White Paper on Blood Transfusions in Skilled Nursing Facilties

Why Blood Transfusions for Nursing Facility Residents Should be Administered at the Resident's Bedside in the Skilled Nursing Facility (SNF) and NOT in an Acute Care Hospital

Our health care system currently has a two-tiered approach to offering medically necessary blood transfusions for nursing facility residents. Medicare Part A residents can receive this service at the bedside in the SNF while Medicaid residents must be transported to a hospital to receive their blood transfusion in an Infusion Center or as an inpatient following admission. *This inequity is not only placing Medicaid long term care residents at a much higher medical risk of confusion, delirium, incontinence, skin breakdown and exposure to hospital acquired infections but costing Medicare millions a year in unnecessary and avoidable costs.*

This White Paper has been prepared for CMS to not only highlight the current inequity in the administration of blood transfusions for nursing facility residents but to also emphasize the cost savings potential for Medicare by reimbursing Medicaid nursing facility residents in need of medically necessary blood transfusions to receive those transfusions at their bedside in the SNF instead of requiring them to be transported to an acute care hospital setting.

A Demonstration Model is being requested to prove the quality of care improvements immediately available for Medicaid long term care nursing facility residents and cost savings benefits available to Medicare by eliminating the need to transport vulnerable seniors for a nursing facility setting to an acute care setting for the administration of a blood transfusions.

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Background: When Medicare and Medicaid were initially passed in 1965, the clinical complexity of administering blood transfusions dictated that this service be provided in an acute care hospital setting. At that time, a relatively small number of nursing facility residents required blood transfusions. Today however, the nursing home industry is in a totally different space. Seniors are living longer with multiple chronic conditions and the continuum of care has shifted such that nursing facilities are accepting and caring for much sicker patients. Thus, and the number of nursing facility residents in need of medically appropriate blood transfusion has increased.

Unfortunately, the Medicare reimbursement regulations that were approved in 1965 have not changed and still require a nursing home resident to receive their blood transfusions in a hospital setting to receive Medicare reimbursement.

Until just recently, the economic benefit of providing blood transfusions in skilled nursing facilities was not recognized and thus, the only providers offering this service were hospitals.

Medicare Part A Patients in Need of a Blood Transfusion:

In 2015, a small private company in Maryland providing special IV services to nursing facilities recognized the quality of care benefits that could be available to nursing facility residents by providing their blood transfusions at the patient's bedside in the SNF instead of sending them to the hospital. (See Case Studies in Attachment I for examples of the quality of care benefits)

> *For many years, the hospital was the best setting to administer a blood transfusion to a nursing facility resident. In today's rapidly changing health care environment however, it is safer for the resident and less expensive for the system to have a specially trained nurse come to the facility and administer the transfusions at the resident's bed side. A win for the resident and a win for our health care system.* ***Rozalinde Christodoulos, MSN, CRNP***

The founders of this company began speaking with thought leaders in the long-term care industry with the goal of identifying an economic model that justified providing blood transfusions in the SNF. These discussions began by looking at all payer groups in need of this service but quickly focused on the Medicare Part A patient. Under Medicare's Prospective Payment System (PPS) (Mandated by the Balanced Budget Act of 1997) blood transfusions were included in the per diem comprehensive payment received by skilled nursing facilities.

Under PPS, the SNF is financially responsible for the blood transfusion if administered in a hospital's Infusion Center or other outpatient setting but not if the Medicare Part A patient is admitted to the acute care hospital. When admitted, the financial responsibility shifts away from the SNF and the Medicare Program becomes responsible and pays the hospital directly.

As the evaluation continued, the strategy of admitting these complex, vulnerable Medicare Part A patient in need of a blood transfusion appeared at first glance to be a viable option given the patient's medical condition. This strategy also shifted the financial responsibility for the

transfusion away from the SNF. Upon deeper evaluation, however, it was discovered that the nursing facilities operators were often losing valuable billing opportunities by sending their Medicare Part A patients to a hospital. This analysis proved true not only when admitting the resident but also when sending them to an Infusion Center or other outpatient setting. Given the complex nature of the patients and the time required to administer the blood transfusion, especially in over 60% of the cases when two units of blood are ordered, these patients often converted from an outpatient setting to being admitted to the hospital.

When a Medicare Part A patient is admitted to the hospital, the SNF is no longer able to ill Medicare for the 3 to 4-day hospital stay. Further evaluation discovered that too often, the patient would not return the SNF but transfer to a different SNF further increasing the operator's lost revenue opportunity. In today's highly competitive nursing home environment for Medicare skilled patients, this lost revenue opportunity was viewed as unacceptable.

Based on internal economic feasibility studies by several large nursing home operators in Maryland, it was determined that paying directly for the blood transfusion to be administered within their SNF offered their companies a better economic model compared to transporting a Medicare Part A patient to a hospital setting. Paying directly for the transfusion to be administered within their SNFs allowed these operators to continue billing Medicare and eliminated the risk of losing additional billing days should the resident not return to the SNF.

In 2016, Advanced PICC administer 547 blood transfusions in the nursing facility and at the bed side of Medicare Part A patients in Maryland. Over 66% of those patients receive two units and in all cases, payment was made directly from the SNF for this service. The risk of negative medical outcomes so common when a vulnerable senior is treated in a hospital setting was eliminated.

As Maryland's nursing facilities recognized the economic benefit of paying directly for blood transfusions to be delivered with the SNF, the demand for this service increased. Based on preliminary findings it is estimated that the average nursing facility with a 30-bed skilled care unit will have one Medicare Part A patient a month in need of a blood transfusion. Because the SNFs are paying for these transfusions, Medicare is not incurring the costs.

Based on the experience in Maryland in 2016 with Medicare Part A patients it is estimated that on average, a typical 120 bed nursing facility will generate one Medicare patient a month in need of a blood transfusion. Projecting out nationally and taking a conservative approach, if only half of our nation's 15,500 nursing facilities produced one Medicare Part A patient per month, it represents 93,000 blood transfusions per year. If only 50% of those were admitted to the hospital and using Maryland's per admission cost for a blood transfusion of $13,200, Medicare costs would exceed $600 million dollars.

When nursing facility operators pay directly for blood transfusions to be administered to their Medicare Part A patients at the bed side, two positive outcomes are realized:

1) The patient is placed at a much lower risk because by avoiding the many known medical complications often experienced by vulnerable seniors when cared for in a hospital setting. These well documented risks include; increased confusion, delirium, skin breakdown, incontinence and exposure to hospital acquired infections

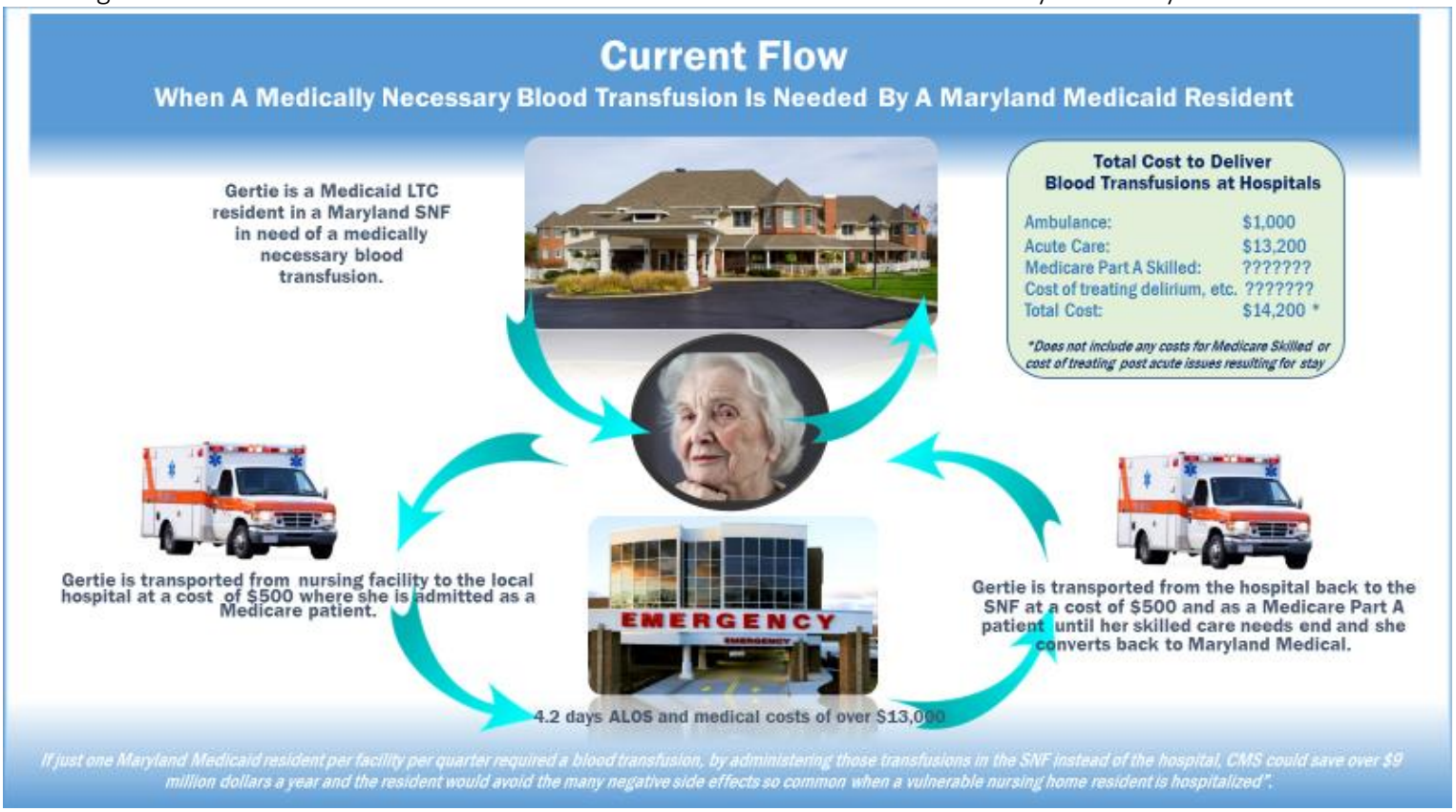
2) The Medicare Program benefits financially. While Medicare is still paying for the additional Medicare skilled days that otherwise would have been avoided if the patient was admitted, these costs are significantly less than the cost Medicare incurs when the patient is admitted.

Because this economic model benefits the patient, the nursing facility operator and the Medicare Program, efforts should be taken to replicate this model national.

Medicaid Long Term Care Residents in Need of a Blood Transfusion:

As positive as this approach is for Medicare Part A patients, it unfortunately does not apply for Medicaid long term care residents. There does not appear to be a comparable economically viable model for Medicaid long term care residents needing a blood transfusion. In fact, our system currently dictates that these vulnerable seniors be transported to a hospital setting where Medicare payment to be realized.

This diagram shows the current flow for a PA Medicaid resident in need of a medically necessary blood transfusion:



Note: This diagram depicts a Medicaid resident that is admitted to the hospital. While some Medicaid residents are receiving their needed blood transfusions in outpatient settings at the hospital, the diagram above represents the highest risk approach for the patient and the costliest approach for Medicare spending.

In addition to the cost of the hospitalization for the blood transfusion (In 2015 the average cost of a nursing facility resident receiving a blood transfusion in a Maryland hospital was $13,200 and included a 4.2 day stay) transporting the resident to and from the SNF to the hospital adds additional cost estimated at $1,000.

While not included in the cost calculation in the diagram above, when a hospital length of stay is over three days, these Medicaid residents could return the SNF and qualify for Medicare skilled care services. This would depend on their skilled care needs and while not every Medicaid resident admitted would qualify for Medicare skilled services, some likely would adding additional costs to Medicare.

Finally, the diagram above did not estimate and costs for treating the many negative outcomes that often result when a vulnerable senior is admitted to the hospital. Those costs would be on a patient by patient basis but for many patients, can become very significant.

Currently, for a Medicaid long term care resident in need of a blood transfusion, the only option available for nursing home operators is to transport that resident to a local hospital as either an outpatient or for that resident to be admitted. In either case, Medicare is financially responsible for that service. Unfortunately, when visiting the hospital, these residents are then susceptible to all the negative exposures historically experienced by vulnerable seniors when cared for in a hospital setting.

Obviously, the risks of these negative medical outcomes are greater with an admission of multiple days when compared to an outpatient visit. Given the time required to administer a blood transfusion plus the added transport time going to and from, even the outpatient setting place the vulnerable seniors at considerable and unnecessary risk of increased confusion, delirium, skin breakdown, incontinence and exposure to hospital acquired infections.

Advantages of Offering Blood Transfusions in the Nursing Facility Setting

- Reduces the potential and severity of delirium and the negative care and cost consequences that often follow
- Eliminates exposure to hospital infections
- Eliminates transport costs
- Eliminates the potential of the resident being admitted to the hospital from the outpatient setting or ER due to the time required when two units of blood are administered and the resident is onsite for up to 12 hours
- Reduces the total cost of administering a blood transfusion to a nursing facility resident compared to a hospital admission or a hospital's outpatient area services

As a direct result of current reimbursement policies, our system has evolved into a two-tier system where Medicare Part A patients can receive their blood transfusion at their bedside in the SNF while Medicaid long term care residents must be transported to an acute care hospital setting for the same service. In addition to being discriminatory to Medicaid residents and placing them at a much higher risk of negative medical outcomes, this current flaw in our health care system is costing Medicare additional costs, especially when the resident is admitted.

While the actual demand for blood transfusions among Medicaid residents is not readily available from any current data base, based on the 45 facilities participating in the provision of transfusions to Medicare Part A patients and their staff's interaction with the management team at these facilities, the number of Medicaid residents in need of a blood transfusion appears to be comparable to the Medicare demand rate of approximately 1 resident per facility per month.

While the exact potential of Medicare savings available by allowing Medicaid long term care residents to receive medically necessary blood transfusions in the SNF at their bedside is not known, it is evident that significant Medicare savings, as well as dramatic reductions in the medical risk factor for these residents will be achieved.

Conclusions: The quality of life improvements for the resident by administering blood transfusions in the skilled nursing facility instead of transporting highly vulnerable residents to the hospital makes this service worthy of consideration even before evaluating the economic implications. Add the potential of saving the Medicare Program hundreds of millions of dollars a year and it quickly becomes evident that our health care system should be actively advocating to replace the current practice of administering blood transfusions in the hospital setting by administering transfusions directly at the resident's bedside in the nursing facility. This will require strong quality control protocols, including the use of outside specialty nurse practitioners and certified nurses to complement the nursing staff at individual nursing facilities in this effort. Doing so will not only improve life for those seniors being served, but also save significant dollars for our health care system.

Limitations of this White Paper and Expected Updates: Securing accurate information concerning the volume of residents receiving blood transfusions and the cost of providing those blood transfusions in the hospital and hospital outpatient settings was difficult. With an approved Demonstration Model this data could be accurately captured to prove not the benefit of providing blood transfusions at the bed side, but rather the level of benefits our system would gain.

While it is anticipated that these numbers will change, the estimates used in preparing this document were purposely conservative. It is fully anticipated that any new volume and cost data secured will only increase the economic value of this analysis.

Request: To prove the extent of the positive impact on quality of care for Medicaid long term care residents in need of a medically appropriate blood transfusion, and the savings available to Medicare, it is recommended that CMS approve a Demonstration Model that would provide reimbursement for administering blood transfusions within a skilled nursing facility for dual eligible nursing home residents in need of this service.

By eliminating the need to transport residents to the hospital setting, not only would Medicare realize significant savings, but the Medicaid resident would avoid the many negative medical risks associated with being cared for in a hospital setting. At the same time, this would eliminate the current inequities found between providing blood transfusion services to Medicaid residents compared to Medicare Part A patients.

In addition, this demonstration model would be used to encourage all SNFs with Medicare Part A residents to pay for the administration of blood transfusions in their SNFs and avoid admitting those residents to the hospital. Economic models will be developed showing why paying directly for the transfusions is not only in the best interest of the residents entrusted to their care, but also in the best economic interest of their organizations as well as the Medicare Program.

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