payers for direct patient care services provided to such individual.

Informal consultation with a few nursing home medical directors suggests that many or most nursing home medical directors would not see nursing home patients admitted to a hospital, although some nursing home medical directors might also work as hospitalists. In a February 2003 OIG report,[19] about half of the 119 responding nursing home medical directors said they were not expected by the nursing homes to provide direct care to patients, 86 percent spent 8 hours or less per week in the nursing home(s), 70 percent reported that 1 to 10 percent of their overall medical practice was devoted to their medical director role, and 62 percent visited the nursing facility 1 time per week or less. This information relating to the role of the nursing facility medical director, especially in their attending physician capacity, appears to complement information provided earlier in this report when discussing the potential implications of differences in Medicare payment and coverage policies relating to physician E&M services provided to patients in different settings.

Finally, given the incentives arising from Medicare SNF payment policy and the related consolidated billing requirement (discussed earlier) and the fact that a SNF's own medical director might also serve as the attending physician for many of the facility's residents (thereby being directly responsible for decisions to transfer some SNF residents to the hospital), there is at least the appearance of a potential conflict of interest in the medical director's discharge of his or her two roles (as facility medical director and as attending physician). Further, a facility's medical director could also be the decision maker with respect to the transfer of patients whose attending physician cannot be contacted in an emergency, and a facility's own nursing staff also has the option of immediately transferring a patient to the hospital under certain circumstances.

[19] Office of the Inspector General, Department of Health and Human Services, "Nursing Home Medical Directors Survey," OEI-06-99-00300, February 2003.

The Hospice Setting

The Medicare hospice benefit covers "a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician [and] who…agree to forgo curative treatment for their terminal condition."[20] Medicare pays hospices one of four possible daily rates: routine home care (representing more than 95 percent of all hospice days), continuous home care, inpatient respite care, and general inpatient care.

The Medicare Benefit Policy Manual, Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," notes that a Medicare beneficiary who resides in a SNF or NF may elect the hospice benefit under certain circumstances, including if the beneficiary is eligible for Medicaid and the facility is being reimbursed for the beneficiary's care by Medicaid. If so, Medicare pays the hospice for the hospice benefit and the state Medicaid agency pays the hospice the daily amount allowed by the state for room and board while the patient is receiving hospice care, and the hospice pays the facility for room and board and perhaps for other services as well. In this context, room and board is viewed as including "the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies." The Manual also acknowledges that a beneficiary could be in a SNF under the SNF benefit for a condition unrelated to the terminal condition and simultaneously be receiving hospice care for the terminal condition.

The Medicare Claims Processing Manual, Chapter 11, "Processing Hospice Claims," states that payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. In addition, an attending physician is defined as a doctor of medicine or osteopathy or a nurse practitioner who is identified by the patient, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of his or her medical care. If that individual is employed by the hospice or working under arrangement with the hospice, the hospice establishes a charge and bills the Medicare contractor for these direct patient care services under Medicare Part A and the Medicare contractor pays the hospice at the lesser of the actual charge or 100 percent of the Medicare fee schedule amount for physician services or 85 percent of the fee schedule amount for nurse practitioner services (this payment is in addition to the daily hospice rates). On the other hand, if direct patient care services are provided by an independent attending physician, they are billed in the usual way and paid under Medicare Part B if they are reasonable and necessary for the treatment and management of a hospice patient's terminal illness. Note that a hospice patient may receive direct patient care services both from hospice-employed physicians and an independent attending physician.

One OIG report found that nursing home hospice patients received 46 percent fewer nursing and aide services from hospice staff than hospice patients living at home.[21] Another found that almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.[22] ***These findings suggest that both hospices and nursing homes may inappropriately benefit when nursing home residents receive hospice care.***

[20] Medicare Payment Advisory Commission, "Hospice Services Payment System," Revised October 2009.
[21] Office of the Inspector General, "Hospice Patients in Nursing Home," September 1997.
[22] Office of the Inspector General, "Hospice and Nursing Home Contractual Relationships," November 1997.

And although the two OIG reports are more than a decade old, concerns about the relationships between hospices and nursing homes remain.

In fact, the Medicare Payment Advisory Commission (MedPAC), which has recently devoted considerable attention to reforming Medicare's hospice benefit, believes that NFs and hospices have financial incentives to refer and admit certain beneficiaries to hospices. Among other things, the Commission has recommended that the Secretary direct the OIG to investigate the prevalence of financial relationships between hospices and long-term care facilities such as NFs and ALFs that may represent a conflict of interest and influence admissions to hospice. MedPAC has also noted that an NF medical director "often serves as a resident's primary care physician…is typically in a position to arrange for hospice services when the beneficiary's health status is determined to be terminal [acting as one of the cosigners of the certification of eligibility for hospice]…and can potentially be a source of real or perceived financial conflict of interest with respect to hospice referrals."[23] This resembles the conflict of interest potential described above in terms of the role of a SNF or NF medical director in determining whether a nursing home resident should be transferred to the hospital for additional care.

The Assisted Living Facility Setting

It is beyond the scope of this paper to fully consider the financial incentives that apply to the ALF setting and that might influence the transfer of ALF residents to the hospital inpatient setting under various circumstances. However, a few relevant observations can be made.

First, oversight of ALFs occurs primarily at the state level.[24] Among the issues covered in state laws or regulations is third party scope of care, that is, whether third parties, such as home health agencies or hospice providers, may provide services to residents of ALFs. These policies would help determine what level of nursing and other support would be available to a physician attempting to care for ALF residents (in addition to the ALF's own staff). States also specify whether they offer Medicaid coverage to pay for services in ALFs. In California, for example, dementia and hospice care may be provided by ALFs if statutory and regulatory requirements are met, and outside agencies, such as those providing home health or hospice services may provide licensed medical services within their scope of practice to residents at the facility. And, under a Federal home and community-based services waiver, California provides a Medi-Cal benefit to persons participating in the Assisted Living Waiver (ALW). They must be both Medi-Cal and nursing-home eligible. The ALW has been serving five counties and was expected to expand into two more counties in 2010. In Connecticut, assisted living services agencies may provide nursing services and assistance with activities of daily living. And a Medicaid home and community-based services waiver covers services for eligible low-income residents. In Florida, home health agencies may provide services under contract with ALF residents, and a Medicaid home and community-based services waiver and the Medicaid Assistive Care Services program under the Medicaid state plan cover services for low-income ALF residents.

Second, Medicare does not cover ALF care although it may cover individual services provided to residents of ALFs, such as physician visits and hospice care.

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[23] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009.

[24] National Center for Assisted Living, "Assisted Living State Regulatory Review 2010," Prepared by Karl Polzer, March 2010.

Third, as noted elsewhere in this report, Medicare payments for physician visits provided to Medicare beneficiaries residing in an ALF do not vary substantially from those for similar services furnished to patients in other settings, all things considered. ***Thus, Medicare payment differentials alone would be unlikely to explain any physician preference for treating the resident of an ALF in a hospital setting.*** In this regard, of course, other factors discussed previously also appear relevant, including the likelihood that two different physicians would care for the same patient in the ALF and hospital inpatient settings, respectively. In addition, given the relatively limited nursing and other support available to a physician caring for an ALF resident, it is easy to understand why a physician might prefer to transfer a sick patient to the hospital setting rather than attempt to manage the patient's condition in the ALF.

Changes Under the New Health Reform Law

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), all of which is now simply referred to as the ACA, includes a number of provisions relevant to Medicare and Medicaid payment of SNFs, NFs, and hospices. While it is beyond the scope of this paper to describe these provisions in detail, they call for the following:

- A Medicaid demonstration project to evaluate integrated care around a hospitalization (section 2704);
- Secretarial development of an implementation plan for Medicare value-based purchasing (pay-for-performance) for SNFs by 10/1/2011 (section 3006);
- A national pilot program on payment bundling under Medicare for an episode of care around a hospitalization for 10 conditions selected by the Secretary (with the episode beginning 3 days prior to the hospital admission and ending 30 days following hospital discharge, unless the Secretary determines another timeframe is more appropriate), with covered services to include post-acute care services including home health, SNF, inpatient rehabilitation, and long-term care hospital services (section 3023);
- A hospital readmission reduction program involving Medicare payment reduction for hospitals with excess readmissions and creation of a quality improvement program to assist poor performing hospitals through use of patient safety organizations; (section 3025);
- Hospice reform beginning with enhanced data collection followed by issuance of regulations revising the methodology for determining hospice payment rates, and Medicare contractor reviews of hospice stays in excess of 180 days in hospices for which such stays exceed a threshold determined by the Secretary (section 3132);
- A 3-year demonstration project involving not more than 15 hospice programs to test the concept of concurrently furnishing Medicare beneficiaries both hospice care and any other covered Medicare items and services (section 3140);
- Required productivity adjustments to market basket updates provided to SNFs, beginning in 2012, which may cause a negative update and may result in payment rates for a year being less than the payment rates for the preceding year (section 3401); and
- Delayed implementation of RUG-IV and other changes to Medicare SNF payment, including steps to ensure that only services furnished after admission to a SNF are used in determining case mix classification (section 10325).

While it is not feasible to assess the likely impact of these provisions at this time, they do demonstrate Congressional recognition of the fact that Medicare and Medicaid payment policies relating to NF and hospice care are far from perfect and require modification.

Another indication of ongoing discomfort with the status quo is work being undertaken by the OIG, whose FY 2010 Work Plan includes: a review of Medicaid data to identify NFs that may have provided substandard care resulting in or contributing to beneficiaries' subsequent hospital admissions, including those for diagnoses of pressure sores, infections or both; a review of Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit; and a review of Medicare hospice utilization trends.[25]

Concluding Thoughts

As evidenced by the preceding discussion, decisions to transfer the resident of a long-term care facility to a hospital for further care might be influenced by factors other than purely clinical considerations. In a specific case, one or more of the following might be applicable:

- Modest differences in Medicare payments for physician E&M services provided in different settings and at least perceived differences in Medicare contractor willingness to pay for relatively frequent (but medically necessary) physician visits in these different settings;
- Limitations in Medicare's SNF payment methodology that make SNF resident transfer to a hospital emergency department and/or inpatient hospital setting for care of some acute condition a financially reasonable preference;
- Opportunities for SNFs and NFs to receive payment for holding a specific bed while a SNF or NF resident is hospitalized;
- Potential conflicts of interest arising from the dual roles played by a physician serving as both a SNF or NF medical director and a specific SNF or NF resident's attending physician; and
- A host of other considerations, such as fear of malpractice litigation if a nursing home resident is not transferred to a hospital and dies or suffers serious complications.

In addition, financial incentives associated with the provision of hospice care to SNF or NF residents (affecting both the nursing home and the hospice) may lead to arrangements not necessarily in the best interests of the patients and/or the public programs paying for SNF, NF, and hospice care. To oversimplify, it appears there is a significant risk that the affected nursing home residents are not necessarily getting full value for the payments made on their behalf under the Medicare and/or Medicaid programs.

Finally, while the ACA has mandated a number of policy changes, demonstrations, and other initiatives relating to SNF, NF and hospice care, it is far from clear that these changes will significantly alter the incentives influencing the transfer of long-term care facility residents to a hospital (rather than appropriately caring for them in the long-term care facility itself), or those affecting the provision of hospice care to SNF and NF residents.

[25] Office of the Inspector General, Department of Health and Human Services, Work Plan, Fiscal Year 2010.

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