



RISING TO THE CHALLENGE

CONSULTANT PHARMACISTS JUST MIGHT BE
YOUR SECRET WEAPON FOR PDPM SUCCESS

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In the scramble to understand the vast changes embedded in skilled nursing's new payment model, providers may be overlooking a critical partner.

Consultant pharmacists have the knowledge and skills required to manage medically complex patients and find the most appropriate treatments for a range of conditions common among today's skilled nursing residents.

They also are uniquely capable of understanding the Patient-Driven Payment Model's increased emphasis on drug therapy as a pivotal element of patient care, and they stand ready to offer clinical insights that will allow skilled nursing providers to thrive in a transformed reimbursement environment.

"Under PDPM, there is a shift in cost away from rehab and we expect it to draw into pharmacy services," said Nancy Losben, R.Ph., CCP, FASCP, CG, Omnicare's senior director of quality. "That means you need someone who not only understands their business, but you need a pharmacy provider that understands your business to help manage costs."

From spotting unnecessary medications to recommending less costly drug alternatives and streamlining care transitions, an engaged pharmacy partner will be an invaluable colleague as skilled nursing facilities look to maximize patient outcomes and remain solvent.

The right pharmacist will team with building staff to promote disease-state management, open their eyes to new admissions possibilities and develop niche services.

Those kinds of partnership might help providers identify strategies they hadn't realized were at their disposal, said Todd King, Pharm.D., CGP, FASCP, Omnicare's director of clinical services.

"You should be partnering with your therapy providers and partnering with your consultant pharmacists and partnering with your electronic health record providers," King said. "There's going to be a lot of technology coming out to help providers comply with this new process. All of these people want to partner with you because we're all in this together. Our outcome and our goal is to provide the highest care that we can to our residents."

Under the new model, medically complex patients whom facilities once shied away from taking because of their intense use of resources may become sought-after residents.

That's because PDPM — while designed to be budget-neutral for skilled nursing providers — bases reimbursements on each resident's unique needs and characteristics. There are 28,800 possible clinical combinations that recognize conditions across five case-mix categories.

Where providers may have once derived much of their income from physical and occupational therapy, PDPM will reimburse for care based on indexes and points assigned to certain high-cost diagnoses.

Providing more appropriate services or adding new ones to attract referrals can be supported by a knowledgeable pharmacist who becomes a pivotal part of the clinical team from Day One.

“There are a lot of opportunities here to take the type of residents that facilities were a little shy about taking before, but it does mean we’ll need to lean on one another to deliver holistic clinical services that are multidisciplinary,” Losben said.

PHARMACIST AS FRIEND

Providers first need to understand their current medication charges to estimate how those will affect their bottom line after Oct. 1.

Under PDPM, skilled nursing providers will be reimbursed for non-therapy ancillary (NTA) services at 43% of the nursing rate they received last October.

NTA scores are calculated with a nod to cost of medications, which the Centers for Medicare & Medicaid Services estimated based on Part D claims. But NTA payments also taper by two-thirds on the fourth day of any resident’s stay.

“Pharmacists may need to help you optimize drug therapy early in a resident’s stay — such as by providing admission medications regimen review to help you identify adverse effects and medication errors upon transition — to assure the resident has a successful stay,” Losben said.

In some cases, a pharmacist is an integral part of the patient-care team responsible for optimizing drug therapy. A hospital patient can come in on a powerful IV medication, but after the three-day window, a pharmacist may be able to identify a clinically effective-but-less-expensive oral version.

A pharmacist also can assist in



Under PDPM, providers will need to get a firm understanding of their medication charges.

establishing a robust disease-management program, such as one that aims to better control residents’ diabetes and reduce the number of insulin doses delivered by staff daily.

It’s also within the pharmacist’s wheelhouse to recognize generic or emerging drugs, to point out alternative therapies, and to help find efficiencies when dealing with chronic diseases. In other cases, pharmacists might assist facilities and physicians in identifying more appropriate care for patients.

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OMNICARE**

“Look at places you might not have looked at before,” King said. “Dig into the clinical aspects and also look at the changing environment for opportunities to provide the highest quality outcomes at the most appropriate cost for your residents.”

With PDPM, many conditions for which medications are integral to treatment — or the only treatment — will be reimbursed at a level that reflects those higher costs. For instance, PDPM adds ulcerative colitis, Crohn’s disease and inflammatory

bowel disease as comorbidities to the MDS for the first time, acknowledging that facilities caring for those patients will have higher drug costs.

Most conditions will get a stackable, 1-point basis for NTA reimbursement, but 14, ranging from diabetes to HIV/AIDS, will be reimbursed on a scale from 2 to 8 points that reflects their complexity. (SEE GRAPHIC)

That payment is exclusive of reimbursement for treatment of needed therapy services, which are scored additionally according to the completion of relevant MDS sections.

Another factor to consider as providers look to adjust their abilities and attract new referrals: PDPM accounts for age, cognition and respiratory factors in computing the NTA comorbidity score.

An impact analysis conducted by CMS estimates that some resident subpopulations will draw higher payments, including a 7.2% increase in payment for residents under 65 and a 3.1% increase for those 65 to 74.

SERVING MEDICALLY COMPLEX RESIDENTS

Stacked reimbursement may make facilities more willing to take patients with resource-intensive conditions, but those providers need to prepare now for systemic changes they'll need to make.

“Facilities will need to understand what we need to have available and understand the types of medication such as the specialty drugs that are used today to treat multiple sclerosis, asthma, COPD and chronic lung disease,” Losben said.

Pharmacists, nurse managers, MDS coordinators, dietitians and other staff members should come together to accurately capture all conditions that should be included in the patient's case-mix designation.

PDPM will require the completion of new MDS sections I, an ICD-10 code for primary diagnosis; J, for patient surgical history after a qualifying hospital stay; O for discharge therapy items; and GG for functional abilities and goals.

Providers should understand the resource intensity and higher drug costs that come with many chronic care residents and their subsequent ICD-10 codes. Individuals may need extensive services — including infusion feedings — infusion medications, diabetes management and tube feeding or be prone to major threats like septicemia or pneumonia. Others will need access to dialysis, supports for multiple sclerosis or Parkinson's disease, additional medical devices or respiratory care.

With careful and complete initial assessments, providers need not avoid those demands.

“There's great value in taking the complex resident into your facility and treating them because, finally, the facility will be reimbursed for these services,” Losben said.

The importance of accurate initial assessments increases under PDPM, and that's all the more reason to be sure a pharmacist has a chance to weigh in before submission.

CONDITIONS WITH ADJUSTED BASE PAYMENTS FOR NON-THERAPY ANCILLARY SERVICES

Non-therapy services for most common conditions will be reimbursed on a 1-point basis. CMS has said it will pay more for the following diagnoses, which require more medications and demand higher use of staff resources:

HIV/AIDS	8 POINTS	MULTIPLE SCLEROSIS	2 POINTS
IV FEEDINGS	7 POINTS	OPPORTUNISTIC INFECTIONS	2 POINTS
IV MEDICATION	5 POINTS	ASTHMA, COPD, CHRONIC LUNG DISEASE	2 POINTS
VENTILATOR/RESPIRATOR	4 POINTS	BONE AND JOINT INFECTIONS/NECROSIS	2 POINTS
LUNG TRANSPLANT	2 POINTS	CHRONIC MYELOID LEUKEMIA	2 POINTS
TRANSFUSION	2 POINTS	WOUND INFECTIONS	2 POINTS
MAJOR ORGAN TRANSPLANT	2 POINTS	DIABETES MELLITUS	2 POINTS

If residents are admitted with a long list of current prescriptions — and no clear reason why they have them — the pharmacist and other clinical staff should be prepared to connect quickly with community physicians and referring hospitals to get a clearer picture of prior conditions being treated.

Instead of reviewing charts retrospectively, pharmacists should be moving closer to the admissions process.

“This is an opportunity to get in front of that for more positive outcomes,” King said.

FULL PAY FOR THE STAY

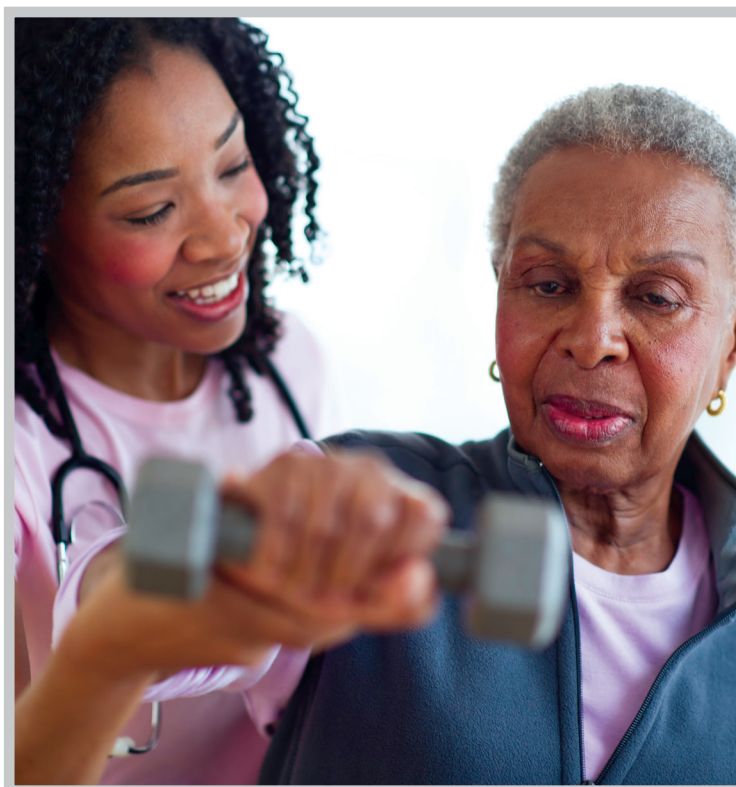
While NTA reimbursement tapers after just three days, payments for physical and occupational therapy do not regress until 20 days and they don't at all for speech language pathology.

Nursing services, to be paid at 57% of the 2018 rate, won't regress either.

Nursing services include gathering clinical information, measuring functional status and helping with activities of daily living, screening for depression and providing restorative care — the final item a service CMS does not reimburse for under the current RUG system.

All of these should help contribute to a resident's functional gains. Under PDPM, function will be calculated based on Section GG rather than the current Section G.

Section GG is used to track functional independence rather than functional dependence, and it better aligns the payment model with other quality measures. Section GG also assesses early functional losses rather than late



PDPM is expected to encourage new and old therapeutic options.

loss activities of daily living items as in section G.

The functional score for the PT and OT components is calculated based on 10 Section GG items that are highly predictive of PT and OT costs per day. The Nursing Functional Score classifies patients under the nursing component, with a total based on one eating item, one toileting hygiene item and five mobility items.

“Involving a pharmacist to identify medications that hinder functional abilities and goals — such as antipsychotics — and eliminate adverse drug effects will improve functional independence,” Losben said.

“What you don't want to see is a loss of capabilities during that Part A stay,” Losben said.

For early-stage Alzheimer's or patients with other mild cognitive impairment, one strategy could be to look for interventions that can improve minor impediments before they become major challenges — for instance, treating swallowing disorders that should respond to speech therapy.

“This is where it becomes exciting, where these earlier interventions can be grabbed and used successfully and you'll be reimbursed for them,” Losben said. ■

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