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MEDICATION MANAGED

The Latest Medicare/Medicaid Policies and Best Practices for Pharmacy in Long-Term Care

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CMS finalizes Medicaid Prescription Drug Reforms

Nicole Stempak, *Long-Term Living*

The Centers for Medicare & Medicaid Services (CMS) will save an estimated $2.7 billion over the next five years by revamping the way it charges for prescription drugs within the Medicaid program.

The final ruling on "Covered Outpatient Drugs," outlines how Medicaid prescription drug reimbursements and rebates will be calculated and how Medicaid will account for market prices accurately. The rule also closes loopholes, incentivizes pharmacies to use generic drugs and gives territories additional tools to manage Medicaid drug costs.

"Millions of Medicaid beneficiaries rely on prescription medications to manage chronic illnesses or treat acute conditions. But recently, the cost of prescription drugs has been rising rapidly, creating fiscal pressure and potentially compromising beneficiary access," says Vikki Wachino, CMS deputy administrator and director of the Center for Medicaid and CHIP Services, in a press release. "This final rule makes changes that will save taxpayers billions and ultimately improve beneficiary access to prescription drugs."

The Affordable Care Act brought about changes to Medicaid payments for prescription drugs, increased rebates and set limits on federal reimbursements.

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OIG Announces 2016 Plans: What the New Policies for Nursing Homes and Medicare Mean

Excerpted from Office of Inspector General Plans to Crack Down on Fraud and Cut Costs, November 6, 2015

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) outlined its plans for fiscal year 2016: focus on delivery system reform and examine the effectiveness of alternate payment models, coordinated care programs and value-based purchasing.

The Work Plan for fiscal year 2016 summarizes new and ongoing OIG audits, evaluations, legal and investigative initiatives. The OIG provides independent and objective oversight to improve the economy, efficiency and effectiveness of programs operated by the HHS.

The OIG serves more than 100 programs administered by HHS. The majority of the office's funding is directed at overseeing Centers for Medicare & Medicaid Services (CMS) programs, 76 percent of the office's budget in 2014.

The full report can be read at http://www.oig.hhs.gov. Here are notable revisions and changes for the upcoming year:

Medicare Part A and Part B

Nursing Homes

New: Skilled nursing facility prospective payment system requirements

What it means: The OIG will review complaints with the skilled nursing facility (SNF) prospective payment system, including the documentation

required for Medicare claims, to ensure SNF care is reasonable and necessary. Documentation includes:

- A physician order at the time of admission for the resident's immediate care
- A comprehensive assessment
- A comprehensive plan of care prepared by an interdisciplinary team that includes the attending physician, a registered nurse and other appropriate staff.

Reason: Prior OIG reviews found Medicare paid more than the facility's cost for therapy. The OIG also found SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same.

Prescription drugs – policies and practices

Revised: Part B Payments for drugs purchased under the 340B Program

What it means: The OIG will calculate the cost of 340B-covered entities, the Medicare program and Medicaid beneficiaries of three different shared savings arrangements that would enable Medicare and its beneficiaries to share in the cost savings resulting from 340B discounts—and how much ASP-based payments exceed 340B prices.

Reason: Previous reporting found some Medicare payments for 340B-purchased drugs substantially exceeded the providers' costs. Under the 340B Program design and Part B payment rules, the difference between what Medicare pays and what it costs to acquire the drugs is fully retained by the participating 340B entities, allowing them to stretch Federal dollars. Policymakers question whether some of the savings mandated through the 340B program should be passed on to Medicare and its beneficiaries.

Medicare Part C and Part D

Part D – Prescription Drug Program

Medicare, Sponsor, and Manufacturer Policies and Practices

New: Part D Pharmacy Enrollment

What it means: The office will review CMS's ability to oversee Part D pharmacies and the extent to which pharmacies that bill for Part D drugs, particularly those identified as high risk, are enrolled in Medicare.

Reason: OIG participated in the largest national health care fraud takedown in history in June 2015. More than 240 people were charged with defrauding Medicare and Medicaid, much of which involved prescription drugs and pharmacies.

Part D Billing and Payments

New: Increase in prices for brand-name drugs under Part D

What it means: The office will compare the rate of change in pharmacy reimbursement for brand-name drugs Medicare Part D changed between 2010 and 2014 to the rate of inflation for the same period.

Reason: Prices for the most commonly used brand-name drugs increased nearly 13 percent in 2013, eight times greater than the general inflation rate for the same year.

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Proactive medication management

Mark D. Coggins, Diversicare

Long-term care (LTC) pharmacists are geriatric medication experts. In the past, LTC pharmacists have been most recognized for their efforts in helping to keep long-term care (LTC) facilities in compliance with regulatory requirements. However, as the healthcare landscape moves toward outcome-based reimbursement and value-based purchasing, LTC communities are wise to focus on the LTC pharmacists' value in improving medication-related outcomes.

The primary referral sources for LTC facilities are hospitals, which have increased expectations around quality with a focus on reducing length of stay, discharging patients to less costly settings, fewer re-hospitalizations and greater interest in five-star ratings. LTC and post-acute providers who demonstrate efficient, high-quality care will become the providers of choice within preferred provider networks. Additionally, the Centers for Medicare & Medicaid Services (CMS) continues to create direct incentives to improve and is establishing a mandatory skilled nursing facility (SNF) Value-Based Purchasing program which will affect payments beginning in 2019 and has finalized inclusion of a 30-day, all-cause readmission measure.

Providing effective patient-centered care requires considerable teamwork. Consider the statement regarding teams made by the American College of Physicians in 2013: "Although physicians have extensive education, skills, and training that make them uniquely qualified to exercise advanced clinical responsibilities within teams, well-functioning teams will assign responsibilities to advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals for specific dimensions of care commensurate with their training and skills to most effectively serve the needs of the patient."

The statement emphasizes the need for well-designed functional "teams" in order to better manage resident care, while also acknowledging the need for a pharmacist to be an integral participatory member of the healthcare team.

Optimizing medication management is complex and is most effective when there are cooperative relationships among physicians, nurses, nurse aides, pharmacists, other healthcare professionals, residents and families. A team approach promotes optimal use of medications, reduces adverse drug events (ADEs) and promotes cost-effective drug-prescribing practices. This collaboration provides better insight around the resident's needs, typical behaviors, and responses; while also increasing the number of persons who can observe the resident before and after a medication is started.

LTC facilities manage the care for medically complex patients who routinely receive 8 to 10 medications per day to manage multiple chronic conditions. LTC pharmacists focus on optimizing medication management and improving quality outcomes and have become more involved with prescribers, nurses, other healthcare team members, family members and residents.

ADVERSE DRUG EVENTS

At least monthly, the LTC pharmacists review each resident's medical record and conduct a comprehensive medication regimen review. Based on this review and interactions with the healthcare team, LTC pharmacists make recommendations to improve medication management. These may include recommendations to adjust medication dosages, discontinue inappropriate or unnecessary medications, monitor and make recommendations on medication therapy based on patient vital signs or labs based on patient specific goals, consider cost effective alternative therapies and/or consider treatment options per evidence-based clinical practice guidelines. The value of medication regimen reviews by LTC pharmacists has been recognized as improving prescribing and potentially decreasing costs.

Inappropriate medication use can lead to substantial healthcare costs, including increased ADEs, emergency room visits and hospitalizations. One of the most important roles of LTC pharmacists is to evaluate the entire medication delivery process to help identify and prevent ADEs. With the pending CMS focus on 30-day re-hospitalizations rates, ADEs should be viewed as one of the most likely contributors of potential negative outcomes. Studies suggest that at least one in seven LTC residents will be hospitalized as a result of an ADE.

CMS recently initiated "Medication Adverse Drug Event" focus surveys noting that one in three SNF residents is harmed by an adverse event or temporary harm event within the first 35 days of a SNF stay, and 37 percent of those adverse events are related to medication. The second-most frequent cause of ADEs is excessive bleeding related to anticoagulant use—causing harm ranging from hospitalization to death. As many as 50 percent of ADEs are believed to be preventable, and LTC pharmacists can provide essential education to LTC team members on how to recognize the potential side effects and triggers of ADEs.

When quality-of-care issues—including medication management—are addressed utilizing a team approach, patients are more likely experience positive quality outcomes. The facility can achieve additional benefits related to their financial viability and business outlook. Facility-wide improvement initiatives with predetermined outcome goals and measures are essential in order to achieve optimal medication management practices.

MEDICATION RECONCILIATION

Medication reconciliation is the process used to identify medication discrepancies and prevent medication errors by evaluating any medication orders at each point during a person's transition of care. Medication reconciliation is a priority across healthcare settings, since studies have

shown that unintentional medication discrepancies occur commonly during transitions of care--and about one-third of the discrepancies have the potential to cause discomfort or deterioration. Studies have shown that medication reconciliation interventions conducted by pharmacy staff are the most effective, especially interventions that target high-risk residents.

Adherence to clinical practice guidelines is vital in the management of common chronic medical conditions including chronic heart failure, chronic obstructive pulmonary disease, hypertension and stroke. The effective management of these conditions is also common in risk-based agreements. Residents who receive disease state management services from an LTC pharmacist are four to seven times more likely to be compliant with these evidence-based guidelines, which can improve therapeutic outcomes and reduce negative events with fewer re-hospitalizations.

LTC pharmacists' participation in quality assurance and process improvement (QAPI) efforts and other risk management processes is important. LTC pharmacists can help assess trends in medication use, assist with root-cause analysis and help implement and monitor process improvement plans. Common efforts undertaken by LTC pharmacists include:

- Optimizing diabetes therapy for patients receiving sliding-scale insulin
- Implementing processes to identify and discontinue high risk medications including antipsychotics and BEER's medications Identify and providing education to prescribers who have low compliance rates around clinical practice guidelines
- Identify and increasing focus on patients at highest risk of re-hospitalizations.

While direct face-to-face collaboration among LTC pharmacists, prescribers and other healthcare team members is often preferable, technologies such as videoconferencing can allow pharmacists to participate on teams and even review high-risk residents from offsite. Many LTC facilities have electronic medical record capabilities, giving pharmacists off-site access to essential information, including nursing notes, care planning information, the medication administration record, vital signs, behavior monitoring records and assessments. Electronic access to clinical data enables LTC pharmacists to respond more quickly to requests to review residents who may be experiencing a change of condition, such as a fall, weight loss or increased confusion. By identifying and addressing potential medication-related issues early on, pharmacists can help improve resident care and reduce negative outcomes.

Improving medication optimization will continue to grow in importance in the future, both in terms of improving patient outcomes and also helping with long-term care facility viability. By increasing the focus on appropriate medication management including the prevention of adverse drug events, significant quality outcomes can be achieved. Ultimately, both patients and LTCF will benefit through increased collaboration between LTC pharmacists and other members of the facility healthcare team.

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Why pharmacy data is key to your SNF's future

Pamela Tabar, *Long-Term Living*

Pharmacy services are mainly about getting the prescribed medications to residents and keeping them on their medication treatment plans, right? Not anymore—not by a long shot.

New standards are in the making to involve pharmacists in much greater roles in senior care delivery and to integrate pharmacy data into other senior health information efforts, noted presenters at the recent Long Term and Post Acute Care Health IT Summit in Baltimore.

Wherever seniors may visit within their care continuum, including primary care physician offices, hospitals and skilled nursing or rehabilitation sites, the one person who interacts with residents the most is the pharmacist, says Frank Grosso, RPh, executive director and COO of the American Society of Consultant Pharmacists (ASCP). That should logically make the pharmacist one of the most important players in resident medication management and data capture, yet it is a role that many senior care communities have not yet fully embraced, he says.

Enter the consultant pharmacist, whose role is far beyond mere pill-counting or drug distribution. Consultant pharmacists review the drug regimen of each resident on a regular basis, review the prescribed drugs in light of the current clinical conditions over time, review related lab work, review the physician progress notes and watch for possible polypharmacy interactions. In short, the consultant pharmacist is the right hand of the prescribing physician, filling in all the crucial meds data in between physician visits, while simultaneously tracking medication compliance and drug effectiveness.

The emerging importance of pharmacists in the senior care continuum has led to the Pharmacy HIT Collaborative, whose nine founding members include ASCP, the American College of Clinical Pharmacy, and the Accreditation Council for Pharmacy Education and the American Pharmacists Association. The collaborative works closely with the NCPDP (National Council for Prescription Drug Programs) and HL7 workgroups to improve the coding standards and information exchange processes for pharmacy information within long-term care and other care settings.

The collaborative participates in continuity of care documentation efforts and is a key player in establishing protocols for e-prescribing and the shifts toward skilled nursing's inclusion in the bi-directional information exchange as required under Meaningful Use Stage 3. And those new regs are not just about medication lists—they're about data on clinical indications, intended use and drug-related change of therapy (COT), too.

"We don't need any more studies. We know what needs to happen, so we need to figure out how to manage the process during transitions of care," Grosso says. "The information is out there, it's in the PBM (prescription benefits manager), and it's in the EHR." But the crucial medication reconciliation process is frustrating at the site level, and too much information is still siloed in documentation fields that don't transfer easily from one IT system to another, he adds. Fixing the frustrations means dealing with connectivity issues, which still abound, Grosso says.

Plenty of data exchange hurdles still exist between pharmacy dispensing sites and EHRs, but more problems also surface at the people-level, says Arnold Clayman, PD, vice president of government affairs at ASCP. Consultant pharmacists report that a lack of training on facility-specific EHRs and roadblocks to information access are also key barriers.

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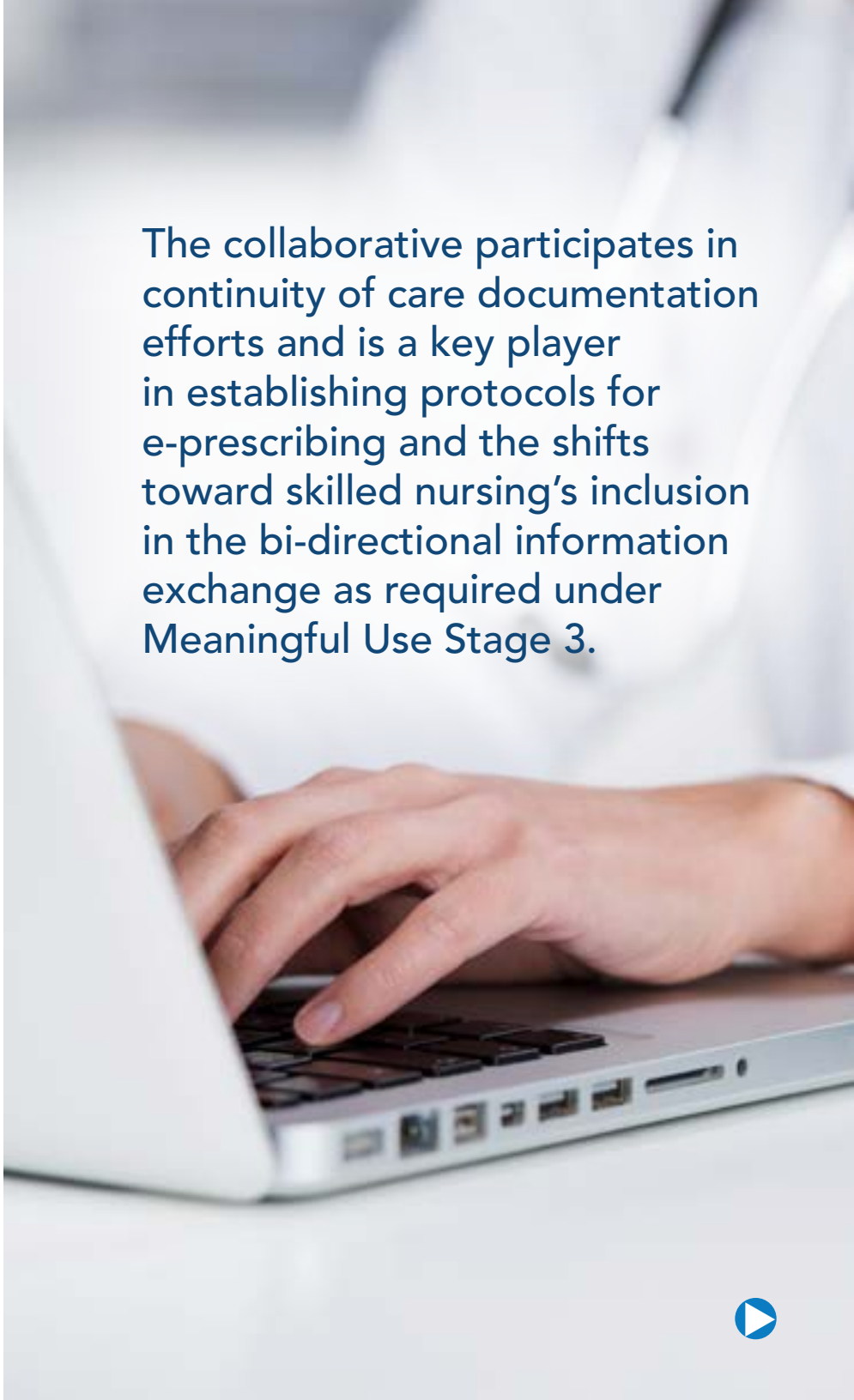

The home health service line can add another layer of potential hurdles, Clayman says. "Home health systems don't always integrate or are proprietary, there are still lots of paper or scanned PDFs/attachments, and multiple third-party players can be involved, depending on clinical needs." Not to mention the documentation differences between home health's OAIS documentation system and skilled nursing's MDS system, he adds. "Providers and system vendors both need to sidle up to the plate."

The Changing Role of the Consultant Pharmacist and Long Term Care Pharmacy

Mary Balaskas, PharmD., Omnicare
Todd King, Pharm.D.,CGP, Omnicare

Much has changed in the world of consulting pharmacy and long term care pharmacy in recent decades. Much of this change is being driven by the type of patient residing in a skilled nursing facility today as compared to the patient in a skilled nursing facility twenty years ago. Admission rates to skilled nursing facilities have declined as has the average length of stay. We are witnessing the change to a transitional model, where patients "step down" from the hospital before they move back home or to the assisted living facility. This change from traditional long term care to this transitional care has brought with it changes in other areas of the long term care arena, most notably in how long term care facilities are reimbursed, the expectations for care from the SNF facility and thus the types of services rendered by the pharmacy and the consultant pharmacist.

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In 2012, the American Health Care Association (AHCA) created a Quality Initiative that focused on three main areas:

- Improved Organizational Success
- Improved Short Stay/Post-Acute Outcomes
- Improved Long Term/Dementia Care

In May of 2015, AHCA expanded these Quality Initiatives to include an increase of discharges into the community by 10% or to achieve a discharge of new admissions of 70%. All these together have challenged facilities to adapt or risk failing.

Coming out of this paradigm shift are new reimbursement models. We are witnessing a change from the traditional Fee-For-Service (FFS) model to new methods of reimbursement, ranging from Accountable Care Organizations (ACOs), Value-Based Purchasing (VBP) to Bundle Payments for Care Improvements (BPCI). The Department of Health and Human Services (HHS) is looking for 30% of payments to be through one of these "new payments" by the end of 2016, and up to 50% by the end of 2018.

This paradigm shift allows for new opportunities for the pharmacist in the process of Medication Therapy Management (MTM). MTM allows the consultant pharmacist to use their expertise to improve outcomes and reduce medication costs. MTM programs are continuing to expand to focus on complex medical regimens and patients who are at risk for hospitalizations. This is a great opportunity for the consultant pharmacist to display their skills.

So, what does this mean for the pharmacy relationship with the facility, and how does the pharmacy play a role in helping facilities meet these new goals? The pharmacy should partner with facilities to find efficient ways of meeting patient demands and on increasing patient-centered care. Becoming an invested partner will go a long way in achieving positive outcomes for both parties involved.

An emerging challenge has been providing facilities and patients with first doses of medications. Increased admissions, late day/weekend admissions and decreased length of stays have mandated the quick turnaround of medications for new patients. Electronic emergency kits that hold large amounts of necessary mediations are becoming the norm in some of these high acuity facilities.

Technology is playing a role in helping all members of the healthcare team to follow the patient from before the admission to the long term care facility, all the way to the post discharge stay. Gone are the days of consultant pharmacists or a long term care pharmacy ending its relationship with a patient merely because the patient was discharged from a facility. A full medication reconciliation of a new patient helps ensure that important medications are not omitted, that duplicate therapies are avoided, and that there is a smooth transition from the hospital to the long term care facility. A post discharge reconciliation, with a counseling and follow-up calls to the patient or caregiver ensures that there are no issues with the patient at home. This continued relationship with the patient post discharge provides another opportunity for the consultant pharmacist to interact with these patients ongoing.

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Consultant pharmacists play an important role in this new health care model. A consultant pharmacist can go beyond the required regulatory component of the job and play a role in the overall healthcare of a patient. Consultant pharmacists can, and should be an active participant in the interdisciplinary team. For facilities with very high acuity and turnover of patients, there is a demonstrated benefit to the overall care of a patient when a pharmacist works full-time in a facility. A dedicated consultant pharmacist can help with cost-containment, with meeting immediate patient needs, and with providing feedback on the quality improvement process. A dedicated, shared pharmacist resource can help facilitate the facility's goals by intimately understanding both aspects of the business and contributing to quick solutions to problems, and better yet, preventing problems from ever arising. The changing landscape of long term care, and the shift in reimbursement for the healthcare system, creates opportunities for pharmacists who care for our seniors. These opportunities include Medication Therapy Management, new operational processes, an increased responsibility in the overall functioning of nursing facilities and the ability to care for patients after their stay in the long term care facility. Consultant pharmacists need to position themselves to be an integral partner in traditional and non-traditional services involved in the post-acute care setting. The pharmacies themselves need to be able to adapt to these changes by finding innovative ways with processes, technology and communication that will allow them to partner with skilled nursing facilities to meet the new expectations that have been created in the modern healthcare system.

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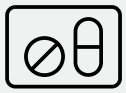

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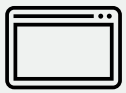

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