Public Policy

Fiscal Trends for the Nursing Home Practitioner in 2012

By Charles Crecelius, MD, PhD, FACPM, CMD

The past year has had several areas of interest regarding fiscal trends for the long-term care practitioner. Generally favorable trends have occurred, although some areas remain unclear. The more pertinent trends:

Discharge Codes 99315 & 99316
Relative value units (RVUs) for all physician services are reviewed no less often than every 5 years by AMA, and the Social Security Administration (SSA) updates the Relative Value Update Committee (RVUC). In 2006, AMDA worked with organizations including the American Geriatric Society (AGS), the American College of Physicians (ACP), and the American Academy of Family Physicians (A AFP) to obtain higher payment for initial and subsequent codes.

Recently, compelling evidence for change in the work for the discharge codes was presented to AMA RUC by Dr. Eric Tangelos, CMD, and me. AMDA partnered with the AGS and AAFP and was supported by the ACP in this successful effort. Effective Jan. 1, 2012, payments for physician work for discharge codes increased by more than $6.6 million, a 13% increase for 99315 and a 25% increase for 99316.

Overall, AMDA’s efforts to improve reimbursement for the family of nursing home codes have netted a 13.5% increase in physician payment. As important, there is now parity in payment for the same level of work across nursing home, office, and hospital sites of service.

Better Representation for LTC
The AMA RUC is composed of people who possess a technical-expert body of the knowledge needed to make comparisons of various codes and is not representative of the number of physicians billing any particular code. In 2011, there were 29 members, with 23 appointed by national societies. Fourteen were considered proceduralists (e.g., surgeons), and nine represented cognitive-based physicians (such as the ACP, AAFP, and medical specialty societies).

Members work hard to be impartial and unbiased, but it had been questioned whether primary care, chronic medical problems, and geriatrics were adequately represented from an expert-knowledge basis. To address these issues, the AMA RUC has recently added two new seats, one primary care and the other geriatrics. This has shifted the composition of the AMA RUC to now include 14 proceduralists and 11 cognitive-based physicians and may help the RUC better understand the value of chronic care patients that are commonly seen across the spectrum, including LTC.

Transitions and Coordination
The increased complexity of patients who often require extensive but non-face-to-face services for optimal care has been acknowledged to be poorly reimbursed in the current system. This is especially true for transitions of care such as nursing home or hospital to home.

The Centers for Medicare & Medicaid Services and the AMA RUC agreed to evaluate and “fast-track” newly proposed codes in late 2011. A joint workgroup, the Care Coordination CPT Workgroup (CCW), was established by the AMA in 2012, with Dr. Dennis Stone, CMD, and me representing AMDA.

CPT codes for Transitions of Care and Chronic Care, both of which include payment for non-face-to-face and staff time, were first established. The AMA RUC established payment in September 2012 and the final rule, which publishes CMS’s decision, has just come out. CMS has decided to pay for the Transitions of Care codes but not the Chronic Care codes starting Jan. 1, 2013.

Key features of these newly reimbursed Transitions of Care codes include:

- Allow for a global payment of work related to non-face-to-face services provided by receiving physicians and staff.
- Used after hospital, observation, emergency room, or SNF discharge; cannot be used in conjunction with Care Plan Oversight codes, with the patient returning to home, assisted living, or residential care.
- Patient must have medical or psycho-social problems requiring moderate- or high-complexity medical decision making.
- Require contact with patient very shortly after discharge, an office visit in a timely fashion, and all services needed to effectively manage the patient (e.g., med reconciliation, records review, coordinating care, any communication, and education).
- Tiered, based on patient complexity.

It is estimated that the addition of the Transition Care codes could increase primary care reimbursement by as much as 5%, although this number is speculative.

Whether CMS will eventually pay for the Transitions of Care codes remains to be seen. Doing so could have an even more dramatic effect on primary care reimbursement.

As currently described by CPT, it would not apply to nursing home residents. It is a home, assisted living, and residential-based global code with the patient having at least one chronic condition placing him or her at serious risk and requiring significant services and coordination of care. There are understandable difficulties in estimating how many people could be billed under this code.

The SGR Problem
There is now a proposed 27% payment cut in physician services in 2013 unless Congress acts to either repeal the sustainable growth rate (SGR) formula, a daunting fiscal task, or temporarily delay it once again—as in past years—to avoid the political suicide that would occur if not dealt with in some fashion. This election year has not helped progress toward any permanent solution.

The threat of sequestration, which would involve across-the-board cuts for this and many other programs does exist, but again would have fairly catastrophic political implications. It is suspected that the issue will again be temporized by a delay in cuts to 2014, but it may as in past years not be “fixed” until the first few weeks of 2013.

AMDA has supported the AMA’s proposed three-pronged approach to payment reform, which includes eliminating the SGR immediately, providing 5 years of stable updates (to allow physicians to plan and invest and to develop and test new payment models), and phase-in multiple payment and delivery models.

New Payment Models and LTC
CMS has attempted to refine accountable care organization (ACO) participation requirements in order to encourage participation by physicians. Some features include providing more information on prospective patients, counting specialists’ primary care patients, new options without downside risk in the first 3 years, providing “up-front” compensation, reducing required quality measures from 65 to 33, and removing “meaningful use” requirements.

ACOs still are feasible mainly for large organizations, and many questions remain as to how to logistically and fiscally incorporate the work and payment of the LTC physician. One particularly troublesome regulatory ACO requirement is that the LTC physician must participate only in a single ACO. Nursing homes with referrals from multiple ACOs would have to arrange for at least one dedicated physician for each ACO. This could significantly affect the home’s ability to participate in multiple ACOs, restrict the referral patterns of the existing physicians, put pressure on the administration and medical director to find qualified LTC practitioners from each ACO and result in awkward coverage arrangements, to name only a few difficulties.

The Center for Medicare & Medicaid Innovations is spending $10 billion to test generally physician-friendly payment and delivery options, including: Advanced Payment Option, upfront money to physician-only ACOs that share savings; Bundled Care Initiative, which envisions various ways of packaging care during and following hospital admission; Comprehensive Primary Care Initiative, where Medicare partners with private payers; Health Care Innovation Challenge, which offers 3-year grants of $1 million to $30 million for innovative projects to “drive significant healthcare improvements.”

RAC Audits
Plans for systemic audits of E/M codes were announced by Connolly Inc., a recovery audit contractor (RAC) this year. So far, these audits have not extended into the nursing home code family, although for how long is unclear. The AMA is protesting systemic audits in the office setting, noting difficulty distinguishing between higher levels.

General Medicare Spending Trends
Medicare fee schedule spending increased in 2012 by 3.6%. The majority of this was due to an increase in Medicare enrollees and in fee schedule payments. A more interesting metric is total utilization per enrollee (UPE), which increased by only 0.7% in total but varied substantially across different sites of service.

UPE depends on many factors including, but not limited to, community resources, patient expectation, and responsive medical management. Hospital UPE increased 1%, while both emergency room and critical care UPEs increased by 5%. Imaging UPE increased by 0%, while procedures increased 4%. Office UPE increased 0%, although total spending increased 7% because of the new wellness visits. Nursing home UPE increased 4% with total spending increasing 7%, with less than a 1% increase in the number of patient days. This increase has been duly noted by CMS, and the reasons for such changes will be the focus of an upcoming column.

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