Better Serve Your Customers

At McKesson, we're committed to collaborating with alternate site pharmacies to help you better serve your customers. Our Alternate Site Pharmacy Advisory Board, made up of business owners and pharmacies of all sizes, comes together to share lessons learned and find applications for those lessons to create unique solutions for your success.

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2012 Medicare Reimbursement Cuts to Nursing Homes: Implications and Strategies for Long-Term Care Pharmacy

In July 2011, the Centers for Medicare and Medicaid Services (CMS) delivered news of an upset to the financial stability of skilled nursing facilities across the nation: an 11.1% reimbursement cut through the Medicare Part A Prospective Payment System would be instituted, effective October 1, 2011. With these cuts, facilities have experienced a direct impact on revenue and cash flow, and sharpened their focus on ways to decrease expenses, including pharmacy costs.

Recognizing the potential impact to long-term care (LTC) pharmacies that serve these facilities, McKesson held a roundtable in November 2011 with LTC pharmacy owners and operators.

Discussions focused on how skilled nursing facilities are reacting to this reimbursement cut, what is being expected of the pharmacies that serve them, and what pharmacies are doing in response. The following is a summary of the key insights drawn from this discussion.

Background on Medicare Reimbursement Cuts

The Centers for Medicare and Medicaid Services published the 2012 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Final Rule on July 29, 2011, with all changes effective October 1, 2011. Based on utilization patterns from the first seven months of 2011, as well as "unintended excess payments" that occurred in therapy-related reimbursement in 2011, CMS implemented a net reduction of 11.1% in payments, estimated at $3.87 billion, to SNFs in fiscal year 2012.

11.1%
reimbursement cuts

Effective October 1, 2011, CMS implemented an 11.1% reduction to Medicare Part A reimbursement, directly impacting SNF revenues and increasing focus on expenses.

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EXHIBIT A

Background and Panelists

On November 15, 2011, McKesson held a roundtable with 13 LTC pharmacy owners and operators to discuss the recent Medicare reimbursement cuts and the implications for their pharmacies. This group represented alternate site pharmacies located across the United States.

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Tom Noesen
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Rick Steinhauser
President
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This action was implemented due to unanticipated higher payments to facilities within therapy-focused RUG-IV categories. In 2010, CMS went from a RUG-III reimbursement-payment system with 53 resident-assessment categories to RUG-IV with 66 resident-assessment categories. CMS expected implementation of RUG-IV to be budget-neutral — that is, spending under RUG-IV would be the same as spending would have been under RUG-III. Unfortunately, spending under RUG-IV in FY 2011 was higher than CMS anticipated. In response, CMS reduced RUG-IV payment rates for FY 2012 (in the FY 2012 SNF final rule).

From a pharmacy perspective, these reimbursement cuts are not the result of increased medication utilization or costs. The driving factor was a greater-than-expected number of days in the highest-paying therapy RUG categories, as shown in table 1.[1]

Panelists emphasized that this is not the only cost pressure occurring in facilities and healthcare providers who serve these facilities. Medicaid reductions are also affecting reimbursement to facilities at the state level. These state cuts are not just planned for the future, but are occurring now, with some being retroactively implemented.

Response from Facilities

These cuts have resulted in financial hardship for many SNFs. Panelists emphasized that facilities generate greater profit with their Medicare population compared to the Medicaid population.[2] One panelist stated, "A Medicare resident generates two to three times the revenue, but not nearly the same care expenses as a Medicaid resident." As non-therapy costs such as medications do not appear to be the intended focus of CMS with these reimbursement cuts, facilities are looking at all Medicare Part A expenses and evaluating ways to reduce costs and improve efficiencies.

More than 90% of panelists noted that facilities have approached them to find ways to reduce costs for their Medicare residents. The primary person contacting these pharmacies has been the facility administrator, chief operating officer or director of operations. Reactions within facilities will vary depending upon the percentage and importance of their Medicare population — the greater the facility profit margin tied to Medicare, the greater the need to evaluate pharmacy services.

All panelists stated that the overwhelming request from facilities was to find ways for the pharmacy to reduce resident costs, while maintaining the same quality of service. Facilities are mandated to provide a high level of resident care while working within these new financial constraints, and they expect their business partners (including pharmacies) to evaluate how services are provided and to justify costs.

Panelists noted that it is questionable how much influence the pharmacy can have on overall facility expenses and revenue. Medications are a small component of a facility's overall costs. In fact, panelists estimated that pharmacy costs amount to only 3 to 5% of overall facility costs. In addition, as noted above, medication use was not a contributing factor to the FY 2012 reduction in Medicare payment rates, so limiting pharmacy spending would not necessarily have an effect on payment rates for FY 2013 and subsequent fiscal years.

TABLE 1

Expected Compared to Actual RUG-IV Utilization for FY 2011[1]

RUG	EXPECTED	ACTUAL	DIFFERENCE
RUX	0.18%	0.55%	0.37%
RUL	0.05%	0.55%	0.50%
RUC	3.56%	13.76%	10.21%
RUB	3.26%	17.41%	14.15%
RVA	8.61%	8.98%	0.36%
RHA	11.41%	3.46%	-7.95%
PC1	1.26%	0.40%	-0.86%
PB1	0.59%	0.17%	-0.42%
PA1	0.40%	0.16%	-0.25%

Expected utilization based on data collection and analysis derived from STRIVE project, which is data collected in 2006–2007. Actual utilization is based on claims and matched MDS 3.0 data from first eight months of FY 2011.

Initial Response from Pharmacies

Nearly all panelists have been approached by at least one of their facilities about this issue. The resulting discussions centered around the following general steps taken when a facility seeks to engage pharmacy partners in reducing costs.

- Pharmacies need to sell "solutions," not just programs. A pharmacy owner or operator must understand the facility's needs, focus on the issues of greatest importance, identify what the facility will value from the pharmacy, and provide strategies to meet these needs. An example of this would be to not sell the facility on just the mantra of "lower pharmacy costs," but on methods to improve a facility's revenue stream.
- Focus on the facility's bottom line by considering ways to help the facility increase revenue or decrease expenses. Increasing revenue may come from finding ways to assist the facility in increasing census. Decreasing expenses might come from finding ways to reduce or redeploy labor and other costs that are not directly related to resident-care management.
- Emphasize that medications are a small component of overall cost. As one panelist noted, "Drugs are an easy target for facilities." A key for the pharmacy will be to evaluate not just medications, but other direct and indirect costs associated with medication administration. Another panelist noted, "Improving labor efficiencies in all activities associated with medication procurement, administration and storage can have the greatest effect."
- Evaluate each facility differently. Each facility has different needs; therefore, strategies should be customized for each facility. This is best done by meeting with key personnel within the facility, determining what the key issues are for that specific facility, then developing strategies and programs that can effectively meet facility objectives.
- Pharmacies need to determine what they can "afford" to do for a facility. A pharmacy that has a small profit margin with one facility may have fewer options to reduce costs than a pharmacy with other facilities that provide the pharmacy higher margins. If the pharmacy determines that costs for services can be reduced, it is important for the pharmacy to evaluate cash flow and how a reduction in payment from a facility may affect the pharmacy's financial bottom line.
- Evaluate new technologies such as electronic prescribing, new dispensing systems and new delivery systems. These may improve efficiencies, accuracy and connectivity between the pharmacy and the facility, thereby reducing costs, reducing the risk of medication errors, and reducing facility and pharmacy liabilities.

Pharmacy Examples of Success

Panelists were asked about what successes they have had with nursing home customers, in light of requests from facilities to find ways to reduce expenses. Panelists indicated that the challenge is to not only provide methods to reduce costs, but to also communicate the information that is of greatest relevance to customers.

- Alan Bronfein emphasized that Remedi SeniorCare has tried to "change the dynamics of the discussion" with facilities to improve the interaction between the facility and pharmacy. One area they have looked at is improving labor efficiencies and medication utilization. When evaluating medications, the focus should be on medication utilization, not just cost. The questions should be, "Does the resident need this medication?" or "How can we more efficiently use a nurse's time associated with the medication used to manage this disease?" instead of just, "How can we get the medication at a lower cost?"
- Several panelists have implemented or are implementing formulary-interchange programs within specific therapeutic classes. Panelists noted that it is important to have collaborative practice agreements in place before implementation. Formularies must be closely managed and monitored for adherence to produce results, with the goal to minimize non-formulary expenses and maximize cost-efficient prescribing while maintaining quality healthcare. Achieving this goal requires education of and acceptance from facility providers, including the director of nursing, medical director, attending physicians and nursing staff.
- Sherri Cherman from ModernHEALTH offered several recommendations for helping facilities evaluate which drugs should be considered for therapeutic interchange, such as:
  - Consider the time and route required for administration — such as once-daily dosing versus four times a day or the need for a pump.
  - Consider the method of administration — use of an oral medication instead of an IV, or the use of an infusion pump when simple IV tubing could be used.
  - Consider recommended medication handling and storage — an example would be to evaluate the ability of storing a medication at room temperature to save refrigerator space.
- Frank Grosso recommended developing programs and services that can assist facilities in reducing overall and pharmacy per-patient-day (PPD) costs. This includes evaluating current PPD cost benchmarks and trends; such data is valuable to SNFs and provides the information key decision-makers want to review.
- Tom Noesen from Health Resources Alliance and Alliance Pharmacy Services has implemented "best practice" inter-disciplinary committees in facilities to evaluate methods to improve efficiencies and manage costs. This may include analyzing and streamlining nursing processes so more time can be spent on direct resident care, considering ways to improve medication-administration efficiency, and evaluating more appropriate use of medications. An example of this would be evaluating the appropriate length of proton pump inhibitor (PPI) therapy in skilled nursing facilities. Many residents remain on this therapy beyond the approved duration, presenting an opportunity to potentially reduce costs if therapy can be re-evaluated at the appropriate time.
- Rick Katz and Sherri Cherman from ModernHEALTH recommended monthly or quarterly business reviews with facilities to analyze Medicare Part A pharmacy spending. One current focus area is diabetes and how this chronic disease is best managed for the short-stay Medicare Part A resident.

These recommendations are being implemented with those providers involved with or responsible for managing pharmacy services in the facility, including the director of nursing, administrator and nursing staff. Such actions have helped pharmacy panelists maintain their current business, while working effectively with facilities to provide value and address their financial challenges in this environment of regulatory change and uncertainty.

Remedi SeniorCare has tried to "change the dynamics of the discussion" with facilities

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Summary

Recent Medicare Part A reimbursement cuts are having an effect on skilled nursing facilities. This has resulted in some facilities examining expenses, including pharmacy services, for ways to manage costs while maintaining quality. Most LTC pharmacies have been approached by their facilities with requests for help in meeting these financial challenges. LTC pharmacies can assist facilities by assessing their situation and developing strategies to address reimbursement changes. They can do so by focusing on the unique needs and patient populations of each facility, illuminating the true impact of pharmacy on costs, and partnering with facilities to provide strategies and programs that may help improve margins. By being prepared for these discussions, you can work toward strengthening your customer partnerships in light of reimbursement challenges.

One panelist noted, "Pharmacies tend to wear ballet slippers to a boxing match." Pharmacies can avoid this problem by being equipped to make changes — understand what the facility is looking for, know how these needs match up with the best interests of the pharmacy, and define the best methods to communicate and implement these changes within the facility.

Below is a summary of key actions your pharmacy can consider when partnering with a facility to manage Medicare Part A costs.

Summary of Potential Actions

- Be proactive and prepare to discuss making real changes to maximize your opportunities within the facility.
- Understand the needs of the facility and define those needs in terms that are most useful to the facility (such as PPD).
- Evaluate each facility separately, depending upon its reimbursement mix.
- Customize objectives and strategies by evaluating the needs of the facility first, then making recommendations that are achievable.
- Identify the "value" that the pharmacy may be able to provide the facility — reducing costs may not be the only answer.
- Identify key contacts within each facility and determine what their role is when implementing and monitoring recommended changes.
- Consistently monitor and evaluate programs and services for effectiveness.

References

1. *Comparison of Expected versus Actual RUG-IV Utilization for FY 2011.* Centers for Medicare and Medicaid Services. Available at https://www.cms.gov/SNFPPS/Downloads/Exp_vs_Act_RUG4_8mos_Final.pdf.

2. *A Report on Shortfalls in Medicaid Funding for Nursing Home Care.* ELJAY, LLC. December 2010. Available at http://www.ahcancal.org/research_data/funding/Documents/2010%20Medicaid%20Shortfall%20Report.pdf.

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