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MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING

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EXECUTIVE SUMMARY: MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING
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WHY WE DID THIS STUDY

Nursing homes hospitalize residents when physicians and nursing staff determine that residents require acute-level care. Such transfers to hospitals provide residents with access to needed acute-care services. However, hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents' experiencing harm and other negative care outcomes. High rates of hospitalizations by individual nursing homes could signal quality problems within those homes.

HOW WE DID THIS STUDY

We used administrative and billing data both for nursing homes and hospitals to identify all Medicare residents in Medicare- or Medicaid-certified nursing homes who experienced hospitalizations—i.e., transfers to hospitals for inpatient stays—in fiscal year (FY) 2011. We included all Medicare nursing home residents—those in Medicare-paid skilled nursing and rehabilitative (referred to as "SNF") stays and those in nursing home stays not paid for by Medicare, which include long-term care (LTC) stays)—in our analysis. We calculated the percentage of Medicare nursing home residents that each nursing home hospitalized. We identified the diagnoses associated with these hospitalizations, calculated Medicare reimbursements for the hospital stays, and calculated the rates and costs of hospitalizations of nursing home residents. We also examined the extent to which annual rates of resident hospitalizations varied among individual nursing homes.

WHAT WE FOUND

In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes located in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the Centers for Medicare & Medicaid Services' (CMS) Five-Star Quality Rating System.

WHAT WE RECOMMEND

In its comments on the draft report, CMS concurred with both of our recommendations to: (1) develop a quality measure that describes nursing home resident hospitalization rates and (2) instruct State survey agencies to review the proposed quality measure as part of the survey and certification process.

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OBJECTIVES

1. To determine the percentage of Medicare nursing home residents hospitalized in fiscal year (FY) 2011 and the associated costs to Medicare.
2. To identify the medical conditions most commonly associated with these hospitalizations.
3. To determine the extent to which these hospitalization rates varied across nursing homes.
4. To determine the extent to which these hospitalization rates varied according to select nursing home characteristics.

BACKGROUND

Nursing homes send residents to hospitals when physicians or nursing staff determine that residents require acute-level care. These transfers to hospitals provide residents with access to needed acute-care services.[1]

However, research indicates that transfers between health care facilities increase the risk of residents' experiencing harm and other negative care outcomes and that these hospitalizations are costly to Medicare.[2] The harm that residents experience during hospitalizations can include disruption of their care plans, disorientation, stress, and iatrogenic illness (e.g., adverse events).[3, 4, 5] The Centers for Medicare & Medicaid Services (CMS), in its *2012 Nursing Home Action Plan*, suggests that negative outcomes associated with hospitalizations are further complicated because health care providers often do not communicate critical information when transferring the residents.[6] Financial costs associated with hospitalizations of nursing home residents include, but are not limited to, Medicare

[1] D. Saliba, "Appropriateness of the Decision to Transfer Nursing Facility Residents to the Hospital," *Journal of the American Geriatrics Society*, 48, 2, 2000, p. 155.

[2] Assistant Secretary for Planning and Evaluation (ASPE), *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, p. 1.

[3] D. Saliba, op. cit., pp. 154–155.

[4] J.G. Ouslander, "Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents: Results of a Pilot Quality Improvement Project," *Journal of the American Medical Directors Association*, 2009, p. 645.

[5] E. Hutt, "Precipitants of Emergency Room Visits and Acute Hospitalization in Short-Stay Medicare Nursing Home Residents," *Journal of the American Geriatrics Society*, 50, 2, 2002, pp. 223–224.

[6] CMS, *2012 Nursing Home Action Plan*, 2012. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2012-Nursing-Home-Action-Plan.pdf on February 5, 2013.

reimbursements for hospital stays, physician services during these stays, and applicable copayments.

Although nursing homes may hospitalize residents primarily for clinical reasons, research indicates that several nonclinical factors can also influence homes' decisions to hospitalize residents. These factors include the availability and training of nursing staff in the home, resident and family member preferences, and physician availability and preferences.[7] Additionally, research suggests that aspects of Medicare payment policies and other economic factors can influence hospitalization rates.[8, 9]

Payment for Hospitalizations. Medicare pays for hospitalizations of nursing home residents primarily by reimbursing acute-care hospitals according to the Inpatient Prospective Payment System (IPPS).[10] Under IPPS, hospitals may submit Medicare claims with codes from the Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM codes) representing resident conditions and procedures for each hospital stay.[11] Payment for most Medicare resident hospitalizations is determined largely by grouping the diagnosis and procedure codes into Diagnosis-Related Groups based on the average cost of care for residents with similar conditions.

Nursing Homes

There are two primary types of care for Medicare beneficiaries in nursing homes: skilled nursing and rehabilitative care (referred to as "SNF")[12] and long-term care (LTC). Over 90 percent of nursing homes can admit residents into either type of care, depending on their clinical needs.[13]

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[7] ASPE, *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, pp. 6–7.

[8] Ibid., pp. 8–14.

[9] Congressional Research Service (CRS), *Medicare Hospital Readmissions: Issues, Policy Options and PPACA [the Patient Protection and Affordable Care Act]*, September 21, 2010, pp. 11–17.

[10] CMS does not pay all hospitals for resident stays through the IPPS. CMS pays several types of hospitals (e.g., critical access hospitals, inpatient psychiatric hospitals) and most hospitals in Maryland through alternate payment methodologies. CMS, *Pub. No. 100-04 Medicare Claims Processing*, April 2004. Accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R156CP.pdf on March 18, 2013.

[11] The ICD-9-CM system assigns diagnoses and procedure codes associated with hospital stays and is maintained jointly by CMS and the National Center for Health Statistics. CMS, *Acute Inpatient PPS Overview*, last modified February 22, 2010. Accessed at http://www.cms.gov/AcuteInpatientPPS/01_overview.asp on March 18, 2013.

[12] In this report, we use the commonly used acronym for skilled nursing facility ("SNF") to describe residents in skilled nursing and rehabilitative stays covered under Medicare Part A (i.e., "SNF residents").

[13] Medicare Payment Advisory Committee (MedPAC), *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2013, p. 161.

Federal law requires all nursing homes to provide residents with care that enables them to attain or maintain the highest practicable physical, mental, and psychosocial well-being.[14] (In this report, we refer to all Medicare beneficiaries in nursing homes as "residents" or "nursing home residents.")

SNF Care in Nursing Homes. In 2011, about 20 percent of all hospitalized Medicare beneficiaries went to 1 of the 15,207 nursing homes for SNF care following their hospital stays.[15] Examples of nursing home residents in SNF stays include those recovering from surgical procedures performed in hospitals (e.g., hip or knee replacements) or recovering from acute medical conditions (e.g., septicemia, urinary tract infection, heart failure).[16] In 2009, the Medicare Standard Analytical Files (SAF) categorized over 50 percent of residents in Medicare Part A SNF care as having illnesses of major or extreme severity.[17]

Medicare beneficiaries have access to SNF care benefits through Medicare Part A. Medicare coverage of SNF care is typically limited to 100 days per benefit period.[18] Examples of services provided to SNF residents include the development, management, and evaluation of resident care plans; physical therapy; administration of intravenous feedings; insertion of suprapubic catheters; medication management; and wound care. CMS pays for SNF care when residents have preceding hospital stays of at least 3 days and a medical professional verifies the need for nursing and rehabilitative care related to the hospitalizations.[19] In 2011, Medicare Part A paid $32 billion for SNF stays for Medicare beneficiaries.[20]

LTC in Nursing Homes. Nursing home residents in LTC stays typically need assistance accomplishing two or more activities of daily living (e.g., eating, bathing, dressing, walking). This group includes, but is not limited to, Medicare beneficiaries who are also enrolled in a State Medicaid program (known as dual eligibles).

State Medicaid requirements specify that nursing home residents in LTC stays must have access to several services including basic nursing care,

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[14] Social Security Act § 1819 (b)(2) and §1919 (b)(2).

[15] MedPAC, *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2013, p. 161.

[16] Ibid.

[17] Avalere Publishing, *Medicare SAF Data Book*, 2009, p. 27.

[18] CMS, *Medicare Benefit Policy Manual: Duration of Covered Inpatient Services, Chapter 3*, October 1, 2003.

[19] CMS, *Medicare Benefit Policy Manual: Coverage of Extended Care (SNF) Services Under Hospital Insurance*, Chapter 8, April 4, 2012.

[20] MedPAC, *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2012, p. 171.

medical-related social services, pharmaceutical services, specialized rehabilitative services, individualized dietary services, emergency dental services, and other quality-of-life services.[21] Medicare Part A does not pay for LTC stays in nursing homes, but Medicare Part B may pay for certain LTC services (e.g., enteral nutrition) for these nursing home residents.[22, 23] Payment for Medicare beneficiaries' nursing home LTC comes from sources other than Medicaid, including personal resources, LTC insurance, or (if beneficiaries are dual eligibles) Medicaid.

Medicare Oversight of Nursing Homes

CMS verifies that Medicare- and Medicaid-certified nursing homes comply with Federal requirements.[24] It enters into agreements with State survey agencies to conduct onsite reviews of each nursing home to certify compliance with Federal requirements.[25] When surveyors identify noncompliance, CMS requires nursing homes to submit plans of correction and to correct the problems. If nursing homes do not correct the problems, CMS may take enforcement actions. These actions include imposing civil monetary penalties, denying payment for new admissions of Medicare residents, or terminating the nursing home from participation in Medicare and Medicaid.[26]

Nursing Home Quality Measures. Nursing homes routinely collect resident assessment data at specific intervals during a nursing home stay, and CMS stores the assessment results in the Minimum Data Set (MDS).[27] CMS converts MDS data into 18 Quality Measures (QM).[28, 29] The QMs

[21] CMS, *Nursing Facilities*. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html on January 22, 2013.

[22] CMS. *What is Long-Term Care?*, August 3, 2012. Accessed at http://www.medicare.gov/longtermcare/static/home.asp on May 15, 2013

[23] Office of Inspector General (OIG), *Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrient Pricing*, January 2010, pp. 2-4.

[24] Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987; 42 CFR Part 483.

[25] 42 CFR §§ 488.308(a), 488.330(a)(1)(i), and CMS, *Survey and Certification: General Information*, April, 11, 2013. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html?redirect=/surveycertificationgeninfo/ on May 15, 2013.

[26] 42 CFR §§ 488.402(d), 488.408, and 488.456.

[27] CMS, *MDS 3.0 for Nursing Homes and Swing Bed Providers.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html on March 4, 2013.

[28] CMS, *Nursing Home Quality Initiative: Quality Measures.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html on April 16, 2013.

[29] See Appendix A for a complete listing of the 18 QMs.

indicate how well a nursing home provides care to its residents. Examples of QMs include the percentage of residents who report moderate to severe pain, the percentage of residents who were appropriately given the seasonal influenza vaccine, and the percentage of residents who have lost significant amounts of weight.[30] CMS provides QMs to nursing homes for them to use in quality improvement efforts. Currently, the QMs do not include a measure of how often nursing homes hospitalize residents.

Public Reporting of QMs and Other Data Through the Five-Star Quality Rating System. CMS publicly reports nursing home QMs through the Five-Star Quality Rating System. CMS gives each Medicare- and Medicaid-certified nursing home an overall rating between one and five stars. A rating of one star indicates that a nursing home is "much below average" in terms of quality, and a rating of five stars indicates that a nursing home is "much above average."[31]

CMS bases the overall five-star rating on the nursing homes' ratings in three areas: performance on inspection surveys (survey metric), QMs (quality metric), and staffing (staffing metric). CMS calculates these three metrics as follows:

- The survey metric is based on points assigned to the results of nursing home surveys, complaint surveys, and survey revisits conducted within the last 3 years.
- The quality metric is based on nursing homes' performance on 10 QMs. Seven of the QMs relate to LTC residents (e.g., mobility decline, use of physical restraints), and the three remaining QMs relate to SNF residents (e.g., delirium, level of pain).
- The staffing metric is based on registered nurse (RN) hours per resident day and total staffing hours (hours by RNs, licensed practical nurses, and nurse aides).

Efforts To Monitor and Reduce Rates of Hospitalization and Other Types of Transfers

Rates of hospitalizations and other types of resident transfers have received increased attention from government agencies and key stakeholders because of the resident risk and high associated cost.

[30] RTI [Research Triangle Institute] International, *MDS 3.0 Quality Measures User's Manual*. Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V60.pdf on February 19, 2013.

[31] CMS, *Consumer Fact Sheet*, December 2008. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/consumerfactsheet.pdf on October 4, 2013.

Congress, through the Affordable Care Act, established several initiatives designed to reduce hospital resident readmissions.[32, 33] CMS publicly reports hospital readmission rates, has requested that Quality Improvement Organizations examine resident transfers, and is developing nursing home surveyor guidance related to the evaluation of hospitalizations of nursing home residents.[34, 35, 36] The National Quality Forum (NQF) adopted measures of hospital performance based on hospital resident readmission rates.[37] MedPAC made recommendations to CMS to limit payment policies that incentivize unnecessary hospitalizations of nursing home residents.[38] Researchers have suggested changes to Medicare payment policies that can reduce hospitalization rates for the benefit of both the program and beneficiaries.[39, 40] The provider community has also focused attention on developing best practices to reduce hospitalizations of nursing home residents.[41]

METHODOLOGY

To determine the percentage of Medicare residents transferred to hospitals for acute inpatient stays in FY 2011, we collected nursing home resident assessment data from the MDS, beneficiary information from the Enrollment Database (EDB), and hospital claims data from the National Claims History (NCH). We combined these data sources to identify all transfers of Medicare nursing home residents to hospitals for inpatient stays. For this report, we defined a Medicare nursing home resident as any Medicare beneficiary who stayed in a Medicare- or Medicaid-certified

[32] Patient Protection and Affordable Care Act of 2010, P.L. 111-148 § 3025.

[33] CMS, *Community-Based Care Transitions Program Fact Sheet.* Accessed at http://innovations.cms.gov/Files/fact-sheet/Community-based-Care-Transitions-Program-Fact-Sheet-.pdf on February 5, 2013.

[34] CMS, *Hospital Quality Initiatives: Outcome Measures.* Accessed at https://www.cms.gov/HospitalQualityInits/20_OutcomeMeasures.asp on January 12, 2012.

[35] CMS, *Medicare Quality Improvement Organization 9th Scope of Work*, p. 69. Accessed at http://www.cms.gov/QualityImprovementOrgs/Downloads/9thSOWBaseContract_C_08-01-2008_2_.pdf on September 13, 2011.

[36] CMS, *2012 Nursing Home Action Plan*, 2012, pp. 25–26 and 37–39.

[37] NQF, *Candidate Hospital Care Additional Priorities: 2007 Performance Measure*. Washington, DC, 2007.

[38] MedPAC, *Report to the Congress: Reforming the Delivery System*, June 2008, p. 87.

[39] ASPE, *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, pp. 15–23.

[40] CRS, *Medicare Hospital Readmissions: Issues, Policy Options and PPACA*, September 21, 2010, pp. 18–36.

[41] National Transitions of Care Coalition, 2011. Accessed at http://www.ntocc.org/ on September 13, 2011.

nursing home for at least 1 day in FY 2011. We defined a hospitalization as an instance when a Medicare nursing home resident went to a hospital for a Medicare-reimbursed inpatient stay within 1 day of discharge from a nursing home.

Identifying Hospitalizations of Medicare Nursing Home Residents

We identified hospitalizations of Medicare nursing home residents using data from the MDS, the EDB, and the NCH. To identify all Medicare beneficiaries who were nursing home residents in FY 2011, we used the MDS and the EDB. The MDS contains resident Social Security Numbers (SSN), admission and discharge dates, and the related nursing home identification numbers. We matched SSNs in the MDS to those in the EDB to identify Medicare beneficiaries and their associated Medicare Health Insurance Claim Numbers. We excluded from this analysis the small number of beneficiaries in the MDS who had SSNs that did not match their SSNs as listed in the EDB. We used the Medicare Part A claims data in the NCH to determine whether nursing home residents entered hospitals following their nursing home stays and to determine whether the nursing home stays were reimbursed through Medicare Part A.[42]

The resulting data set enabled us to determine when beneficiaries were admitted to nursing homes, whether they were discharged from nursing homes, and whether they were hospitalized following discharge from nursing homes.

Analysis

Using the data set described above, we determined the percentage of Medicare nursing home residents hospitalized in FY 2011, the Medicare costs associated with hospitalizations of nursing home residents, the medical conditions associated with the hospitalizations, each nursing home's rate of resident hospitalization (which we refer to as the "annual hospitalization rate"), and the extent to which annual hospitalization rates varied according to select characteristics. For analysis, we combined all Medicare nursing home residents—those in Medicare-paid SNF stays and

[42] We excluded nursing home stays that occurred in "swing bed" units within hospitals from our analysis. (A swing-bed unit is a hospital unit in which residents receive skilled nursing services.) We excluded these stays because the associated facilities differ substantially from the freestanding nursing homes that are the focus of this report. Excluding these stays removed 111,298 stays and 1,149 hospital swing-bed facilities from our analysis. CMS, *Swing Bed Services*, January 2013. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf on March 18, 2013.

those in nursing home stays not paid by Medicare—and refer to them as "Medicare nursing home residents" or "nursing home residents."

Calculating the Percentage of Hospitalized Nursing Home Residents. To calculate the percentage of nursing home residents hospitalized, we divided the total number of Medicare nursing home residents hospitalized at least once in FY 2011 by the total number of residents who had nursing home stays of at least 1 day in FY 2011.

Calculating the Medicare Costs Associated With Resident Hospitalizations. We calculated the amount Medicare spent on hospitalizations of nursing home residents by summing the Medicare reimbursements for each hospital stay that we identified as a hospitalization of a Medicare nursing home resident. These costs represent only the amounts that Medicare paid hospitals for the residents' acute-care hospital stays. Our analysis included payments made to IPPS and non-IPPS hospitals. When hospitalized residents were transferred from their initial hospitals to other hospitals, we combined the reimbursements paid by Medicare to each hospital.[43]

We calculated the amount Medicare spent on all hospitalizations of Medicare beneficiaries by summing Part A reimbursements for all hospital stays with admission dates in FY 2011.

Identification of Medical Conditions Associated With Hospitalization. To identify the medical conditions associated with hospitalizations of nursing home residents, we reviewed the primary ICD-9-CM diagnosis codes on the Medicare claims submitted for the hospital stays. To categorize the diagnosis codes, we used the clinical classification system (CCS) of the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project (HCUP). The CCS enables researchers to collapse ICD-9-CM codes into clinically meaningful categories for analysis and comparison between studies. [44]

Calculating Annual Hospitalization Rates for Nursing Homes. To calculate the annual hospitalization rate for each nursing home in FY 2011, we divided the number of nursing home stays that ended in hospitalization in a given home by the total number of nursing home stays

[43] Under CMS's transfer policy, CMS reduces reimbursements for hospitalizations under several scenarios, including instances when residents are transferred to other hospitals covered by the IPPS. CMS, *Acute Care Hospital Inpatient Prospective Payment System*, February 2012. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf on March 18, 2013.

[44] See Appendix B for a detailed description of the methodology we used to describe the ICD-9-CM codes on the hospital claims using the HCUP CCS.

of at least 1 day in the home. We calculated annual hospitalization rates only for homes that provided care to 30 or more Medicare residents in FY 2011.

Analysis of Characteristics Associated With Variation in Annual Hospitalization Rates. To determine whether annual hospitalization rates varied according to select nursing characteristics, we divided homes into subgroups based on characteristics and then calculated average annual hospitalization rates for the subgroups. To determine how much annual hospitalization rates varied by geographic location, we divided homes into groups by the State code in their billing addresses and then calculated the average annual hospitalization rate for nursing homes in each State and the District of Columbia. To determine how much annual hospitalization rates varied by scores on the four CMS Five-Star Quality Rating System metrics, we divided nursing homes into two groups—one group consisting of those with one, two, or three stars and the other consisting of those with four or five stars—for each metric and calculated the rates for each group. To determine how much annual hospitalization rates varied by nursing home size, we divided nursing homes into three categories based on the number of beds within each home and then calculated the rate for each group. To determine how much annual hospitalization rates varied by ownership type, we divided nursing homes into three groups based on ownership type and then calculated the rate for each group.

We collected information on nursing homes' locations, bed counts, and ownership categories from CMS's Certification and Survey Provider Enhanced Reports (CASPER) database. CMS provided five-star ratings data applicable to our observation period.

Limitations. The annual hospitalization rates are not adjusted to account for "case mix"—in this instance, the physical and mental health of residents in a given nursing home—or other factors. Additionally, the cost figures associated with the hospitalizations of nursing home residents do not include copayments for the hospital stays, physician reimbursements for the hospital stays, or payments made by the Medicare program or other payers for post-hospitalization services (e.g., followup physician office visits). Therefore, we likely underestimate the costs associated with hospitalizations of nursing home residents to the Medicare program and beneficiaries.

Standards

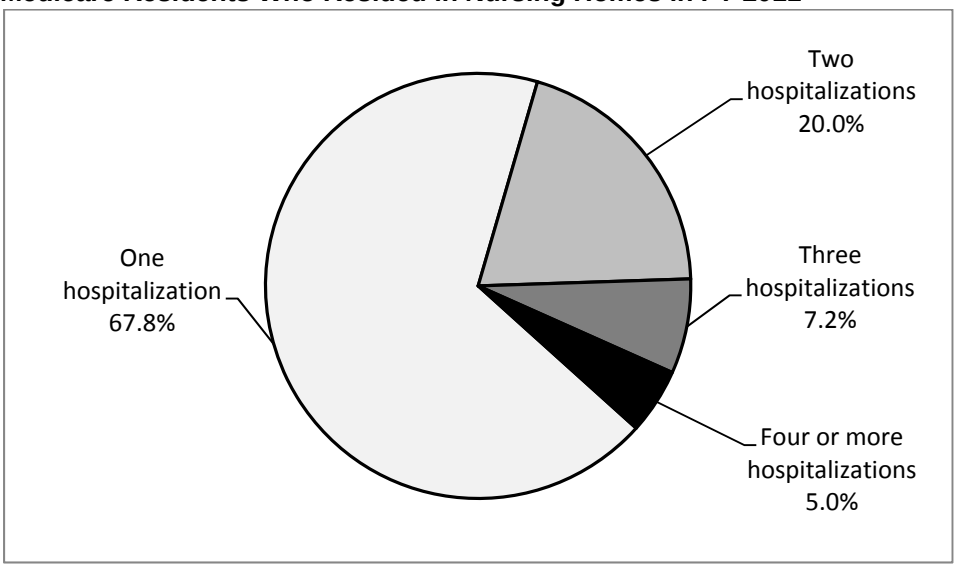
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

One-quarter of Medicare nursing home residents experienced hospitalizations in FY 2011, and Medicare spent $14.3 billion on these hospitalizations

Of the 3.3 million Medicare residents who stayed in nursing homes for at least 1 day in FY 2011, 825,765 (24.8 percent) experienced hospitalizations. The majority of hospitalized residents (67.8 percent) transferred from nursing homes to hospitals only once. Twenty percent transferred two times, 7.2 percent transferred three times, and the remaining 5 percent transferred four or more times (see Figure 1).

Figure 1: Number of Hospitalizations Experienced by Hospitalized Medicare Residents Who Resided in Nursing Homes in FY 2011



Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Medicare spent $14.3 billion in FY 2011 on hospital stays for nursing home residents, spending 33 percent more per stay than for the average Medicare hospitalization

Medicare spent $14.3 billion on 1.3 million hospital stays associated with hospitalizations of nursing home residents. These costs represent 11.4 percent of Medicare Part A spending on all hospital admissions ($126 billion) in the same year.[45] Medicare spent an average of $11,255 on each hospitalization of a nursing home resident, which was 33.2 percent above the average cost ($8,447) of hospitalizations for all Medicare residents.

[45] Cost estimates presented in this report are based only on reimbursements paid by Medicare Part A for the initial hospitalizations. They do not include any other costs paid by Medicare or by other payers for further medical care—such as physician office visits or additional nursing home stays—needed as a result of the hospitalizations.

Nursing home residents went to hospitals most commonly for septicemia, pneumonia, and congestive heart failure

Medicare nursing home residents went to hospitals for a wide range of conditions—236 of the possible 285 primary diagnosis categories described in the HCUP CCS. The primary diagnosis describes the most significant medical condition found during an inpatient admission.[46] The 15 most frequent CCS diagnosis categories accounted for 60.9 percent of all resident hospitalizations (see Table 1).

Table 1: Primary Diagnoses on Claims of All Hospitalized Medicare Nursing Home Residents in FY 2011

CCS Primary Diagnosis Category	Percentage of Hospitalizations
Fifteen Most Frequent CCS Categories	**60.9%**
Septicemia	13.4%
Pneumonia	7.0%
Congestive heart failure, nonhypertensive	5.8%
Urinary tract infections	5.3%
Aspiration pneumonitis, food/vomitus	4.0%
Acute renal failure	3.9%
Complication of device, implant, or graft	3.3%
Respiratory failure, insufficiency, or arrest	2.7%
Gastrointestinal hemorrhage	2.4%
Complications of surgical procedures or medical care	2.4%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	2.4%
Delirium, dementia, and amnestic and other cognitive disorders	2.2%
Acute cerebrovascular disease	2.1%
Fluid and electrolyte disorders	2.0%
Fracture of neck of femur (hip)	2.0%
Remaining 221 CCS Categories on Nursing Home Claims	**39.1%**
All CCS Diagnosis Categories on Nursing Home Claims	**100%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Hospitalizations for septicemia accounted for 21 percent of Medicare spending on nursing home resident hospitalizations

Septicemia led to the most hospitalizations among all CCS categories (13.4 percent). Septicemia and sepsis (a related condition) are serious bloodstream infections that can rapidly become life threatening.[47]

[46] CMS, *Medicare Claims Processing Manual*, Chapter 23, "Fee Schedule Administration and Coding Requirements."

[47] Centers for Disease Control and Prevention (CDC), *Inpatient Care of Septicemia or Sepsis: A Challenge for Patients and Hospitals*, National Center for Health Statistics Data Brief, 2011. In the data brief, CDC found that the rate of nursing home resident hospitalizations for septicemia more than doubled from 2000 to 2008 and that hospitalizations for septicemia ended in death much more often than hospitalizations for all other conditions.

Medicare spent almost $3 billion on nursing home resident hospitalizations associated with septicemia, more than the next three most expensive conditions combined. The high total reimbursement amount for septicemia is the result of both its frequency as a primary diagnosis on hospital claims and its above-average reimbursement rate. Table 2 shows the costs associated with the 15 most costly CCS diagnosis categories.

Table 2: Medicare Costs Associated With Medicare Nursing Home Resident Hospitalizations in FY 2011 by Sum of Reimbursement

CCS Primary Diagnosis Category	Sum of All Hospital Reimbursements	Percentage of All Hospital Reimbursements	Average Reimbursement
Fifteen Most Costly CCS Categories	**$9,268,066,011**	**65.2%**	**$11,554**
Septicemia	$2,963,329,522	20.8%	$17,430
Pneumonia	$844,817,051	5.9%	$9,464
Congestive heart failure, nonhypertensive	$643,386,174	4.5%	$8,731
Respiratory failure, insufficiency, or arrest	$637,201,272	4.5%	$18,438
Complication of device, implant, or graft	$619,241,745	4.3%	$14,629
Aspiration pneumonitis, food/vomitus	$618,310,799	4.3%	$12,223
Complications of surgical procedures or medical care	$449,236,625	3.2%	$14,731
Acute renal failure	$425,965,874	3.0%	$8,679
Urinary tract infections	$422,251,024	3.0%	$6,296
Delirium, dementia, and amnestic and other cognitive disorders	$321,003,626	2.3%	$11,515
Fracture of neck of femur (hip)	$311,417,099	2.2%	$12,578
Acute cerebrovascular disease	$285,667,898	2.0%	$10,847
Gastrointestinal hemorrhage	$264,867,028	1.9%	$8,544
COPD and bronchiectasis	$238,845,320	1.7%	$7,727
Acute myocardial infarction	$222,524,954	1.6%	$11,475
Remaining 221 CCS Categories	**$4,991,830,494**	**34.4%**	**$11,188**
All CCS Diagnosis Categories on Nursing Home Claims	**$14,259,896,509**	**100%**	**$11,211**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Nursing homes' annual rate of resident hospitalization varied according to select characteristics, including geographic location and rating on CMS's Five-Star Quality Rating System

Nursing homes' individual annual hospitalization rates varied widely, ranging from less than 1 percent to 69.7 percent. The annual hospitalization rate averaged 25 percent. Additionally, 1,059 nursing homes (7 percent) had annual hospitalization rates greater than 40 percent. Table 5 shows the distribution of annual hospitalization rates among Medicare- and Medicaid-certified nursing homes.

Table 5: Percentages of Nursing Homes by Annual Hospitalization Rate in FY 2011

Annual Hospitalization Rate	Percentage of Homes
Above 50 percent	0.6%
40 percent to 49.9 percent	6.2%
30 percent to 39.9 percent	22.1%
20 percent to 29.9 percent	39.9%
10 percent to 19.9 percent	26.9%
Less than 9.9 percent	4.3%
All Homes	**100.0%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Nursing homes' annual hospitalization rates varied by the four characteristics that we examined: the nursing home's geographic location, its size, its rating on CMS' Five-Star Quality Rating System, and the category of its ownership.[48]

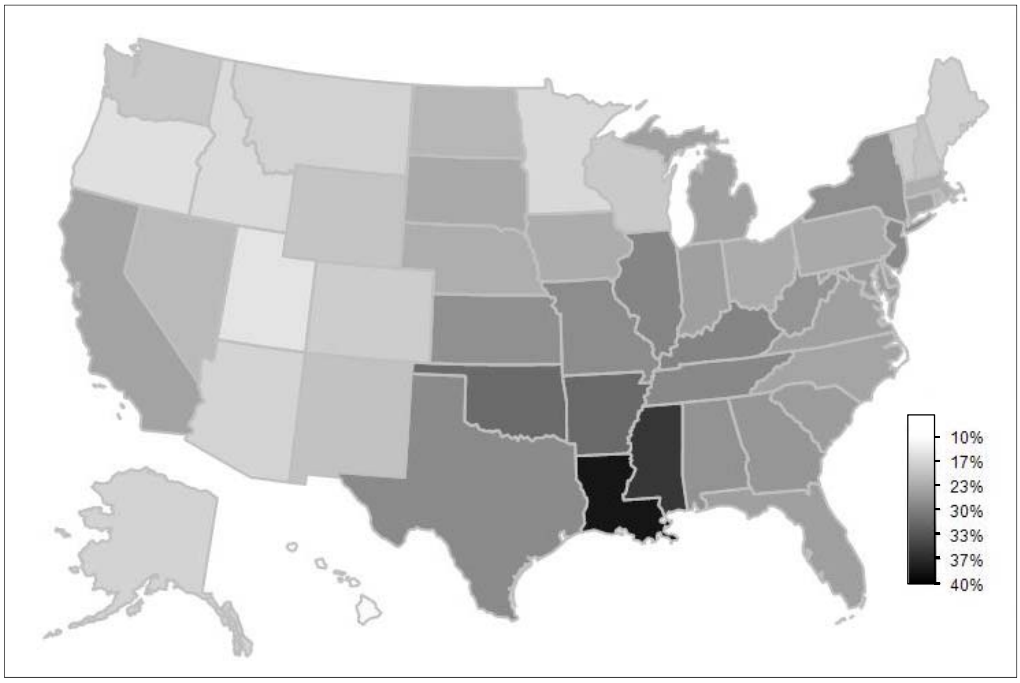
Homes with high annual hospitalization rates were not evenly distributed across the country

Nursing homes in Arkansas, Louisiana, Mississippi, and Oklahoma had the highest annual hospitalization rates when averaged at the State level. The average hospitalization rate for nursing homes in Louisiana (38.3 percent) was 14 percentage points higher than the national average (24.3 percent). Generally, nursing homes in States in the upper Pacific West, Mountain West, upper North Central Midwest, and New England

[48] The extent of identified variations suggests that average annual rates of hospitalization differed by the reviewed characteristics, but we do not try to explain these variations. Other factors—such as State bed hold policies—have been shown to influence hospitalization rates. D.C. Grabowski, "Medicaid bed-hold policy and Medicare skilled nursing facility rehospitalizations," *Health Services Research*, 45, 6, 2010, pp. 1963–1980.

regions had the lowest average annual hospitalization rates (see Figure 2).[49]

Figure 2: Geographic Distribution of Average Annual Hospitalization Rate in FY 2011



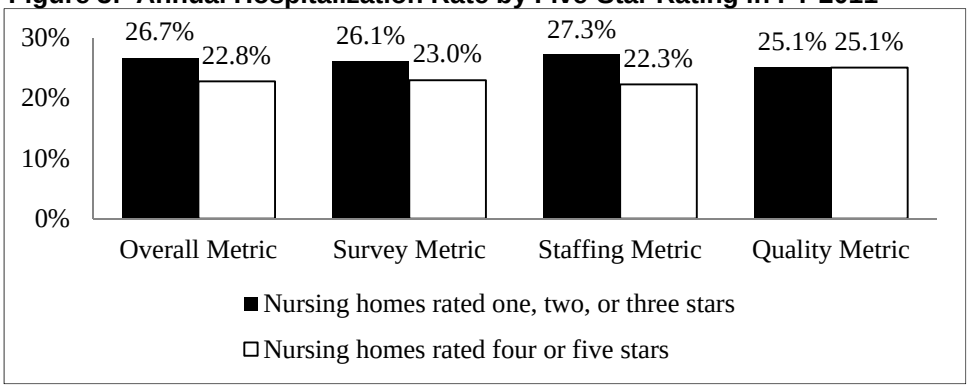
Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

In general, nursing homes rated one, two, or three stars on the Nursing Home Compare Five-Star Quality Rating System had higher annual hospitalization rates than those rated as four or five stars

Nursing homes rated one, two, or three stars (the lowest five-star ratings) on three of the four metrics (the overall, survey, and staffing metrics) had higher annual hospitalization rates than those rated four or five stars (the highest five-star ratings). The biggest difference between annual hospitalization rates appears in the staffing metric, where nursing homes rated one, two, or three stars had hospitalization rates that were 5 percentage points higher than that of those rated four or five stars. The exception is the quality metric, where nursing homes rated one, two, or three stars had the same hospitalization rate as those rated four or five stars (see Figure 3).

[49] Appendix C lists the average annual hospitalization rates for nursing homes in all States. Regions are defined by the Census Bureau.

Figure 3: Annual Hospitalization Rate by Five-Star Rating in FY 2011



Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Large and medium-sized nursing homes had higher annual hospitalization rates than small nursing homes

Small nursing homes had annual hospitalization rates 2.4 percentage points lower than the national average. Large and medium-sized nursing homes had annual hospitalization rates 1.6 and 0.9 percentage points higher than the national average, respectively (see Table 6).

Table 6: Annual Hospitalization Rate by Nursing Home Size in FY 2011

Size of Home	Number of Homes	Average Annual Hospitalization Rate	Percentage Point Difference From National Rate
Nationwide	15,497*	25.0%	n/a
• Large nursing homes (more than 120 beds)	4,749	26.6%	**1.6%**
• Medium-sized nursing homes (80–120 beds)	5,539	25.9%	**0.9%**
• Small nursing homes (fewer than 80 beds)	5,209	22.6%	**-2.4%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.
*CASPER did not contain bed count information for one home.

As a group, for-profit nursing homes had the highest annual hospitalization rate compared to the rate for government-owned and nonprofit nursing homes

As shown in Table 7, for-profit homes had an annual hospitalization rate 1.5 percentage points higher than the national average. Government-owned and nonprofit homes had annual hospitalization rates about 1.5 and 3.8 percentage points lower than the national average, respectively.

Table 7: Average Annual Hospitalization Rate by Ownership Category in FY 2011

Ownership Category	Number of Homes	Percentage of Medicare Population Served Annually	Average Annual Hospitalization Rate	Percentage Point Difference From National Rate
Nationwide	15,497*	109.0%**	25.0%	n/a
• For-profit nursing homes	10,761	76.4%	26.5%	**1.5%**
• Government-owned public nursing homes	850	4.8%	23.5%	**-1.5%**
• Nonprofit nursing homes	3,886	27.8%	21.2%	**-3.8%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.
*CASPER did not contain ownership information for one home.
**Percentage exceeds 100 percent because some residents received care in multiple nursing homes.

CONCLUSION AND RECOMMENDATIONS

We found that nursing homes hospitalized one-quarter of nursing home residents in FY 2011, that these hospitalizations cost Medicare $14.3 billion, and that a small number of medical conditions (e.g., septicemia) accounted for the majority of hospitalizations and costs. We also identified wide variation in rates of hospitalization among individual nursing homes. Among 1,059 nursing homes, more than 40 percent of stays ended in hospitalization. Nursing homes in certain States (Arkansas, Louisiana, Mississippi, and Oklahoma) and nursing homes rated as one, two, or three stars on CMS's Five-Star Quality Rating System had the highest average annual hospitalization rates.

Hospitalizations of nursing home residents are necessary when physicians and nursing staff determine that residents require acute-level care. However, the higher-than-average resident hospitalization rates of some nursing homes in FY 2011 suggest that some hospitalizations could have been avoided through better nursing home care.

We recommend that CMS:

Develop a QM That Describes Nursing Home Rates of Resident Hospitalization

CMS should develop a QM of nursing home rates of resident hospitalization and consider publicly reporting this measure on the Nursing Home Compare Web site. One possible QM could be a measure of each home's overall hospitalization rate. Alternatively, CMS could develop more discrete measures that would identify nursing homes that hospitalize residents more frequently than other homes for certain conditions. Adding a measure of hospitalization rates to the existing QMs not only would enable nursing homes and the public to compare these rates across nursing homes, but also would provide greater incentive for nursing homes to reduce avoidable hospitalizations.

Instruct State Agency Surveyors To Review Nursing Home Rates of Resident Hospitalization as Part of the Survey and Certification Process

After developing the QM recommended above, CMS should instruct State survey agencies to use the QM in preparing to survey homes and provide the agencies with guidance for interpreting and using the QM. Examining these data could help surveyors identify areas of concern—such as infection control practices in homes with high rates of hospitalizations for septicemia—within individual nursing homes.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with both of our recommendations.

CMS concurred with the recommendation to develop a QM that describes nursing home rates of resident hospitalization. CMS stated that it is taking steps to develop and implement a nursing home hospitalization QM in accordance with the rulemaking process. Further, CMS indicated that it is developing a skilled nursing facility readmission measure, which it intends to submit to the National Quality Forum for endorsement in late 2013.

CMS also concurred with the recommendation to instruct State survey agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process. CMS indicated that surveyors should consider measures of hospitalization during their nursing home reviews. CMS stated that reducing hospitalizations is a major public health goal and that hospitalization measures can be used to assess the quality of care that nursing home residents receive.

For the full text of the CMS's comments, see Appendix D. We made minor changes to the report based on technical comments.

APPENDIX A

Nursing Home Quality Measures

Nursing homes routinely collect resident assessment data at specific intervals during a nursing home stay, and CMS stores the assessment results in the MDS. CMS converts MDS data into the 18 QMs described in Table A-1. [50]

Table A-1: Nursing Home Quality Measures

Short Stay Quality Measures
1. Percent of Residents Who Self-Report Moderate to Severe Pain
2. Percent of Residents With Pressure Ulcers That Are New or Worsened
3. Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
4. Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
5. Percent of Short-Stay Residents Who Newly Received Antipsychotic Medications
Long-Stay Quality Measures
6. Percent of Residents Experiencing One or More Falls With Major Injury
7. Percent of Residents Who Self-Report Moderate to Severe Pain
8. Percent of High-Risk Residents With Pressure Ulcers
9. Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
10. Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
11. Percent of Residents With Urinary Tract Infections
12. Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
13. Percent of Residents Who Have/Had Catheters Inserted and Left in Their Bladders
14. Percent of Residents Who Were Physically Restrained
15. Percent of Residents Whose Need for Help With Activities of Daily Living Has Increased
16. Percent of Residents Who Lose Too Much Weight
17. Percent of Residents Who Have Depressive Symptoms
18. Percent of Long-Stay Residents Who Received Antipsychotic Medications

Source: CMS, *MDS 3.0 QM User's Manual V8.0.*

[50] CMS, *Nursing Home Quality Initiative: Quality Measures.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html on April 16, 2013.

APPENDIX B

Detailed Methodology for Categorizing the Primary Diagnosis Codes on Hospital Claims

To describe the ICD-9-CM codes on the hospitalized residents' inpatient claims, we used the CCS established by AHRQ's HCUP.[51] The HCUP CCS enables researchers to identify patterns of diagnosis and procedure codes. Researchers use the CCS to collapse the ICD-9-CM system's 14,000 diagnosis codes and 3,900 procedure codes into a smaller number of clinically meaningful categories for presentation and analysis. AHRQ used the CCS in its 2012 review of data on hospitalizations of nursing home residents.[52]

For this review, we used the CCS "single-level" categorization. The single-level categorization system is designed for ranking diagnoses and procedures. We matched the primary diagnosis codes on the hospital claims associated with the hospitalizations to the appropriate CCS single-level category. See Table B-1 for an example of how the CCS collapses individual ICD-9-CM codes into clinically meaningful groups.

Table B-1: Examples of Single-Level CCS Matching

General Description of Condition	ICD-9-CM Diagnosis Codes Used	CCS Category
Septicemia	0031 0202 0223 0362 0380 0381 03810 03811 03812 03819 0382 0383 03840 03841 03842 03843 03844 03849 0388 0389 0545 449 77181 7907	2
Pneumonia	00322 0203 0204 0205 0212 0221 0310 0391 0521 0551 0730 0830 1124 1140 1144 1145 11505 11515 11595 1304 1363 4800 4801 4802 4803 4808 4809 481 4820 4821 4822 4823 48230 48231 48232 48239 4824 48240 48241 48242 48249 4828 48281 48282 48283 48284 48289 4829 483 4830 4831 4838 4841 4843 4845 4846 4847 4848 485 486 5130 5171	122
Congestive heart failure, nonhypertensive	39891 4280 4281 42820 42821 42822 42823 42830 42831 42832 42833 42840 42841 42842 42843 4289	108

Source: HCUP, *Clinical Classifications Software (CCS) 2013 User Guide*.

[51] A. Elixhauser, C. Steiner, and L. Palmer, *Clinical Classifications Software (CCS)*, AHRQ, 2013. Accessed at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp on February 5, 2013.

[52] AHRQ, *Transitions between Nursing Homes and Hospitals in the Elderly Population, 2009*, September 2012. Accessed at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb141.pdf on February 5, 2013.

APPENDIX C

Average Annual Rate of Hospitalization of Nursing Home Residents by State

Table C-1 reports the average annual rates of resident hospitalization in FY 2011 for nursing homes in all States. We did not include in this analysis homes with fewer than 30 admissions in FY 2011 or facilities designated as "swing bed" providers.

Table C-1: Average Annual Hospitalization Rates by State in FY 2011

State	Rate	State	Rate	State	Rate
Louisiana	38.3%	Maryland	25.3%	Nevada	20.9%
Mississippi	35.7%	Indiana	24.9%	New Mexico	19.5%
Arkansas	31.7%	Florida	24.9%	Wyoming	19.1%
Oklahoma	31.6%	Michigan	24.8%	New Hampshire	19.0%
Kentucky	29.2%	Virginia	24.8%	Washington	18.6%
Illinois	29.0%	Connecticut	24.7%	Wisconsin	18.3%
Tennessee	28.4%	California	24.2%	Vermont	17.9%
New Jersey	28.2%	North Carolina	24.2%	Colorado	17.8%
Texas	28.2%	Delaware	24.2%	Maine	17.2%
Missouri	27.9%	Pennsylvania	23.4%	Montana	17.0%
Kansas	27.5%	South Dakota	23.4%	Alaska	16.9%
New York	27.4%	Ohio	23.0%	Arizona	16.7%
Alabama	26.9%	Iowa	22.9%	Minnesota	16.0%
West Virginia	26.5%	Nebraska	22.7%	Idaho	15.9%
District Of Columbia	26.5%	Massachusetts	22.5%	Oregon	14.9%
Georgia	26.3%	Rhode Island	21.6%	Utah	14.2%
South Carolina	25.3%	North Dakota	21.4%	Hawaii	10.6%

Source: Office of Inspector General analysis of data on FY 2011 hospitalizations of nursing home residents.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 19 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring (OEI-06-11-00040)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above subject OIG draft report. Nursing home quality measurement and oversight is of critical importance to us, including addressing unnecessary hospital admissions and readmissions. One example, focusing on dual eligible beneficiaries, is the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. In this initiative, which was launched in 2012, CMS selected organizations to partner with nursing facilities and deploy interventions aimed at reducing avoidable hospitalizations, improving transitions and outcomes, and reducing costs among Medicare-Medicaid enrollees. Lessons learned from this initiative will help inform future policy decisions.[1]

In addition, the Fiscal Year (FY) 2014 President's Budget includes a proposal addressing high rates of hospital readmissions in skilled nursing facilities (SNFs). Currently, there is a Hospital Readmission Reduction program that reduces payments for hospitals with high rates of readmission, many of which could have been avoided with better care. To promote similar high-quality care in SNFs, the President's Budget proposal would reduce payments by up to three percent for SNFs with high rates of care-sensitive, preventable hospital readmissions.

The purpose of this OIG study was to (1) Determine the proportion of Medicare nursing home residents hospitalized in FY 2011 and the associated costs to Medicare; (2) Identify the medical conditions most commonly associated with these hospitalizations; (3) Describe the extent to which these hospitalization rates varied across nursing homes; and (4) Describe the extent to which these hospitalization rates varied according to select nursing home characteristics.

The OIG recommendations and CMS's responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS develop a quality measure that describes hospitalization rates for residents of nursing homes.

[1] Additional information on this initiative is available at http://innovation.cms.gov/initiatives/rahnfr

CMS Response

The CMS concurs. The rate of nursing home resident hospitalization measure concept was included in CMS's Measures under Consideration (MUC) list that we made public on December 1, 2012, in accordance with the pre-rulemaking process established by section 1890A(a)(2) of the Affordable Care Act. This MUC list was posted for CMS on the website of the National Quality Forum (NQF), and NQF's stakeholder group, the Measure Applications Partnership supported this measure concept for future development. Making this list public is one step in CMS's obligation to establish a pre-rulemaking process prior to adopting certain categories of measures. CMS must include potential measures on the MUC list if it is considering adopting them through rulemaking at any time in the future. Development of this proposed hospitalization outcome measure is commencing later this year and is intended to measure the percent of long-stay residents who are hospitalized during a specific reporting period.

In addition, CMS is developing a Skilled Nursing Facility 30-Day All-Cause Readmission Measure and intends to submit this measure to the NQF for endorsement in late 2013. The specifications for this measure will be designed to harmonize, to the extent possible, with CMS's hospital-wide all-cause unplanned readmission measure endorsed by the NQF for the Hospital Readmission Reduction Program.

OIG Recommendation

The OIG recommends that CMS instruct state agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process.

CMS Response

The CMS concurs. Reducing re-hospitalizations is a major public health goal of CMS and the Department of Health and Human Services, as well as a goal that has been widely embraced by health care providers. As noted above, CMS is actively developing a hospitalization measure for all nursing home residents and a re-hospitalization measure for Medicare SNF residents. We concur that evidence suggests these types of measures are important to assess the quality of care that residents receive. We concur that adding measures of hospitalization and/or re-hospitalization to the list of quality measures that nursing home surveyors review is a logical and useful outcome of CMS's quality measure development efforts.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Jeremy Moore served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Maria Balderas, Nathan Dong, and Chetra Yean. Central office staff who provided support include Kevin Farber, Heather Barton, Sandy Khoury, Starr Kidda, and Christine Moritz.

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