# Nursing Facility Policy Priorities in 2017

As the long-term care pharmacy industry looks forward to 2017, we take some time to consider the issue priorities of our host community—the nursing home industry. As we talk with our partners, it will be important to keep in mind the environment in which they operate and how it affects their ability to care for their residents.

The overarching issue area for SNF/NFs is the alleged "reform" of both Medicare and Medicaid payment systems. According to the Medicare Payment Advisory Commission (MedPAC), in 2016, Medicare spending for SNF patients was $30 billion. Medicare makes up about 12 % of total facility days but 21 percent of revenue. Medicaid accounts for more than 65% of days but a disproportionately small percentage of revenue. However, Medicaid reimbursement has for some years now been very low and research indicates that while a few states -- apparently very few – have reasonable levels of reimbursement, overall the funding gap between costs and reimbursement is huge.

## Medicare Funding

CMS appears to be intent on "reforming" the SNF PPS system. Its primary data driven work is almost done. Since 1998, Medicare has paid for services provided by skilled nursing facilities (SNFs) under the Medicare Part A benefit on a per diem basis through the skilled nursing facility prospective payment system (SNF PPS). Currently, therapy payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the specific patient characteristics and care needs.

Recommendations to change the reimbursement model have come from multiple sources, including MedPAC, the Office of the Inspector General (OIG), and research conducted by The Urban Institute that was commissioned by CMS. These reports advocate for a new payment model to promote individualized care for residents by using specific patient characteristics and care needs to ensure accurate payments for all services.

To address these opportunities for improvement, CMS is considering alternative payment approaches to strengthen the overall SNF PPS system. CMS contracted with Acumen, LLC to identify potential alternatives to the existing methodology used to pay for services under the SNF PPS. Acumen proceeded in phases utilizing several Technical Expert Panels.

It would appear that CMS and Acumen are going into the last phase of their work before unveiling the new proposed approach. The one certainty is that the new system will base payments on patient's characteristics and not the volume of rehabilitation provided. What is not clear is exactly when CMS will provide the payment reform through a proposed rule. But more will be heard from Acumen in 2017. CMS indicates that the the contractor is continuing with further refinements and considering potential improvements to the overall SNF PPS payment structure.

An interesting sidebar is that the MedPAC Commissioners have expressed frustration over what they perceive as an inexplicable delay in CMS action on the new CMS SNF PPS payment model. There was concern about the timing of CMS implementation of a revised PPS and the roll out of MedPAC's unified payment system for post-acute care - -site-neutral payment which is organized around the individual's needs, rather than around the settings where care is delivered.

However, in the December 8/9th MedPAC open meeting, MedPAC staff expressed their judgment that CMS was making good progress and that the SNF PPS design was foundational work for the MedPAC's Post-Acute unified payment system. They pointed out to the Commissioners that CMS in using patient characteristics rather than services to set payment…" it was a good glide path to the other" unified system.

We understand that the American Health Care Association (AHCA) is developing its own SNF PPS Reform Model. Like CMS' model, it too takes into consideration patient characteristics but may have aspects that would soften the transition from the current PPS to the next reform, and might put a greater value on the benefits of rehab therapy than the CMS model. These are issues that we hope get a fair hearing by CMS and Congress.

## Medicaid Funding

This year nursing homes face challenges regarding the current Medicaid payment system and the threat of alternatives that could pose problems. The issues of "provider taxes" and the expansion of Medicaid Managed Care are gaining attention, as is the prospect of Congress imposing a Medicaid overhaul, including block grants and per capita caps.

### Provider Taxes

According to Kaiser Family Foundation , provider taxes are an integral source of Medicaid financing governed by long-standing regulations. In 2015 , all but one state (Alaska) reported a provider tax in FY 2015. Provider taxes are imposed by states on health care services where the burden of the tax falls mostly on providers, such as a tax on inpatient hospital services or nursing facility beds. States use the additional revenue collected by provider taxes in a number of ways to support Medicaid programs. For example, provider taxes help to support provider rate increases or to help mitigate provider rate cuts.

Congress in the past has been considering proposals to limit the use of provider taxes. This would restrict states' ability on how to come up with the state share to finance Medicaid and could therefore shift additional costs to states. Kaiser comments that if states were not able to find additional funds to replace provider tax funding with other state sources, limits on provider taxes could result in program cuts with

implications for Medicaid providers and beneficiaries. Since states use provider taxes differently, limits would have different effects across states.

## Medicaid Managed Care

Kaiser indicates that Medicaid long-term care is rapidly changing, and some of those trends may eventually remake the way all of us receive personal assistance as we age or become disabled. Kaiser notes that more than half of all Medicaid beneficiaries nationally receive most or all their care from risk-based managed care organizations that contract with state Medicaid programs to deliver comprehensive Medicaid services to enrollees. Although not all state Medicaid programs contract with MCOs, a large and growing majority do, and states are also rapidly expanding their use of MCOs to reach larger geographic areas, serve more medically complex beneficiaries, deliver long-term services and supports, and in states that have expanded Medicaid under the Affordable Care Act (ACA) to serve millions of newly eligible low-income adults.

Nearly half of all states are now providing Medicaid long-term care benefits through managed care, and 13 states are requiring older adults to receive care that way. At the same time, four out of five states are expanding home care benefits through Medicaid and 16 are even beginning to provide housing services with their Medicaid dollars. These are just a few of the key findings in the Kaiser Family Foundation's latest annual survey of state Medicaid programs. Those two trends—managed care and the accelerating move towards home-based care—are redefining long-term supports and services, at least under the Medicaid program.

The Kaiser study shows the impact of those changes on state Medicaid programs. In 2013, for the first time, Medicaid's long-term supports and services (LTSS) programs spent more on home and community based services than on nursing home care. In each of the past two years, four out of five states expanded, or planned to expand, their home and community-based care programs, shifting increasing numbers of older adults and younger people with disabilities from nursing homes to home care.

## Block Grants and Per Capita Caps

Among the biggest threats for the Nursing Home industry are alternative financing arrangements such as block grants and per capita caps. Block grants are typically structured to provide lump sum grants to states with grant amounts based on a predetermined formula. A per capita cap would establish per enrollee limits on federal payments to a state with federal spending rising based on the number of enrollees but not on the cost per enrollee. There are several variations in Congress for both of these models and other similar ones.

## Continuing Policy Implementation

### Observation Stays

The nursing home industry and beneficiary advocates across the country continue to press for all time spent in observation as part of the requisite 3-day hospital stay required for post-acute SNF coverage. Almost all are in unison on the position that CMS itself has the authority to implement this change in policy. The negative impact of the current policy could be increased by the growing trend of hospitals in discharging patients within a day to two days after certain types of surgeries.

### Quality Measures

With the release of the final rule for long-term care facilities, and the ongoing implementation of CMS requirements related to value-based purchasing and quality indicators, nursing facilities continue to implement and monitor these measures.

CMS has focused on two major issues: the reduction in hospital readmissions; and the continued reduction in unnecessary use of anti-psychotic drugs.

### Arbitration

In last year's final long-term care rule, CMS imposed a requirement that nursing facilities cannot refuse to admit a Medicare or Medicaid beneficiary if they refuse to accept arbitration as an alternative to filing a lawsuit.

The industry went to court and persuaded a federal judge to enjoin CMS from enforcing this requirement. Court and congressional action is likely to keep the industry engaged throughout the new year.

.