*The Run-up to PDPM on October 1, 2019*
**Furnishing Appropriate Services for Appropriate Reimbursement**
**Elise Smith, *LTC Pharmacy Newsletter*, 2019 Brief #2, March 2019**

The PDPM dye is cast. The effective date is October 1, 2019. There is no transition period. If you want a refresher on the basics of PDPM, we have discussed PDPM in several *LTC Pharmacy* articles including those of August 2018, November 2018, and January 2019 and provided our take on the nuts and bolts. [1] Our intention is not to burden you yet again with these details but instead to give you a sense of the buzz out there. What does CMS continue to say? What are providers saying?

As the PDPM due date approaches, we have monitored the reaction reflected in webinars, articles, consultant blogs, CMS Open Door calls, the MedPAC March Report and our own interviews with SNF providers. We will continue to monitor the very active ongoing debate in the run-up to October 1, 2019 and report back. The following comments reflect a few results of our perusal to date. There is disagreement in the SNF provider community as to the impact of PDPM and there is disagreement in the consulting and health care journalism communities.

## *Background*

In the proposed and final PDPM rules, CMS discussed in detail its own research on the impact of the current RUG IV payment model and the research of MedPAC and the OIG -- all to the effect that RUG IV encourages the provision of excessive rehabilitation services and does not accurately target payments for nontherapy ancillaries.

CMS identified the two most notable trends: the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds had also increased.[2] According to CMS, this thresholding accruing was a strong indication of service provision predicated on financial considerations rather than resident need.

It took intensive research and quite some time, but CMS developed the PDPM to correct such activity. CMS hopes that the changes to classifying nursing services and non-therapy ancillaries will enable providers to furnish appropriate services for appropriate reimbursement. It will pay providers for preserving access for "all categories of SNF residents, particularly those with complex medical and nursing needs." [3] Specifically, under PDPM the clinical condition of a patient rather that the number of therapy minutes that patient receives will drive Medicare reimbursement.

## *Budget Neutrality*

However, CMS has adjusted the PDPM rates to facilitate budget neutrality -- that no more would be spent under PDPM as would have been spent had RUG IV continued in place. CMS posits that there will be a shift in reimbursement but not an overall increase in payments. [4]

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.

39257 For example CMS projects that for residents whose most common therapy level is RU (ultra -high therapy, the highest therapy level) there would be there would be a reduction in associated payments of 8.4 percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent.[5] Other resident types for which there may be higher relative payments under the PDPM are:

- *Residents who have high NTA costs (primarily drugs)*
- Receive extensive services
- Are dually enrolled in Medicare and Medicaid
- Use IV medication
- Have ESRD, diabetes, or a wound infection

PDPM is also projected to increase the proportion of total payment associated with the following potentially vulnerable subpopulations: Residents with addictions, bleeding disorders, behavioral issues, chronic neurological conditions, and bariatric care.

CMS did not stop with implementation of the new system. CMS also provided warnings that provider behavior would be monitored. Commenters on the PDPM proposed rule had raised the specter of some providers stinting on care or providing fewer services to patients under PDPM. CMS used these comments to support its intent to monitor closely service utilization, payment and quality trends. It stated clearly – and has reiterated in every SNF Open Door call, public presentations CMS webinars etc. -- that if changes in practice and/or coding patterns arise, then CMS may take further action, which may include administrative action against providers as appropriate (actions against individual providers), and/or proposing changes in policy, for example:[6]

- system recalibration,
- rebasing case-mix weights
- case-mix creep adjustment

The above are types of statutory and regulatory adjustments that CMS could bring to bear to better align provider costs to payment. In short, they provide ways in which CMS can enforce budget neutrality. According to Alex Spanko, Assistant Editor of *Skilled Nursing News:*

> …while providers seem to be focused on the upside of CMS not making any payment cuts under PDPM, the optimism ignores another key truth about a budget-neutral policy change: If the government changes the way providers are reimbursed for key services, but doesn't adjust the overall faucet of dollars going into the program, there must be winners and losers — and the losers could find themselves out of the industry, given how tight margins already are for providers across the country.
>
> Then there's the matter of what will happen once CMS officials get their hands on cold, hard data about how providers actually operate under PDPM. Various consultants and operators have identified ways they can boost reimbursements with the new system, either by deliberately taking on more complex patients through the introduction of clinical specialties, or by simply identifying the everyday procedures and services that suddenly have an effect on reimbursements with PDPM.

> I could be proven wrong, but it's highly unlikely that CMS would stand for a scenario in which Medicare spending at skilled nursing facilities actually goes up in fiscal 2020 and beyond as providers learn which strategies can give them an edge. CMS probably won't be able to adjust rates downward by the end of calendar 2019, with just three months' worth of data to go on, but I expect Washington to be watching those numbers closely — with an eye toward potential downward adjustments in 2020 and beyond. [7]

MedPAC agrees that such adjustment may be necessary. In this year' annual March Report, MedPAC opined that " While CMS estimated the redesign to be budget neutral, provider responses to the new PPS may alter program spending and facilities' cost structures and mix of cases. Thus, behavioral responses will dictate whether rebasing and recalibration will be needed to keep payment aligned with cost of care.[8]

## *Industry Reaction to PDPM*

Industry reaction seems all over the map. Advocates for SNF care tried to be positive by in general welcoming the PDPM for paying on the basis of patient characteristics. However, concern appears to be growing especially among SNFs who have historically provided a high percentage of Ultra-High therapy.

Therapy provider companies have put on a brave face. Their message seems to be that if SNF and therapy providers are dedicated to educating themselves on all the coding and assessment aspects of post-acute care in a SNF, then all will be well. These codes would include ICD 10 **diagnosis** codes and the long term care Minimum Data Set (MDS) **screening and assessment tool** of health status which **forms** the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. There are several therapy provider companies giving this advice, and we have at present no way to judge or comment on their assumptions and conclusions.

Providers who have succeeded with the current model, according to some experts, may be the primary candidates for a reduction in payment because of the reliance on a system based on volume – not, according to CMS, value. Indeed, there is much talk of winners and losers due to the possible impact on of payment on provider behavior. According to Sherri Robins, managing consultant at accounting and advisory firm BKD, actually thinks that there could end up being more winners under the new system than regulators expect.[9]

Her reasoning is that under RUG IV operators may not have been be recording all of the necessary MDS data that will soon be vital to reimbursements. Sherri has been in skilled nursing for 30-plus years and has seen "…[the] common practice … when you have somebody who's going to calculate into a rehab RUG group, the majority of the other areas on the MDS assessment don't get a lot of attention…I think there were so many inaccurate MDS assessments out there that just focused mainly on the therapy-type services, and didn't really take into consideration a lot of the clinical things that could have gone onto the MDS. So I think we're going to have a lot more winners." [10]

Robbins emphasized that "It's really going to be imperative under PDPM that the whole entire MDS is correct, because therapy days and minutes aren't going to drive the payment… Individual items that we are talking about … are going to drive the payment, and if they are not on the MDS, they aren't going to drive your payment.[11] …[b]ecause the program is revenue-neutral, providers will still be competing for the same overall share of Medicare skilled nursing dollars, creating winners and losers in the month ahead. Even the most optimistic

prognosticators admitted that smaller, mom-and-pop nursing providers might simply bow out of the marketplace altogether rather than deal with the changes, foreseeing a wave of mergers-and-acquisitions activity as these properties hit the marketplace.[12]

In December 2018, SNN conducted a survey of its readers -- executives and other leaders at operators, lenders, investors, and vendors. The results revealed the uncertainty on the part of this broad spectrum. [13] When asked whether PDPM would be an overall positive or negative for their businesses in 2019, 49% of respondents said positive — while a slight majority, 51%, picked either negative or neutral. Furthermore, there was a perfectly even split between those who predicted reimbursement gains and losses, with a plurality of 40% seeing no change ahead.

There was a bit more consensus when SSN asked exactly how PDPM would affect provider behavior. A clear majority said they'll place a greater emphasis on coding going forward, as ICD-10 codes form the basis for reimbursements, and 43% said they plan to target more medically complex residents in the future.

In addition, a wave of sell-offs has begun in skilled nursing. [14] This is transition from those who fear what is coming and just want out to those who think they can manage this latest level of sophistication in SNF payment. Indeed "Each iteration of more sophistication in this business has driven consolidation...Not only "mom and pops making adjustments but regional operators are also moving to cut SNF assets that aren't working for them."

## *NTAS Non-Therapy Ancillary Services – Mostly Drugs*

As seen above, according to CMS, SNFs should be seeing higher relative payments under the PDPM for residents who have high NTA costs (primarily drugs). Indeed that was a major goal of CMS – to develop a PPS system that paid for service provision predicated on resident need.[15] There was agreement across the health care research universe that SNFs were not financially supported with regard to their efforts to care for the clincially complex. It is the hope of CMS that SNFs will now be in a much better position to adequately care for these patients needing NTA services.

Long Term Care pharmacies who intend to respond robustly to the challenge and opportunity of PDPM should realize that their clients may be changing. They may not, overall, be losing clients so much as acquiring far more sophisticated clientele. In short, they may not be looking at loss of business but rather a notch up on the sophistication of services they may be dealing with.

Nevertheless, whatever the make-up of an expanded clientel, SNFs may be dealing with an array of drugs that they may not have handled before or dealing with an increased number of patients on complex drug regimens. In the proliferating "to do" lists for PDPM "success" there are recommendations surfacing to the effect that rehabilitation therapists should be involved in partnering with nurses to complete the therapy component aspect of the MDS. By the same token we posit that long term care pharmacists might consider working out with their SNF clients ways that the pharmacists may increase their support for SNFs especially with far more complex medication management.

[1] http://www.ltcpharmacynews.com/Newsletters.html

[2] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, CMS, 83 Federal Register 39162, at 39184, August 8, 2018 , CMS-1696-F.

[3] Ibid at 39185.

4 Ibid at 39257.

[5] Ibid.

[6] Ibid at 31986.

[7] Alex Spanko, *Looking Ahead to the Top Skilled Nursing Trends of 2019* , Skilled Nursing News (SNN), December 17, 2018, https://skillednursingnews.com/2018/12/looking-ahead-top-skilled-nursing-trends-2019/

[8] *Report to Congress: Medicare Payment Policy*, March 2019, pages 215, 216.

[9] Maggie Flynn, *More Winners Than CMS Expects Could Emerge Under PDPM,* SNN, January 29, 2019

[10] Sherri Robbins quoted in *More Winners Than CMS Expects Could Emerge Under PDPM* by Maggie Flynn, Id.

[11]Ibid.

[12] Alex Spanko , *Skilled Nursing Industry Split on Whether PDPM Will Boost or Cut Revenues*, SNN January 16, 2019.

[13] Alex Spanko , Ibid.

[14] Maggie Flynn, *Wave of PDPM Sell-Offs Has Already Begun in Skilled Nursing,* SNN, December 13, 2018, https://skillednursingnews.com/2018/12/wave-pdpm-sell-offs-already-begun-skilled-nursing/

[15] Id., 83 Federal Register at 31984.