PHARMACY
New Focus for Medicare SNF Reimbursement
CMS PDPM Final Rule for FY 2019 and FY 2020

On July 31, 2018, CMS issued the SNF PPS Final Rule for FY 2019, updating the payment rates for FY 2019 and replacing the existing case-mix classification methodology, RUG IV, with the Patient-Driven Payment Model (PDPM) beginning on October 1, 2019. On August 8, 2018, CMS issued the formal Federal Register copy. [1]

PDPM removes "amount "of services from driving Medicare reimbursement and shifts to SNF payment based on patient "need." ***This is an important development for patients and LTC pharmacists.***

We ask you to refer to the May issue of *LTC Pharmacy News* for the details on the new CMS SNF PDPM payment methodology. [2] The final PDPM with minimal exceptions adopted the proposed PDPM. Below, we focus on the aspects of PDPM regarding payment for drugs and the increased accuracy of the PDPM methodology. In short, we devote this *LTCPharmacyNews* blog to LTC pharmacy!

PDPM Payment for Drugs

In the current RUG IV model, drugs are a component of non-therapy ancillaries (NTAs). NTA services include drugs, laboratory services, respiratory therapy, and medical supplies.[3] Medication is the largest component of NTA costs.[4]

CMS has always included NTA costs within its nursing component rather than accounting for them separately. CMS tells us that the longstanding concerns about this approach were, in fact, the very impetus behind the development of a separate component for NTA costs under the PDPM.

When the SNF PPS system was provided by Congress in 1999, CMS had to find a mechanism for reimbursement other than the then current retrospective cost-based reimbursement. Congress required the Secretary to provide an appropriate adjustment to account for case mix, case mix being the characteristics of residents related to their resource use. Such an adjustment had to be based on a resident classification system that accounted for the relative resource utilization of different patient types.

CMS developed the RUG–III case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. The current case mix classification system uses **a combination of resident characteristics and service intensity metrics** (for **example, therapy minutes)** to assign residents to one of 66 RUGs, each of which corresponds to a therapy case-mix index (CMI) and a nursing CMI. These were assumed to be indicative of the relative cost to a SNF of treating residents within that classification category.

Under the current SNF PPS, RUG IV, has 2 case-mix adjusted components: therapy and nursing; and two non-case mix adjusted components, therapy non-case mix and non-case mix (room and board and various capital related expenses.) As indicated above, payments for pharmacy services are incorporated into a non-therapy ancillary subcomponent of the nursing component. This means that the case mix indices used to adjust the nursing component of the SNF PPS were intended to reflect not only differences in nursing resource use but also in NTA costs. But this goal was not achieved.

As is now very well known, there have been concerns that the current nursing CMIs do not accurately reflect the basis for or the magnitude of relative differences in resident NTA costs. CMS and other entities such as MedPAC have concluded that this payment situation promotes the attractiveness of rehabilitation therapy patients, discourages facility interest in medically complex patients, and promotes inappropriate and questionable RUG reporting.

In the March 2016 Report to Congress, MedPAC wrote: "Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs.[5] With PDPM CMS has developed a methodology that it believes will case-mix adjust SNF PPS payments more appropriately to reflect differences in NTA costs.

PDPM incorporates the two major recommendations from the research community and the Medicare Payment Advisory Commission (MedPAC). It removes therapy minutes as the basis for therapy payment and it establishes <u>a separate case-mix-adjusted component for NTA services,</u> thereby mitigating financial incentives to provide excessive therapy and improving allocation of system resources to medically complex beneficiaries. It creates five case-mix indexed components: Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP), NTA, and Nursing. The rates assigned to the five indexes are combined with a non-indexed component to derive the daily rate for a patient.

Acumen, CMS' contractor on development of the new system used extensive analysis to determine cost related characteristics for NTA and identified the following 3 categories:[6]

- Resident comorbidities,
- The use of extensive services (services provided to residents that are particularly expensive and/or invasive), and
- Resident age. (However, CMS removed age from further consideration as part of the NTA component based on concerns shared by TEP panelists during the June 2016 TEP, particularly concern that including age as a determinant of NTA payment could create access issues for older populations.)

Conditions and services were defined in three ways:

- First, clinicians identified MDS items that correspond to conditions/extensive services likely related to NTA utilization.

- However, since many conditions/extensive services related to NTA utilization are not included on the MDS assessment, CMS then mapped ICD–10 diagnosis codes from the prior inpatient claim, the first SNF claim, and section I8000 of the 5-day MDS assessment to condition categories from the Part C risk adjustment model (CCs) and the Part D risk adjustment model (RxCCs).

- Lastly, CMS used ICD–10 diagnosis codes to define additional conditions that clinicians who advised CMS during PDPM development identified as being potentially associated with increased NTA service utilization but are not fully reflected in either the MDS or the CCs/RxCCs.

The resulting list is meant to encompass as many diverse and expensive conditions and extensive services as possible from the MDS assessment, the CCs, the RxCCs, and diagnoses.

After identifying the list of relevant conditions and services for adjusting NTA payments, CMS then proceeded to devise the methodology for capturing the variation in NTA costs explained by the identified conditions and services.

PDPM Impact on SNFs[7]

PDPM may capture the costs of drugs far better than under RUGs IV, but pharmacists will want to know how SNFs will react to the new system and what affect the system will have on SNFs. There are no certain answers to such questions. What is certain is that the new system undoes the RUG IV therapy driven feature and in effect reallocates how money is distributed toward more medically complex patients. CMS intends the new system to be budget neutral, i.e., overall the SNF sector will receive the same reimbursement total as under RUG IV. That is CMS' intent, but the result remains to be seen. Facility level payment may differ widely from the current levels depending on each facility's response – the behavioral factor --to the change in the payment formula and its incentives.

CMS' intent to implement the PDPM in a budget neutral manner is consistent with prior system transitions. In proposing changes to the case-mix methodology, CMS does not intend to change the aggregate amount of Medicare payments to SNFs. Thus, CMS' impact analysis is built on a series of assumptions:

- First, the impact analysis assumes consistent provider behavior in terms of how care is provided under RUG-IV and how care might be provided under the PDPM, as CMS does not make any attempt to anticipate or predict provider reactions to the implementation of the PDPM.

- However, CMS acknowledges the possibility that implementing the PDPM could substantially affect resident care and coding behaviors. The agency acknowledges the possibility that, as therapy payments under the PDPM would not have the same connection to service provision as they do under RUG-IV, it is possible that some providers may choose to reduce their provision of therapy services to increase margins under the PDPM.

- CMS indicates that it does not have any basis on which to assume the approximate nature or magnitude of behavioral responses. As a result, lacking an appropriate basis to forecast behavioral responses, CMS does not adjust its analysis of resident and provider impacts for projected changes in provider behavior.

However, CMS does intend to monitor behavior which may occur in response to the implementation of PDPM and may consider proposing policies in the future to address such behaviors to the extent determined appropriate. CMS aims to utilize the new case-mix methodology to classify residents in such a manner as to best ensure that payments made for specific residents are an accurate reflection of resource utilization without introducing potential incentives which could encourage inappropriate care delivery, as CMS believes may exist under the current case-mix methodology.

CMS observes that the most significant shift in payments created by implementation of the PDPM would be to redirect payments away from residents who are receiving very high amounts of therapy under the current SNF PPS, which strongly incentivizes the provision of therapy, to residents with more complex clinical needs.

Other resident types for which there may be higher relative payments under the PDPM are: residents who have high NTA costs, receive extensive services, are dually enrolled in Medicare and Medicaid, use IV medication, have ESRD, diabetes, or a wound infection, receive amputation/prosthesis care, and/or have longer prior inpatient stays.

The most significant shift in Medicare payments created by implementation of the PDPM would be from facilities with a high proportion of rehabilitation residents (particularly facilities with high proportions of Ultra-High Rehabilitation residents) to facilities with high proportions of non-rehabilitation residents. CMS projects the following:

- Payments to facilities that bill 0 to 10 percent of utilization days as RU (ultra-high rehabilitation) would increase an estimated 27.6 percent under the PDPM;

- While facilities that bill 90 to 100 percent of utilization days as RU would see an estimated decrease in payments of 9.8 percent;

- Other facility types that may see higher relative payments under the PDPM are small facilities, non-profit facilities, government owned facilities, and hospital-based and swing-bed facilities.

Pharmacy Strategic Planning

We cannot and do not want to enter into any debate about the efficacy and impact of the PDPM treatment of rehabilitation therapy which has worried the therapy and the SNF communities. But we do wish to inform the LTC pharmacy community about its reinvigorated ability to work with SNFs on medication management and other aspects of pharmacy care that will facilitate and enhance SNF ability to take care of the critical care patients that need SNF post-acute care.

What is sure is that the new system, the PDPM, moves medication – which is the largest component of NTA services -- to a new place in the recognition of SNF costs in caring for patients. This development is long overdue.

This change comes at a critical time when steep and rising drug prices are causing problems for all citizens including Medicare beneficiaries and Medicare institutional providers -- while at the same time drug research would appear to be producing breakthroughs at a very healthy pace. A new enlightened relationship between LTC pharmacies and their SNF clients may be called for.

My colleague, Paul Baldwin, asks that you consider the implications of this rule for LTC Pharmacy:

- **CMS has changed the incentives**: The payment system will no longer reward SNFs for focusing on therapy but will reward SNFs for caring for medically-complex residents. The new incentives correct a huge flaw in the various RUG iterations, including RUG IV, that, in effect crippled care for complex medical patients! Consultant pharmacists are the recognized masters of rationalizing drug therapy for complex medical conditions.
- **The NTA payment index rewards vigilance**: CMS has determined that NTA (mostly drug costs) are much higher in the early days of the admission and has tripled the NTA multiplier for the first three days of care, and then reduces the scoring to one for the remainder of the stay. Consultant pharmacists that demonstrate the ability to get prescription drug therapy optimized have a strong selling point with SNF operators.
- **Smart operators need smart pharmacies**: With incentives for admitting complex residents arriving in 2019, SNFs will likely reward pharmacies and consultant pharmacists who understand the new system and can advise medical directors, directors of nursing, attending physicians and administrators how to best manage a population they may not be fully experienced in serving.

CMS will be issuing new guidance documents to transition to the new payment model over the next several months. Make a commitment now to read and understand changes to procedures, data sources and changes to the CMS manuals to be ready to serve residents and facilities.

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[1] CMS Final Rule, SNF PPS – PDPM, August 8, 2018, 83 Federal Register 39162, https://www.gpo.gov/fdsys/pkg/FR-2018-08-08/pdf/2018-16570.pdf
[2] http://ltcpharmacynews.com/docs/newsletters/Newsletter%20June%202018.html
[3] 83 Federal Register at 39189, 39220.
[4] CMS Proposed Rule, SNF PPS – PDPM May 8, 2018, 89 Federal Register at page 21056.
[5] http://www.medpac.gov/docs/default-source/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0, page 180.
[6] For CMS' analysis of NTA costs and case-mix development see the May 8, 2018, Proposed Rule at Section V.D.2.e, pages 21055-21061and the August 8, 2018, Final Rule at Section V.C.e, 39219-39225.
[7]See August 8, 2018 Final Rule, at Section V.I. pages 39255-39265.