SNFs Face Steep Challenges in 2019
Role for LTC Pharmacies
Elise Smith, *LTC Pharmacy News, Brief # 1, January 2019*

In prior years, *LTC Pharmacy News* has provided in January to LTC pharmacists, a summary of challenges that their provider clients, SNFs, would more than likely face in the new year. We do this again for 2019. Below, we highlight an abbreviated list – some entries are new, others ongoing but together they constitute the environment facing SNFs for 2019.

Some analysts have had a field day predicting disaster for SNFs due to PDPM and the other factors discussed below. Others have taken a more tempered approach that says while some SNFs will not be able to succeed or survive, that for well-managed, high quality SNFs, there is still a future, perhaps even a bright future under PDPM.

The fact is that SNFs do face a rough landscape: (1) PDPM, a massive overhaul of their own Medicare payment system (2) an array of ongoing regulatory pressures including several (not just one) complex CMS quality programs; (3) reform of requirements of participation for long term care facilities (4) rapidly growing Medicare Advantage plans; (5) powerful care reform models continually expanding and getting stronger such as bundling and (6) Accountable Care Organizations (ACOs), (7) Medicaid Managed Care and (8) Medicaid Block Grants.

The underlying key to clinical and financial success for SNFs is the provision of high-quality care and one key to that is adequate and correct reimbursement for all aspects of SNF care. **CMS in PDPM has now addressed the importance of adequate drug reimbursement in SNF reimbursement, a missing link that took them years to correct.**

PDPM will enable SNFs to open their doors to clinically acute patients and care for them appropriately. **LTC pharmacies cannot ignore this long awaited and long overdue development.** We hope you will conclude that the role of LTC pharmacies is critical for SNFs to provide the best pharmacy program and high-quality care underlying **all** of the diverse regulatory mandates and market forces that they face anew and have endured a long time.

SNFs have an amazing track record of surviving and they will, in our opinion, continue to do so. By and large they will transform. Guesses are being made as to what SNF sector – large chains, medium chains, small providers etc. have the best chance. Each of these groups have their own specific problems and will have their own success strategies.

1. PATIENT DRIVEN PAYMENT MODEL (PDPM)

PDPM is effective October 1, 2019. But now is the time for SNFs to prepare for it. And our sources tell us that they are preparing. As we have written before, PDPM is squarely based on patient characteristics. See May and August 2018 *LTC Pharmacy Newsletters.* SNF staff are already educating themselves on the coding skills required to capture patient characteristics. Medication is a huge percentage of the PDPM component of non-therapy ancillaries (NTAs.) As we have previously noted,

on a CMS nationwide open call, the CMS presenter said, "when you think NTA, think drugs." **So, let us think LTC pharmacy!**

NTA classification is determined by the presence of certain conditions or the use of extensive services that were found to be correlated with increases in NTA costs for SNF patients. CMS identified a list of 50 conditions and extensive services that were associated with increases in NTA costs. The presence of these conditions and extensive services is reported by providers on the MDS 3.0, with some of these conditions being identified by ICD-10-CM codes that are coded in Item I8000 of the MDS.

Once a provider knows what conditions and extensive services are present for a given patient, the next step is to calculate the patient's NTA comorbidity score. Under PDPM, the NTA comorbidity score is the result of a weighted count of a patient's comorbidities. See *CMS Fact Sheet: NTA Comorbidity Score* . https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/SNFPPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_Final.pdf.

Under PDPM, SNFs may be treating patients with conditions not previous addressed by the SNFs. LTC pharmacies might wish to consider studying the NTA co-morbidity scores and the NTA classification process and join SNFs in becoming very familiar with the 50 conditions or co-morbidities that CMS concluded were related to increases in NTA costs in the SNF. In so doing they will be better prepared to assist SNFs in their efforts to accurately capture NTA co-morbidities and to effectively provide drugs required for high quality care.

2. CMS SNF QUALITY PROGRAMS

The array of quality programs and quality measures applied to SNFs over the years is vast and complex. We highlight three: Nursing Home Compare (and Five Star), SNF Quality Reporting, and SNF Value-Based Purchasing Program (VBP). However, the available data can also be scrutinized by entities such as Medicare Advantage, bundling providers, and ACOs searching for the highest quality most dependable SNFs that they can include in their systems.

While SNFs do not question the need for providing the best quality care, but they face a dizzying array of programs and measures with transgressions carrying an array of severe punishments.

- ***Nursing Home Compare***

In 2002 CMS released Nursing Home Compare, a Web-based guide detailing quality of care, inspection results, and staff data. Nursing Home Compare is not only tracked by CMS, but also by consumers such as potential residents, the families of potential residents, hospitals and other health systems considering placement or collaboration.

Nursing Home Compare has evolved. It has now published additional quality measures skilled-nursing facilities. The release of the new quality data was mandated by Congress as part of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the Impact Act). There are currently five measures included in the program: percentage of SNF patients who develop new or worsened pressure ulcers; percentage of patients

whose activities of daily living and thinking skills were assessed and related goals were included in their treatment plan; percentage of patients who experience one or more falls with major injury during their SNF stay; Medicare spending per beneficiary for patients in SNFs; and rate of successful return to home or community from a SNF.

CMS opted not to add the potentially preventable 30-day post-discharge readmissions measure. The agency said it needed additional time to allow for more testing to determine if there are modifications that may be needed both to the measure and to the method for displaying the measure.

In addition, Nursing Home Compare features a rating system – ***Five Star*** -- that gives each facility a rating between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average.

- *SNF Quality Reporting Program (QRP)*

The IMPACT Act established the Skilled Nursing Facility Quality Reporting Program, which requires SNFs to report quality performance on several measures or risk a **2-percentage point Medicare payment reduction.** Specifically, the goals of the SNF QRP and the measures used in the program cover most of the include making care safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable.

- *SNF Value-Based Purchasing Program (VBP)*

The VBP program uses a single measure, the SNF 30-day all-cause readmission measure (SNFRM), to assess adjustments to SNF's Medicare fee-for-services rates beginning October 1, 2018 (FY2019). In short, the SNF VBP Program starts with fiscal year 2019 payment.

This measure was finalized in the FY2016 SNF PPS final rule. Under law, CMS is required to transition from the SNFRM to the SNF 30-day Potentially Preventable Readmission (SNFPPR), whose definition was finalized in the FY2017 SNF PPS final rule. This transition to the SNFPPR is to happen "as soon as practicable" but according to CMS will not occur before FY2021 and this latest proposed rule reinforces this timeline.

Under the new payment method, participating SNFs will stand a 2% withhold of their Medicare payment. The 2% will be placed in an incentive payment pool for 50-70% to be redistributed. Only SNFs ranked in the top 60% nationally will receive incentives based on performance. The key metric for the program will be the SNF 30-Day All-Cause Readmission Measure (SNFRM). This measure was designed to identify outcomes of unplanned all-cause hospital readmissions within 30 days of discharge from their prior acute hospital discharge. The single claims-based all cause 30-day hospital readmissions measure in the SNF VBP aims to improve individual outcomes **through rewarding providers** that take steps to limit the readmission of their patients to a hospital.

3. REFORM OF REQUIREMENTS FOR LONG - TERM CARE FACILITIES

On September 28, 2016, CMS had issued a final rule comprehensively updating and extensively revising the requirements for participation for long-term care (LTC) facilities participating in the Medicare and Medicaid programs. [1]As the first major update to the requirements for LTC facilities in 25 years, CMS itself acknowledged that the rule would have dramatic impact on LTC facility operations and finances. This update, the first in 25 years, establishes significant new regulatory requirements and modifies existing requirements. **The last phase of regulation begins in November of 2019**.

As an indication of the expected impact of the Final Rule, CMS stated that it expects complying with the requirements to cost SNFs $831 million in the first year (up from $729 million), or an estimated $62,900 per facility (up from $46,491 per facility), and approximately $736 million annually in the second and subsequent years (up from $638 million), or $55,000 per facility (up from $40,685 per facility). According to some analysts, the rule's projected costs are exceedingly conservative.

The stakes for a facility's noncompliance are high, as LTC facilities face penalties, denial of payment for new admissions, and possible termination from the Medicare and Medicare programs for failure to achieve substantial compliance with the rule.

4. MEDICARE ADVANTAGE PLANS

Very simply put, CMS pays Medicare Advantage (MA) managed care companies for the care of each beneficiary – usually a monthly payment based on comparison to FFS for similar patients. MA plans have to manage and provide quality care within such restrictions.

According to the Kaiser Family Foundation (KFF), more than 20 million Medicare beneficiaries (34%) are enrolled in Medicare Advantage plans, which are mainly HMOs and PPOs offered by private insurers as an alternative to the traditional Medicare program. KFF has provided an overview of the Medicare Advantage plans that will be available in 2019, based on an analysis of data from CMS. Findings include:

- Nationwide, 2,734 Medicare Advantage plans will be available for individual enrollment in 2019 – an increase of 417 plans since 2018. The preponderance of the growth in plans will occur in Florida.
- The average beneficiary will be able to choose among 24 plans in 2019, up from 21 in 2018. The number of Special Needs Plans (SNPs) will also increase from 630 plans in 2018 to 717 plans in 2019.
- Fourteen insurers will be entering the Medicare Advantage market for the first time in 2019, offering products in 26 states.
- Five insurers, together accounting for about 23,000 Medicare beneficiaries in 2018, will be exiting in 2019, four of which offered SNPs in 2018. These firms account for a small share of the insurers offering Medicare Advantage plans in 2019.

As is well-known, managed care contracts are tough for SNFs. MA plans have the upper hand in establishing the payment to SNFs, which by and large is far less then SNF FFS payment from CMS, and they keep tight control over length of stay.

There may be a bright spot on this horizon regarding Medicare SNPs. Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO) that limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

In addition to the new plans available for individual enrollment, more Special Needs Plans (SNPs) will be available in 2019, increasing from 630 plans in 2018 to 717 plans in 2019, reflecting an increase in SNPs for beneficiaries dually eligible for Medicare and Medicaid (D-SNPs; 401 plans in 2018 to 465 plans in 2019) and **SNPs for people requiring an institutional-level of care (I-SNPs; 97 plans in 2018 to 125 plans in 2019**). The number of SNPs for people with chronic or disabling conditions (C-SNPs) will decline from 132 plans to 127 plans between 2018 and 2019

Long-term care providers are largely responsible for driving rapid growth (23%) in the number of MA special needs plans enrolling institutionalized Medicare beneficiaries over the last two years. The number of provider-sponsored I-SNPs doubled from 2016 to 2018, and enrollment has more than doubled. Long-term care providers now lead 21 of the 24 provider-led I-SNPs.

According to Anne Tumlinson, CEO of *Anne Tumlinson Innovations* many nursing home operators view healthcare risk models, such as SNPs, as the only viable business path forward. According to Anne, nursing home operators have told her that the traditional nursing home business model — where margin depends solely on volume and daily rates — is becoming unviable. [2]

5. BUNDLING

In 2013, the CMS Innovation Center (CMMI) began testing the Bundled Payments for Care Improvement (BPCI) initiative. [3] BPCI focused on generating savings and improving quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and readmissions. The initiative was created as a way to link payments across all healthcare providers delivering care during an episode of care.

In short this was a major effort to provide a system that tries to remove the wrong incentives by allocating a single, pre-determined payment amount ("bundle") for an episode of care called bundled payment. The innovation started in 2013 and is still in play but with changes that may perhaps hobble the efforts of SNFs to participate in the innovative systems of the future and mature as major players in health care reform. There are two important themes from our perspective that run through CMS' efforts on bundling innovation: whether the models are voluntary or mandatory and the changing role of post-acute providers.

In the BCPI initiative there were 4 models and all were voluntary. Models 2 and 3 included post-acute care . These BPCI models have now ended. At the same time as BPCI was getting started two other key model categories were in play: *Episode Payment Models (EPMs) and the Cardiac Rehabilitation Incentive Payment and Model and The Comprehensive Care for Joint Replacement (CJR) Model* The EPMs were scheduled to begin on January 1, 2018. These were both mandatory.

In December 2017, CMS canceled EPMs and the Cardiac Rehabilitation (CR) Incentive Payment Model which had been scheduled to begin on Jan. 1, 2018. [4]In addition, CMS made participation voluntary for all hospitals in approximately half of the geographic areas selected for participation in the CJR model (33 of 67 Metropolitan Statistical Areas selected. Participation for the remaining half of participants remained mandatory. The reduction must have reflected both very strong provider pushback against mandates and the impact of the anti-regulatory environment of the current Administration.

SNFs and other post-acute providers were relieved at the reduction in the number of mandated models. However, consternation set in again when CMS unveiled BPCI Advanced and did not provide post-acute providers with the ability to initiate an episode and individually undertake a bundle.

What impact does bundling have on SNFs? Some optimistic analysts point to the original "staggering" participation in CMS Bundled Payments for Care Improvement program including many SNFs. They read this level of interest as indicating that providers across the care continuum, including SNFs, are reevaluating how care is delivered.

Other less optimistic experts and analysts say that SNF usage will decline in these models. They and CMS point to the fact that decreased Medicare spending on hip- and knee replacement episodes in hospitals in the CJR program was nearly exclusively related to reductions in the use of post–acute care services in SNFs and inpatient rehabilitation facilities. [5] Post–acute care services are a large e fraction of spending in hip- or knee-replacement episodes, and hospitals have strong financial incentives to reduce the frequency of post–acute care services.

However, and this is a big however, just how far SNF usage will decline remains a matter of speculation, as CJR and other bundled-payment programs are still relatively new on the scene — and the care coordination they require may take years to reach full optimization.

6. ACCOUNTABLE CARE ORGANIZATIONS (ACOs) (THE MEDICARE SHARED SAVINGS PROGRAM (MSPP))

ACOs are groups of doctors, hospitals, and other health care providers who voluntarily form partnerships to collaborate and share accountability for the quality and cost of care delivered to their patients. CMS has offered a range of ACO models in Medicare that vary by key design features, including levels of financial risk, up-front payments for infrastructure costs, and beneficiary involvement. The MSSP program is a permanent program in Medicare and does not have an end date.

The Medicare Shared Savings program (MSSP) launched in 2012 and currently over 10.4 million beneficiaries in Fee-for-Service Medicare (of the 38 million total Fee-for-Service beneficiaries) receive care from providers participating in a Medicare ACO. Most Medicare ACOs currently do not face financial consequences when costs increase. The Medicare Shared Savings program (MSSP) launched in 2012 and currently over 10.4 million beneficiaries in Fee-for-Service Medicare (of the 38 million total Fee-for-Service beneficiaries) receive care from providers participating in a Medicare ACO. Most Medicare ACOs currently do not face financial consequences when costs increase.

On December 21, 2018, CMS issued a final rule that dramatically redesigns and sets a new direction for ACOs. https://www.cms.gov/newsroom/press-releases/cms-finalizes-pathways-success-overhaul-medicares-national-aco-program . The new program, *Pathways to Success* will change this. CMS proffers that having more ACOs take on real risk, while offering them the incentives and flexibility they need to coordinate care and innovate, is an important step forward in how Medicare pays for value.

CMS' data on ACO performance has shown that over time ACOs taking accountability for costs perform better than those that do not. As a result of today's changes, the projected savings to Medicare total $2.9 billion over ten years. CMS payments to ACOs incorporate financial incentives for lowering spending and meeting specified quality goals for their beneficiary population. These financial incentives -- which can include shared savings or losses (bonuses or penalties) -- are paid to or collected from the ACO, rather than the individual providers or facilities that may have treated each of the ACO's beneficiaries.

By and large, ACOs have not shared savings with SNFs . Both Anne Tumlinson, CEO of *Anne Tumlinson Innovations* and Mary Coppage, Vice-President, opine that "Part of the problem is that ACOs, which get a single pool of funds to maintain care quality while reducing overall costs, don't have a reason to share the resulting savings with a SNF – even if a SNF is doing its part to help the ACO succeed in providing care at a lower cost...There aren't really incentives for them to share with SNFs, and there's nothing telling them they have to... SNFs are in a relatively vulnerable position and need those strong relationships with the ACOs to maintain their volumes [of patients]." [6] See Tumlinson and Coppage ask if SNFs are prepared to take on some of the downside risk for post-acute spend, able to partner with some of the home health companies that they discharge to have that continuity of care, operate as an ER diversion for some patients?[7]

Unfortunately, many of the financially successful ACOs have found cost-savings by cutting out SNF care as much as possible, Coppage noted. One study in the American Journal of Accountable Care found that for every 1% a given ACO cut skilled nursing spending, the overall savings rate increased by 0.82%. And with CMS' recently overhauling the rules for ACOs so that they have to take on risk, they will have an even stronger incentive to hunt for savings.

7. MEDICAID MANAGED CARE

According to KFF, the Medicaid benefit forms the bed rock of most SNF's financial stability covering 62% of all residents. Medicaid managed care roughly pays managed care providers a set payment for each beneficiary. The managed care entity must provide care within the limits of that set payment. There may be a plethora of different contractual nuances between states and managed care entities, but the key point is that a LTC provider such as a SNF and LTC provider will be paid by the Medicaid managed care plan what it intends to pay.

Managed care organizations (MCOs) cover nearly two-thirds of all Medicaid beneficiaries nationwide, making managed care the nation's dominant delivery system for Medicaid enrollees.

To understand how Medicaid managed care plans approach access to care and the challenges they face in ensuring such access, the Kaiser Family Foundation conducted a survey of plans in 2017. The following are highlights from the full survey report.

More than half of all Medicaid beneficiaries nationally receive most or all of their care from risk-based managed care organizations (MCOs) 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.

As of July 1, 2018, 39 states had contracts with Medicaid MCOs. Thirty-two states (including DC) had implemented the Medicaid expansion, and 27 of these states operated Medicaid MCOs. Finally, reforms in benefits, payment and delivery systems continue to evolve as states and the federal government focus on managed care and social determinants of health, prescription drugs, and community based long-term care.

8. MEDICAID BLOCK GRANTS

Perhaps you thought that the concept of Medicaid block grants, front and center in 2017, had been safely taken off the table. Not so. First, what is a block grant?

Basically, states would receive a fixed, preset amount of federal Medicaid funding—a block grant—each year to use to provide health coverage to their low-income residents. The federal contribution to state Medicaid programs in a given year would not change if the number of enrollees were to increase or if the cost of health care services were to rise. But it would likely rise annually by some amount, such as the rate of consumer inflation plus one percentage point.

Unlike the purely federal Medicare program, Medicaid functions as a hybrid in which states receive money from Washington but have more leeway over how their individual programs

are run. Under a block-grant model, states would see a set amount of Medicaid funding per year — a serious contrast from the current model, in which state-level Medicaid programs receive open-ended reimbursements based on actual care needs.

Politico has recently reported that the Administration is considering proposals to convert Medicaid to a block-grant system which has reignited a "a fight that caused a serious backlash from skilled nursing and other long-term health care providers over the summer of 2017." [8] A similar proposal in 2017 would have cut overall Medicaid funding by $770 billion. Despite the *Politico* report, it remains unclear whether the administration has the authority to change Medicaid funding without amending federal law through legislation.

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[1] https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf
[2] https://skillednursingnews.com/2018/12/long-term-care-providers-drive-growth-special-medicare-advantage-plans/
[3] https://innovation.cms.gov/initiatives/BPCI-Model-2/
[4] https://www.modernhealthcare.com/article/20171130/NEWS/171139986
[5] https://www.medicaldesignandoutsourcing.com/hospitals-saved-money-under-medicare-bundled-payment-program/
[6] https://skillednursingnews.com/2019/01/without-incentive-to-share-savings-acos-add-to-snfs-financial-headaches/

[7] Ibid.
[8] https://www.politico.com/story/2019/01/11/trump-bypass-congress-medicaid-plan-1078885