In July 2018, the Centers for Medicare & Medicaid Services (CMS) finalized a new case mix classification model, the Patient Driven Payment Model (PDPM), which will be used under the Skilled Nursing Facility Prospective Payment System (PPS) for classifying SNF patients in a covered Part A stay (https://go.cms.gov/252hRR). Beginning October 1, 2019, PDPM will replace the current case mix classification system, the Resource Utilization Group, Version IV (RUG-IV).

Many informative articles have been published to date explaining the roles of the nurse, physician, and other health care professionals in a SNF to operationalize this new billing model. An opportunity to focus on optimizing medications to achieve improved patient outcomes with prudent spending and potential cost savings exists, and the consultant pharmacist can play a key role in driving this change.

## MDS and Medications

Reimbursement for medications included on the initial Minimum Data Set (MDS) assessment is provided for the duration of a patient’s stay in a SNF as long as it is documented accurately. This new payment model is designed to reimburse the SNF to “do the right thing” for medically complex patients. Thorough and appropriate documentation of a patient’s medical condition upon admission is paramount to selecting drug therapies that maximize reimbursement and improve patient outcomes. The new PDPM allows SNFs to move away from considering medications only as a cost center where the focus has been to purchase the “cheapest pill” and move toward including medications as an important factor in the care process to achieve optimal patient outcomes.

The MDS that is completed upon admission and updated at intervals during the stay drives the reimbursement “score” and dollars. Under PDPM, payment is determined through the combination of six payment components. Five of the components are case mix adjusted, including the physical therapy (PT) component, the occupational therapy (OT) component, the speech-language pathology (SLP) component, the non-therapy ancillary (NTA) services component, and the nursing component. NTA carries a threefold multiplier for the first 3 days of an admission to help offset the costs related to medications and complex medical conditions.

Additionally, there is a non–case mix adjusted component to cover utilization of SNF resources that do not vary according to patient characteristics. Medication costs are reimbursed under the NTA component. For the NTA, the initial “score” is determined by adding the numeric value of all of the 50 possible conditions and treatments (see the Supplementary table online) that are applicable to the patient on admission. This sum correlates to a case mix group, which correlates to a case mix index. The SNF’s base rate for the NTA component is then multiplied by the patient’s NTA case mix index to achieve the patient’s NTA rate. On day 4, it is reduced to the original rate to calculate the payment for the remainder of the SNF Part A stay.

It is imperative that the consultant pharmacist review the initial diagnosis codes that are entered on the MDS to ensure the medication therapies correlate with the diagnoses. This should be reviewed as part of the patient’s admission Medication Regimen Review (MRR).

There are two ways in which ICD-10 codes will be used under PDPM:

1. Providers will be required to report on the MDS the patient’s primary diagnosis for the SNF stay. Each primary PDPM diagnosis is mapped to one of 10 PDPM clinical categories, representing groups of similar diagnosis codes, which is then used as part of the patient’s classification under the PT, OT, and SLP components.

2. The ICD-10 codes are used to capture additional diagnoses and comorbidities that the patient has, which can factor into the SLP comorbidities that are part of classifying patients under the SLP component and one or more of the 50 conditions that make up the NTA comorbidity score that is used to classify patients under the NTA component.

### PDPM Assessment Schedule

The initial MRR completed upon admission will differ from the monthly MRR for a subacute or long-term care patient. Facilities would benefit from investing in this consultant pharmacist service for medication management because it provides an additional resource and medication expertise for a thorough and precise patient assessment for the initial MDS.

### Deprescribing

Older patients are often prescribed a disproportionate number of medications, resulting in polypharmacy. This leads to reduced medication compliance, increases the risk of adverse drug effects, and may lead to adverse events. There is considerable evidence of inappropriate as well as excessive prescribing for older patients. Although there are risks, medication outcomes can be improved through deprescribing.

The concept of deprescribing first appeared in the health literature in 2003 (J Pharm Pract Res 2003;33:323–328), when Michael Woodward, MBBS, of Austin Health in Heidelberg, Australia, outlined its principles as:

1. Reviewing all current medications
2. Identifying medications to be ceased, substituted, or reduced
3. Planning a deprescribing regimen in partnership with the patient and the prescribing clinician
4. Frequently reviewing and supporting the patient

Deprescribing for patients in a SNF can be initiated by the consultant pharmacist in coordination with the admitting and monthly chart reviews or when a patient is discharged or readmitted to the facility. The consultant pharmacist should participate in an interdisciplinary care team meeting to discuss individual patient recommendations. The reasoning for recommending the discontinuation of any unnecessary medications may also be shared with the patient, if appropriate. The nursing staff can be educated about whether a drug should be tapered or simply stopped, what tapering regimens are most effective, and what parameters should be monitored, how often and for how long (PLOS Med 2016;11:e0161248).

### Antibiotic Stewardship

Studies have shown that 47% to 79% of nursing facility residents receive systemic antibiotics each year, and it is estimated that many of these antibiotics (between 25% and 75%) are unnecessary or inappropriate. Overuse of antibiotics contributes to antibiotic-resistant bacteria, adverse drug events, drug interactions, colonization of bacteria or secondary infection from resistant organisms, and complications that can be attributed to senseless use of antibiotics (Consult Pharm 2017;32[Suppl A]:10–16). Since 2017, federal regulation §483.80(a) mandates an infection prevention and control program (IPCP) and an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use in all SNFs.

Intravenous (IV) antibiotics can be costly, but they are often a necessary part of a patient’s medication regimen in SNFs. As it pertains to a facility’s antibiotic stewardship program, a consultant pharmacist may recommend switching to an oral version of the same medication after a certain amount of days on IV to complete the prescribed course of therapy. This is commonly referred to as an “IV to PO switch,” and it provides the same therapeutic outcome. In most cases, oral medications are easier to administer, are better tolerated by the patient, and are less costly. Under the new PDPM, switching to a less costly oral antibiotic when appropriate may result in significant cost savings, and the SNF will continue to receive the higher NTA rate driven by the IV antibiotic ordered on admission for the entire Part A stay.

### Part A Formulary

Most SNFs have a formulary that is developed in conjunction with the vendor or in-house pharmacy comprising a list of preferred medications used by that facility. Under the new PDPM model, SNFs should reevaluate their current formulary and make updates as necessary. The consultant pharmacist can review and evaluate the medications on the

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**Opt-scribing: Consultant Pharmacist’s Role Under Patient Driven Payment Model**

Jeanne Manzi, PharmD, BCGP, FASCP

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**Medicare MDS Assessment Schedule Type**

<table>
<thead>
<tr>
<th>Assessment Reference Date (ARD)</th>
<th>Applicable Standard Medicare Payment Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-day PPS Assessment Days 1–8</td>
<td>All covered Part A days until Part A discharge (unless an IPA is completed)</td>
</tr>
<tr>
<td>Interim Payment Assessment (IPA) The date the facility chooses to complete the IPA relative to the triggering event that causes the facility to choose to complete the IPA</td>
<td>ARD of the assessment through Part A discharge (unless another IPA assessment is completed)</td>
</tr>
<tr>
<td>PPS Discharge Assessment PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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A voiding an apparently tough challenge that carries an inherently high risk of failure may not always be the best strategy. Failures teach us valuable lessons that may then be applied to tackle the same challenge with a new approach or to address a whole new problem. In *Mindset: The New Psychology of Success* (New York: Random House, 2006), Carol Dweck, PhD, shares her credible research supporting this approach, referring to it as the “growth” mindset. People and organizations with such an attitude, she argues, are set for more success than those with the “fixed” mindset.

Recently, I took on the role of president for AMDA – The Society for Post-Acute and Long-Term Care Medicine. During the annual conference in March, I got to interact with many friends, peers, and mentors. “Times are tough, and it’s hard to have an impact with so much changing” was a comment from one of those peers. Another stated, “It seems we have run into a mountain of challenges, none of which is under our control.” A few others echoed these assessments. I concur with the enormity of the unprecedented health care challenges we face, but the question is, “How should we, as the Society, respond?”

People and organizations with the “growth” mindset are set for more success than those with the “fixed” mindset, according to researcher and author Carol Dweck, PhD.

Lucy Kennedy, a resident of Washington Rehabilitation and Nursing Center, a Signature HealthCare skilled facility in Florida, offers us the most inspiring lesson. In 2014, Lucy, who is more than 80 years old, learned that two state legislators were going to be visiting her facility — so she began to rehearse. Unintimidated by stubborn regulatory frameworks and 150 years of history, when Lucy finally got to meet the legislators, she had donned her most formal attire and was prepared to make her demand: an increase in the $35 per month personal needs allowance for Medicaid-eligible residents of Florida nursing homes.

When challenges are daunting and barriers unprecedented, it takes courage and out-of-the-box thinking for effective solutions. Often, when faced with such challenges, people and organizations revert to a self-preservation mode; they merely “ride the tide,” hoping that solutions will emerge from others. Instead of pushing for new ideas, harder advocacy, and new collaborations, they settle for the status quo, citing lack of resources, time, and control as excuses.

The growth mindset encourages us to invest in bold strategies, such as “budgeting” for experimentation and potential failures. Eric Ries, author of *The Lean Startup* (New York: Crown Business, 2011), advocates for swift (but inexpensive) implementation of new ideas and “quick failures” to gain experience. This is also a guiding principle of the Quality Assessment/Process Improvement (QAPI) paradigm, which is now a mandatory part of nursing facilities’ quality programs. Such approaches can help organizations take the lead when the going gets tough. Jim Collins, author of *Good to Great* (New York: HarperBusiness, 2001), also recommends discipline in creativity and experimentation to attain greatness for organizations.

We, the clinicians and advocates of the post-acute health care system, face a very tough restructuring of the health care system. For example, the rising acuity of patients in our setting, increasing expectations of stakeholders, inadequate reimbursement, lack of trained staff, and transitional care woes along with ever-changing regulatory frameworks are making lives hard for post-acute health care teams. But there is a silver lining: a readiness to change and openness to new ideas among stakeholders that did not exist before. Between regulators, academicians, researchers, clinicians, and others, there is an ongoing dialogue to redesign and test new models of care, build new collaborations, and much more.

The growth mindset encourages us to invest in bold strategies.

I truly believe that the stage is set for the Society to emerge as the leader in the post-acute care redesign. Our dedicated and expert membership, most diverse Board of Directors, capable House of Delegates, and committed volunteers are ready to lead, collaborate, design, and experiment. Keeping a growth mindset will be the key — no idea is off the table or unrealistic. From upgrades in education programs and agility in clinical products, to innovative models of care and use of technology, the Society should seek to bolster all its aspects.

I also believe that we won’t succeed alone, and strengthening our current partnerships and building new ones will be crucial. We need to initiate and participate in all key dialogues that are happening with relevance to all patients in the PALTIC space. We should be the first to test new models and embrace new technologies. Any opportunity to experiment and to fail modestly needs to be taken so that we can learn key lessons that will contribute to successful solutions.

Finally, in the context of health care redesign, I cannot overemphasize the key role AMDA Innovations could play, not just for the future of the Society but for the future of health care as well. With almost three years of hard work invested in the Innovations infrastructure for the Society, we stand ready to lead and embrace change. AMDA Innovations has provided us with the foundation of the growth mindset that is required for the exciting years ahead.

In December 2015, the two state legislators visited Lucy’s facility once again. This time they brought along a shiny plaque — a recognition of Lucy Kennedy’s unwavering advocacy, which led to the passing of “Lucy’s Law” by Florida state legislators: a regulatory tweak that increased the monthly personal needs allowance to $105 for more than 50,000 residents. Now that is the power of a growth mindset. If Lucy can do it, so can we!

Dr. Manzi has been a licensed pharmacist since 1990 and a Board Certified Geriatric Pharmacist since 1998. She is currently a clinical advisor for CVS/Caremark and president of SHC Medical Partners. He is the president of the Society and is also the past chair of its Innovations Platform Advisory Council.

Payment Model from page 3

Opti-scribing Optimizing medication management strategies such as discontinuing unnecessary medications, deprescribing, antibiotic stewardship, and Part A formulary management is essential to minimizing adverse events in patients, improving patient outcomes, and reducing unnecessary medication costs. Consultant pharmacists are the medication experts who possess the knowledge to provide optimal medication management.

Over the last several decades, the pharmacy profession has seen new prescribing terms evolve such as e-prescribing and deprescribing. I have created yet another new term to describe the action of consultant pharmacists will perform in response to the 2019 PDPM reimbursement model: opti-scribing. Opti-scribing by consultant pharmacists will ensure that the health care team in a SNF documents medication orders and responds appropriately, chooses the most effective medication therapy to achieve the intended outcomes, and minimizes adverse events for the patients while maximizing the reimbursement to the SNF.