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Industry Update

Skilled Nursing

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McKnight's
LONG-TERM CARE NEWS

Article One: PDGM: What SNF operators need to know

Written by: Renee Kinder

Home health agencies are now on a new reimbursement model that, like PDPM, focuses on clinical diagnosis rather than volume for reimbursement levels. There are several things we can do to support them and our patients as we discharge Medicare patients to their care.

New Year, new reimbursement model… for our home health counterparts, that is.

Just as skilled nursing providers have settled in to the shift associated with the Patient Driven Payment Model (PDPM), we see a similar wave of changes impacting the setting we often discharge our Medicare Part A patients to following their SNF stay.

Think the changes will not impact you? Think again.

These are the key elements of the Patient Driven Groupings Model (PDGM) for home health providers that SNFs need to remain keenly aware of:

1. The PDGM effective date was 1-1-2020 (i.e. Wednesday!) and the change is the largest shift in home health reimbursement since 1993.
2. PDGM changes, like PDPM, are a result of shifts in the industry associated with the IMPACT Act. Therefore, many of the positive elements we see move us to a more holistic focus on the person and his or her clinical presentation.
3. Like PDPM, PDGM does not change Part A eligibility requirements. However, billing is reduced to 30-day periods.
4. PDGM reimbursement is driven by patient clinical characteristics documented in OASIS and payment is adjusted based on timing of the episode and discharge location to the home health agency, functional level of the patient, and comorbidities.
5. PDGM reimbursement is not impacted by volume of services (i.e. visits).

Now that you know the basics, what are some ways we can support our patients and their next level of care, thereby honoring the IMPACT Act and skilled benefit across the entire post-acute episode?

On a very basic level, and like PDPM, communication of diagnoses and functional status across care teams matters!

We have asked our acute-care partners to step up their game when reporting diagnosis and function on discharge summaries and it is time for us to do the same!

The clinical groupings under PDGM are defined below. Proper communication with your home health partners will be essential to ensure they are able to appropriately identify the area which best reflects their patients' needs.

Musculoskeletal Rehabilitation: Therapy provided (OT, PT, SLP) for a musculoskeletal condition

Neuro/Stroke Rehabilitation: Therapy provided (OT, PT, SLP) for a neurological condition or stroke

Wounds: Assessment, treatment and evaluation of a surgical and non-surgical wounds, burns, ulcers and other lesions

Behavioral Health Care: Assessment, treatment and evaluation of psychiatric conditions including substance use disorders

Complex Nursing Interventions: Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator and ostomies

Medication Management Teaching and Assessment: Assessment, evaluation, teaching and medication management

Furthermore, reporting of functional status is essential when communicating with HHAs as they will also be collecting baseline status on the OASIS for the following areas: grooming, current ability to dress upper body safely, current ability to dress lower body safely, bathing, toilet transfers, transferring, ambulation/locomotion, and risk for hospitalization.

In supporting functional status, consider what practices can be adjusted to refine and improve your therapy teams' home evaluation process prior to discharge from skilled SNF care.

And finally, like PDPM, the Centers for Medicare & Medicaid Services has recognized comorbidities as an important determinant of needs, therefore adding a comorbidity adjustment for the following: heart disease, cerebral vascular disease, circulatory disease and blood disorders, endocrine disease, neoplasm, neurological diseases and associated conditions, respiratory disease and skin disease.

In closing, my hope is that 2020 will be another year of continued clinical focus across care teams, improving the ability to achieve outcomes for those we serve and effectively transitioning to the safest and least restrictive settings of care.

To see this full article, click here.

Article Two: CMS Releases Enhanced Drug Dashboards Updated with Data for 2018

Written by: The Associated Press

New capabilities and information aim to help consumers make more informed drug decisions. In addition to increasing transparency, the goal is to keep cost increases in check. Early data suggests it's working.

Dashboards continue agency's efforts to increase price transparency and lower drug prices.

Today, the Centers for Medicare & Medicaid Services (CMS) released new 2018 data and significantly enhanced its Drug Spending Dashboards in the most comprehensive update of the consumer tools to date. As part of the update, the Dashboards now list prescription drugs in their first year on the market (in this case, drugs that were new in 2018). Under the previous methodology, it would take two years for a new drug to appear in the dashboard. This release also enacts changes that President Trump proposed in his budget by including information on prescription drug units that were paid for in Medicare Part B, but discarded. The update advances the agency's efforts to increase price transparency, lower drug prices, and strengthen the Medicare program to make it sustainable for future generations.

"The Trump Administration's commitments to price transparency and reducing the costs of prescription drugs are historic," said CMS Administrator Seema Verma. "The

continued public release of what Medicare and Medicaid pay for prescription drugs puts manufacturers on notice: the public is watching what you are charging patients. Accountability – the consequence of greater transparency in drug pricing – is an important component of the Trump Administration's efforts to lower prices and empower patients with the information they need to make informed decisions."

All of the information in the Drug Dashboards is presented in an interactive web-based tool, so researchers and consumers can easily sort the data to identify trends. The dashboards focus on average spending per dosage unit (unit price) for prescription drugs paid under Medicare Parts B and D and Medicaid, and track the change in average spending per dosage unit over time. The dashboards also display the manufacturer(s) of each drug as well as information on drug uses and clinical indications. In addition to more comprehensive data, this update to the dashboard includes adding new flags that will help users identify potential data quality issues. The flags highlight values that are based on potentially anomalous data as outliers, so that users can exercise caution when interpreting these results.

The information released today builds on the agency's efforts to increase price transparency, lower prescription drug list prices and prevent drug wastage. In 2017, CMS began requiring all providers submitting Medicare Part B drugs claims to report any discarded amount of a single use vial or other single-use, packaged drug. In response to concerns regarding prescription drug wastage, the FY2020 President's Budget called for CMS to publicly report data on discarded drug units gathered from this new claims-based reporting process. The report released by CMS today aligns with the President's Budget and contains a list of Part B drugs that have the highest percentage of discarded units, potentially due to manufacturers only making available a limited

number of packaging sizes for these products. In 2018, spending on discarded drug units equaled $725 million, approximately 2% of total Part B drug spending.

In 2018, total gross spending on prescription drugs was $168.1 billion in Medicare Part D, $33.3 billion in Medicare Part B, and $66.4 billion in Medicaid. The proportion of prescription drugs with a unit price increase went down from 2017 to 2018 in both the Medicare Part B program and Medicaid. In the Medicare Part D program, the proportion of prescription drugs with a unit price increase remained steady from 2017 to 2018. However, in Medicare Parts B and D and in Medicaid, the proportion of prescription drugs with unit price increases of 10% or more dropped from 2017 to 2018.

The CMS Drug Spending Dashboards can be accessed at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/index.html.

To see this full article, click here.

McKnight's
LONG-TERM CARE NEWS

Article Three: The importance of recognizing and treating depression in cardiac residents at skilled nursing facilities

Written by: Tiney Ray, Ph.D., DNP, FNP-BC

Psychological factors such as depression or anxiety can complicate recovery from a cardiac event. MediTelecare is working with SNF staff and the families of residents to increase awareness and diagnosis, offer treatment, and improve outcomes.

Acute cardiac events, such as heart failure, affect over 2 million individuals in the United States each year, with over half of these individuals being over the age of 65. Annually, cardiac events cause these adults to receive post-acute care in skilled nursing facilities for short-term healing, assistance and rehabilitation. However, older patients are often challenged with a difficult road to recovery due to co-occurring medical conditions, frailty and impaired mobility.

In skilled nursing facilities, rehabilitation is a team effort and does not start and stop with the rehabilitation department. Diagnosing any emotional disturbances is critical for rehabilitation to be effective in heart disease residents. In fact, there is evidence to support the impact of psychological factors on the onset of cardiovascular disease. Depression and anxiety can be unexpected complications after a cardiac event and are often underdiagnosed, leaving residents with reduced quality of life and increased mortality risk. As a result, MediTelecare is ensuring its partnering facilities have the tools and resources in place to assist their cardiac residents.

As their behavioral health partner, below are some of the ways we're helping our facilities with depression screenings for cardiac residents:

- MediTelecare nurse practitioners, psychiatrists and psychologists are offering therapies to improve the overall health and quality of life of residents to reduce rehospitalizations.
- MediTelecare providers may recommend certain psychotropic medications in combination with various psychotherapies including weekly talk therapy, cognitive behavioral therapy and motivational interviewing. These techniques can assist residents with learning coping skills and lifestyle modifications.

Recognizing and treating depression in cardiac residents admitted to skilled nursing facilities for rehabilitation is a major priority. This responsibility is shared between the facility staff, the family and the resident with MediTelecare here to assist. With increased awareness of the prevalence of cardiac depression, cardiac residents have every advantage for a complete recovery in the days and months following a major cardiac event.

To see this full article, click here.

McKnight's
LONG-TERM CARE NEWS

Article Four: Ten bold predictions about the year ahead in long-term care

Written by: John O'Connor

A new year always brings trend forecasts. From payment systems to tech to politics, and even prison, here are ten predictions made by McKnight's Long-Term Care News.

The most dangerous time of the year has arrived.

Many readers are in recovery mode right now. Those holiday sugar plums delivered serious body blows. So did the extended conversations with relatives. Throw in the irregular work hours, lounging around and travel time — and many of us are a bit out of sync.

And now it's go time? Where to start?

If it helps ease the transition, here are 10 predictions about the road ahead in 2020:

Prediction 1: PDPM will play out in ways both obvious and unexpected. We've already seen some of the early moves: therapist layoffs and new approaches to care. The Centers for Medicare & Medicaid Services will surely take stock and tweak both the rules and payment rates.

Prediction 2: Arbitration wars will kick into high gear. Providers love arbitration agreements. AARP hates them. Need more be said?

Prediction 3: It's going to be a tale of two markets for nursing homes. Urban settings will start to see a bit of an influx, thanks in part to the Silver Tsunami. Rural facilities will struggle. Among the latter, the number of closings in 2020 might be shocking.

Prediction 4: Tech will get bigger. Skilled care is doing more than shifting from high-touch to high-tech. It is embracing tech tools in every conceivable new way. That trend won't just continue; it will intensify.

Prediction 5: Healthcare will be a major election year topic; long-term care not so much. Sure, there will be the usual lip service about making things better. But when all is said and not much is done, the insurance companies, healthcare systems, docs and other players with real clout will eat first.

Prediction 6: This will be the ugliest election year ever. Why? For starters, we have a president seeking re-election that 40% of the country loves and 40% can't stand. The battle to win over enough of the rest will be brutish, nasty and long. Fear is what sells, so you can probably imagine what the messaging will look like. Then again, maybe you can't?

Prediction 7: The infamous "Do Not Proceed" logo will not be going anywhere. Everyone knows what an open palm stop sign means. Everyone that is, except CMS. They have heard your concerns about the heavy-handed moniker. But rather than adjust, they have opted instead to go the Mike Mulvaney route. In other words, providers can just deal with it.

Prediction 8: Staffing demands will stiffen. Never mind that finding and keeping workers is arguably the biggest challenge the industry faces. It's election season. That means candidates at every point will be demanding staffing quotas.

Prediction 9: More big fish will be going to the big house. Yes, this is an industry primarily run by people trying to make a good difference. The problem for some is the temptation to grab easy money by cheating ever so slightly. Most who give in won't get caught. But a few will. It happens every year.

Prediction 10: Something we're not noticing now will play a big role. Fast forward to December, and we'll be amazed that an issue that is so blatantly obvious remained under the radar.

There you have it: 10 fearless predictions about the year that will be. Feel free to thank (or ridicule) me later.

To see this full article, click here.

McKnight's
LONG-TERM CARE NEWS

Article Five: Customizable insulin-dosing controller receives FDA approval

Written by: Kimberly Marselas

Technology has long held out hope for diabetes patients. Now a first-of-its-kind automated glycemic controller technology to help control diabetes has been approved and is expected to ship by the end of January. It could be a game changer for type 1 diabetes patients.

Tandem Diabetes Care's Control-IQ Technology last week won marketing approval from the U.S. Food and Drug Administration.

The interoperable, automated glycemic controller device automatically adjusts insulin delivery to a person with diabetes by connecting to an alternate controller-enabled insulin pump and integrated continuous glucose monitor. It is the first controller that can be used with other diabetes devices also designed to be integrated into a customizable diabetes management system for automated insulin delivery.

This FDA authorization paves the way for iCGMs and ACE pumps to be used with an interoperable automated glycemic controller as a complete automated insulin dosing system. AID systems typically consist of a pump, CGM and software to control the system of compatible devices.

The Control-IQ Technology can be used by patients with type 1 diabetes to automatically increase, decrease and suspend delivery of basal insulin to the patient based on insulin delivery history, iCGM readings and predicted glucose values. The

controller can also automatically deliver a specific amount of insulin when the glucose value is predicted to exceed a predefined amount.

“With this clearance, we will be launching the most advanced automated insulin dosing system commercially available in the world today,” said John Sheridan, president and CEO of Tandem Diabetes Care. “This is a testament to our commitment to improving the lives of people with diabetes by offering simple-to-use products that deliver superior performance.”

All in-warranty t:slim X2 pump users in the United States will have the option to add the new feature free of charge via remote software update. The update is expected to be available by the end of January 2020, and new pumps with Control-IQ technology will begin shipping to customers in the same timeframe. The Company will continue to offer the t:slim X2 pump with Basal-IQ® predictive low glucose suspend technology as an option for people who prefer a system designed specifically to help prevent lows.

Other software to automatically control insulin delivery has previously been approved by the FDA as part of a single, predefined diabetes management system. The Control-IQ Technology controller, which is designed to communicate with other compatible diabetes device components meant for an integrated, modular system, was reviewed through the De Novo premarket review pathway, a regulatory pathway for low- to moderate-risk devices of a new type.

To see this full article, click here.

Provider
LONG TERM & POST-ACUTE CARE

Article Six: Senior Not Prone to Switching Medicare Advantage Plans

Written by: Patrick Connole

Despite changes in benefit offerings and structure, once seniors choose a Medicare Advantage plan they're inclined to stay. The reasons are varied, from satisfied seniors to those who don't understand what's changed in their plan to the plethora of plans on the market. Many factors can play a part in this daunting task.

At a time more long term and post-acute care providers are either exploring or actually starting their own Medicare Advantage (MA) plans, new research shows that seniors are not likely to switch from one MA plan to another when given the opportunity every open enrollment period.

In a new report by the Kaiser Family Foundation (KFF), "No Itch to Switch: Few Medicare Beneficiaries Switch Plans During the Open Enrollment Period," researchers said even though MA plans vary greatly from one another and change from year to year in their benefit offerings and structure, the fact is not many beneficiaries change their selection. This also holds true for beneficiaries and stand-alone Part D prescription drugs plans (PDPs), the report said.

The non-movement by consumers also is happening as the Centers for Medicaid & Medicare Services (CMS) encourages beneficiaries to shop around for new plans to potentially save money on prescriptions or get new benefits.

“Overall, a small share of MA-PD [MA-Part D] and PDP enrollees without low-income subsidies (8 percent and 10 percent, respectively) voluntarily switched to another plan during the 2016 annual open enrollment period for the 2017 plan year,” KFF said.

Among 9.4 million MA-PD enrollees without low-income subsidies, 7.6 percent (710,000 beneficiaries) voluntarily switched to another MA-PD during the 2016 open enrollment period for 2017, and another 0.9 percent (90,000 beneficiaries) switched from an MA-PD to traditional Medicare (with a PDP).

And, the report said of the 11.7 million PDP enrollees without low-income subsidies, 8.3 percent (980,000 beneficiaries) changed to another PDP and another 1.7 percent (200,000 beneficiaries) switched to an MA-PD during the 2016 open enrollment period for 2017.

Researchers noted that only a small slice of Part D enrollees switch to MA-only plans or traditional Medicare without Part D coverage; they are excluded from this analysis.

“A substantial majority of Medicare private plan enrollees have not voluntarily switched plans in any given year over the time period of this analysis,” the report said. During the open enrollment periods between 2007 and 2016, the share of enrollees without low-income subsidies switching plans on their own for the coming year ranged between 6 and 11 percent for people in MA drug plans, and between 10 and 13 percent among those in stand-alone PDPs.

Of the individuals who did not switch in any given year are Medicare beneficiaries who were enrolled in plans that left the market and were “crosswalked” (that is, automatically enrolled) by their plan sponsor into a new plan the following year.

"This means their plan is different from the previous year, but they did not voluntarily choose a new plan," report authors said.

For the 2017 plan year (corresponding to the 2016 open enrollment period), this comprised roughly 8 percent of MA-PD enrollees and 3 percent of PDP enrollees. Another small share of enrollees involuntarily switched MA-PDs (3 percent) or PDPs (less than 1 percent) because their plan exited the market for 2017 and they were not automatically crosswalked into a new plan.

In discussing what all of this means, the report said it is important to note that there are indeed a lot of options for most Medicare beneficiaries to weigh with an average of 28 MA plans and the same number of 28 stand-alone Part D plans available to beneficiaries in 2020.

"Relatively low rates of plan switching during the open enrollment period could indicate that beneficiaries are generally satisfied with their current plan and therefore have little motivation to compare and switch plans, or they may be actively choosing to remain in their plan after comparing other available options," the report said.

Conversely, authors said low switching rates could also mean that many beneficiaries find the shopping around for a new plan process too daunting, are possibly not aware of the open enrollment season, or have limited confidence in their ability to choose a better plan.

Find the report at https://tinyurl.com/qlcz6r8.

To see this full article, click here.