Residents, Facilities, and Providers Benefit from Change in Reimbursements for AL Visits

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In 2006, the Centers for Medicare and Medicaid Services (CMS) increased the reimbursement for clinicians' visits to assisted living (AL) residents, making the delivery of clinical services to residents in their AL home much more likely. Prior to the increase, few physicians found it worthwhile to visit AL residents in their home; instead, clinicians were more likely to see the residents in their private offices, either within or outside of the AL facility.

Which is Preferable—Home Visits or Office Visits?

The most obvious benefit to clinicians of AL home visits is the fact that physicians and nurse practitioners are able to visit AL residents without the overhead of an office. Of course, it still is important to operate AL homecare programs efficiently so clinicians' valuable time is not wasted. This can be accomplished by establishing set visit times and scheduling several visits at the same facility.

Assisted Living home visit rates from 2005 to 2006 show a significant increase in reimbursement over previous years, in part because of CMS's realization of the importance of promoting this type of visit. In fact CMS established new codes for AL visits that did not even exist prior to 2006. This sizable increase made development of the home-visit model profitable for efficient practitioners, including nurse practitioners who are paid at a lower rate.

The Clinic Approach

Before the increase in reimbursements for AL visits, many physician practices had developed clinics within AL facilities. They received higher reimbursements by seeing AL residents in their onsite offices, and often negotiated beneficial "use" agreements that allowed them to pay rent only when they used the space. Therefore, even at the required market rates, office expenses were variable and not the typical high, fixed expense of traditional physicians' offices, which is costly when the space goes unused for long periods of time. Paying only for the time the space is utilized is a much more cost-effective approach.

In addition to the reimbursement and office rental opportunities, onsite clinics offered greater access to AL residents and staff and allowed for more frequent office visits. Typically, AL residents initially continue to see their own physicians, using onsite physicians only for urgent or emergency services. As time goes by and they develop a level of comfort with the onsite physician, AL residents usually transition their care from their own physician to the onsite AL physician because it is more convenient. Of course, this increased convenience is possible only if the physician is able to spend an adequate amount of time at the AL facility, which can be accomplished by providing additional services for which the physician is paid. Physicians can also be onsite a significant amount of time by developing AL clinics that draw in seniors from the surrounding community. These clinics also are a benefit to the facility, not only because they allow clinicians to spend more time onsite but also because they expose potential clients to the AL facility.

Having onsite clinics also helps the clinicians and AL staffs develop a closer working relationship, which improves the level of care the residents receive.

The benefits of onsite AL clinics include:

- ready access to AL residents and staff
- efficient use of office space and staff
- slightly higher reimbursement as compared to AL home visits

A comparison of clinic reimbursement to AL home visit reimbursement reveals clinic/office rates that are slightly higher despite the fact that the overhead for office-based practices is much higher. (See Table 1 for a comparison of patient visit reimbursement rates.)

One of the most significant revenue opportunities in developing a relationship with an AL facility is the ability to follow the AL residents to other care settings such as hospitals and subacute sites. Clinical visits in these settings provide the highest reimbursement for time spent with patients with relatively little overhead. Practices that are able to take advantage of this additional revenue source will see significant benefits in building AL practices whether with home visits or at onsite clinics.

Table 1.
Patient Visit Reimbursement 2006

Visit Complexity	Clinic, onsite or offsite	Home	AL Home	Nursing Facility
	99213-15	99347-50	99334-37	99307-09
Low	$50.14	$43.73	$43.73	$32.89
Intermediate	$78.76	$69.45	$69.45	$54.56
High	$115.00	$107.71	$107.36	$76.90

What Does the Future Hold?

It is likely that clinicians will become more involved in AL by taking on new roles, such as medical director, which would allow them to provide increased clinical services and greater oversight of the AL staff. For this to happen, however, state and federal regulators will have to recognize how important it is to have clinicians onsite, and will have to provide both regulatory and reimbursement support.

In addition, several significant issues must be addressed—issues regarding the scope of services provided by the AL staff, documentation, and storage of medical records. The American Geriatric Society (AGS) position statement on AL points out the importance of greater clinical involvement. The AGS position statement can is availalbe at www.americangeriatrics.org/products/positionpapers/ags_alf.shtml. It maintains that primary care providers (including geriatric nurse practitioners as well as physicians) experienced in geriatrics care should be available within each AL facility to help direct staff in optimizing outcomes for each resident. Clearly, this is possible either by having onsite clinics or by providing regular and consistent home visits.

The AGS statement also says that AL facilities must become aligned with other facilities, providers, and systems of care to produce optimum outcomes for seniors. This point encourages clinicians involved with AL residents to maintain relations with these residents as they pass through the continuum of long-term care.

One other AGS position point acknowledges the importance of having AL staffs that are knowledgeable and skilled in carrying out important components of geriatric care, including safe medication administration, falls prevention, incontinence care, communication techniques, dementia care, skin care, and recognition of changes that can signal acute illness, delirium, and depression. This is a position that would be best accomplished by developing AL medical directors who have a significant clinical presence within the facility.

Clearly, there are opportunities for clinicians to develop relationships with AL facilities to improve services for residents, staff, and the facility itself. And as reimbursements, regulatory requirements, and AL residents' needs change, the who, what, and where of care will change, too. ALC

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