Home. It’s a powerful word. It’s a place that signifies refuge, comfort, and security. It’s a place to gather with family and friends, to build memories. Singers write songs about it. If you are a road-weary traveler, heading home brings warm thoughts.

The same could be said when it relates to health care. For someone with health issues, being treated in the familiar surroundings of home is usually preferred to moving to a nursing home or an assisted living facility.

The concept of providing long-term care at home (LTC), or medical at home, has been attracting steady attention for a while. With the COVID-19 pandemic, it is coming into sharper focus.

Bri Morris, PharmD, NCPA senior director for program development, says that for the NCPA Long-Term Care Division, medical at home is its No. 1 priority.

With the pandemic, medical at home may open a door for independent long-term care pharmacy.

by Chris Linville
“We’ve been putting a lot of emphasis on getting our pharmacists to look for diversified revenue opportunities, and dispensing prescriptions in the LTC category makes a lot of sense.”

“I think it makes sense when you look at our membership,” she says. “We have done a lot over the last couple of years to engage more combo and closed door pharmacies to become NCPA and NCPA LTC Division members. They are uniquely qualified to do medical at home, so I think it’s a natural focal point of the division.”

According to the 2019 *NCPA Digest*, sponsored by Cardinal Health, 43 percent of independent pharmacies provided LTC services to their patients, and serviced an average of 162 beds at skilled nursing facilities.

LTC pharmacy for medical at home is generally defined as a closed door pharmacy with no retail walk-up business servicing patients who qualify for LTC level of care in their home and would otherwise be required to be institutionalized or who are identified by their primary physician as eligible. Combo shops could service medical at home patients if they are doing it on the LTC side of the business.

“We’ve been putting a lot of emphasis on getting our pharmacists to look for diversified revenue opportunities, and dispensing prescriptions in the LTC category makes a lot of sense,” says Bill Popomaronis, RPh, NCPA vice president of professional affairs. “And it doesn’t necessarily mean going to nursing homes or skilled nursing facilities. It starts with medical at home. With the tremendous pressures on pharmacies and coronavirus, medical at home seems to be a topic that should be tied into what we are doing here to try to make the case for it.”

Of course, getting paid for services is the battle that independent pharmacists always seem to be fighting, and medical at home is no different. Morris says that NCPA has been advocating with CMS for recognition of medical at home pharmacy services, and ideally, payment. Admittedly things move at a grind at the federal level, and COVID-19 has complicated just about everything. But even if real movement happens later instead of sooner, medical at home seems to be a concept that will continue to attract support. The benefits of LTC include no pharmacy DIR fees, and typically a better deal on costs of goods from holesalers.

“Everything has kind of shifted to wherever that patient is,” Popomaronis says. “If they are in assisted living, they don’t want them to go to skilled nursing. If they are in a group home, they don’t want them to go to assisted living. And if you are at home, the recognition is that care is going to be less expensive in your home. This brings the fruit of medical at home into the equation.”

In the following pages, we look at the various aspects of medical at home from a number of perspectives.

**ADVOCATING FOR HOME**

NCPA Vice President of Policy and Government Affairs Operations Ronna Hauser, PharmD, is familiar with how things tend to move in Washington, D.C. – slow and slower. So she knows that getting federal recognition – and payment – for LTC independent pharmacists providing medical at home pharmacy services is likely a long-term process in itself.

Hauser says that CMS already has care setting definitions and requirements in place for skilled nursing facilities. She says most of the people in those settings receive their drug benefits through Medicare Part D. Hauser points out that CMS requires skilled nursing facilities to have a level of care and services that NCPA LTC members are already providing.

“What we’re trying to tell CMS is, ‘You don’t need more people going into skilled nursing facilities to get those services,’” Hauser says “You need them to get those services in their homes so they don’t go into skilled facilities. And because the PBMs do pay a higher reimbursement in Part D for skilled patients, we need that to translate over to home care because the services we are providing are the same.”
The NCPA LTC Division has been advocating its goals through numerous meetings with CMS officials, along with letters and phone correspondence to state its case.

“I think CMS understands what we are saying and how important it is, but they are also concerned about the Amazons and PillPacks jumping in and saying they are doing medical at home and all trying to get that higher level of compensation,” Hauser says.

NCPA has tried to stress that it is not pushing for a wide-open door for medical at home.

“That’s one of our main caveats – you have to be categorized and doing business as a long-term care pharmacy,” Hauser says. “That’s a whole separate business for a lot of our members – you can’t intermingle inventory – it’s a different line of business, a different cost of goods. The contracts are already in place, the PBMs already know who they are, so they can coordinate and contract and network with them today. We’re not talking about opening this up to any pharmacy.”

Another issue is that CMS seems to like everything defined to fit neat and tidy.

“These services are harder to grasp and put in a box,” Hauser says. “They are asking what exactly are these services you are offering patients in their home, and how can we define the services, and the care that’s being provided?”

Hauser says that NCPA works closely with the National Council for Prescription Drug Programs, which has established LTC service codes, and that CMS respects its efforts.

“We’ve been engaged in the normal NCPDP processes to make sure that these services can be appropriately coded for in a claims submission, so that the PBM knows that this is a long-term care pharmacy submitting a claim for a medical at home patient,” Hauser says.

One issue, Hauser says, is that CMS has said that it doesn’t get all of the reporting data. She acknowledges that presents challenges as different entities tend to be siloed on different systems.

“The pharmacies are going to report certain data to the PBMs, but then the PBMs and the health plans are required to report certain data to CMS, and some of the fields for medical at home are not required to be reported to CMS by the plans,” she says. “That’s been a hiccup, where CMS says maybe the plan would know that it is medical at home patients, but would it (CMS)?”

The NCPDP code has a “7” level of service code, which is “Medical at home with special pharmacy services identical to Long-Term Care.” (See sidebar, “How did medical at home originate?”) Hauser says that CMS claims it doesn’t receive that information from the plans or the PBMs.

With COVID-19 continuing to wreak havoc throughout the country, Hauser says now is the time for CMS to act. She says that NCPA has worked with CMS to promote medical at home, given the agency ideas to promote it, offered proposed edits to the Medicare manual, and suggested language that it could utilize and put out as guidance document for the Part D plans. And she says NCPA’s LTC Division will continue to do so as long as it takes.

Who benefits from medical at home services?

Medical at home patients generally have a wide range of health issues and struggle to manage multiple medications on their own, resulting in the need of a caregiver at home. No matter what the service is, the patient remains “homebound” and medical care is focused on “curing” the patient in his or her home. A health care professional may determine a patient’s level of acuity and deem the patient fit to receive medical care at home even though the patient qualifies to be in a nursing home.

Source: NCPA Advocacy Center
“If you want to get more people staying at home instead of going into COVID-19 filled nursing homes, CMS needs to tell the plans and PBMs that these services are important and they need to pay for it,” Hauser says. “I think if there's a will, there's a way. I think industry can work together to figure this out.”

**MEDICAL AT HOME AND MUCH MORE**

Lewis Drug, Inc. is a regional chain based in Sioux Falls, S.D., with 57 stores in three states in the upper Midwest. It has three closed-door LTC pharmacies, one in Rock Rapids, Iowa, and two in Sioux Falls.

Despite its size, Lewis Senior Vice President of Professional Services Bill Ladwig says, “We're still an independent at heart. As an independent you need to be nimble, progressive, and on the cutting edge, not the bleeding edge.”

As part of its continuing commitment to patient care, Lewis has formed an LLC with Sanford Health, a major entity in the area. Lewis is vertically integrated with Sanford, and the two have built numerous adjoining facilities with the medical clinic and the pharmacy sharing a common doorway. Lewis also has an outpatient pharmacy within Sanford's main hospital.

“We have numerous 40,000-50,000 square-foot clinics attached to a 30,000 square-foot Lewis store,” Ladwig says. “This partnership has been very beneficial to the patient and has been incredibly productive for both Sanford and Lewis.”

When it comes to patient care options, Ladwig says, “I’m a huge ‘medical at home’ proponent. I believe the best place for a person to be is at home, as long as that environment is safe. The number one reason for hospital admission is medication mismanagement, and pharmacists can help mitigate that concern.” He also says the term “medical at home” is a bit of a misnomer as it is much more than that.

“For me, adherence packaging is beneficial for any patient needing assistance in taking their medications properly,” Ladwig says. “The benefit has been confirmed with numerous anecdotal responses from family members about how it’s kept their loved ones out of the hospital and allowed them to stay at home. Now that medications can be accounted for, family members report that it has lessened the worry.”

Ladwig says the genesis of adherence packaging at Lewis Drug was initially influenced years ago when his father-in-law was staying at his home. “He was a World War II veteran, he had 13 medications from the Veterans Administration, and every Saturday night my wife would spend hours sorting them into his little pill reminder. I thought there had to be a better way.”

Lewis visited SynMed in Montreal, Canada, to witness the SynMed robotic technology, an automated system for preparing and dispensing solid oral medications in blister cards. Soon after, Lewis Drug began to use a SynMed machine to fill adherence packaging. “It’s been aggressively adopted,” he says. The medications are
placed in a multi-dose card that eliminates bottles. "With the cards you know if the patient isn’t taking the medications, it’s obvious," Ladwig says.

This model has also been extremely beneficial in the local mental health clinic, according to Ladwig. “We have an embedded pharmacist in the mental health clinic who is able to work directly with the provider to align medication changes to the same day the new adherence packages start. We realized that this is the process where we can get all of the siloed medical entities to work together, and get a better solution.”

Like everyone else advocating for medical at home, Ladwig is hoping to see action from CMS. “The end game from CMS’ perspective is how to keep people in their homes healthier and longer, with the emphasis on healthier. It is an incredible value to have this kind of service that improves patient adherence. Pharmacists in general need to be reviewing this and figuring out how to make it work more efficiently.”

Somewhat ironically, while COVID-19 would seem to provide a sense of urgency to propel medical at home, especially with well-documented outbreaks in nursing homes and other group facilities, Ladwig says the virus has basically locked things down, which impedes discussions and planning. “People and businesses are in survival mode, which is understandable,” he says. “Representatives from Washington were going to come out and visit us to see some of our unique operations but that got COVID-ed.”

How did medical at home originate?

In November 2015, the National Council for Prescription Drug Programs passed DERF 1306, which approved one new level of service referencing medical at home services with special pharmacy services identical to those provided LTC nursing facility beneficiaries (not including emergency kits). In May 2018, NCPDP issued an editorial update reiterating using the medical at home level of service on a claim when identifying extra pharmacy services, including items such as special packaging, and delivery services for patients who reside in their home, but are receiving special pharmacy services identical to LTC beneficiaries.

Specifically, NCPDP instructed industry to use level of service (418-DI) with a value “7” (medical at home with special pharmacy services identical to LTC beneficiaries with the exception of emergency kits) starting in October 2017, which is when the medical at home residence code became available in NCPDP’s External Code List. Currently, NCPDP’s active level of service codes include the following:

- “0” – Not specified
- “1” – Patient consultation
- “2” – Home delivery
- “3” – Emergency
- “4” – 24-hour service
- “5” – Patient consultation regarding generic product selection
- “6” – In-home service
- “7” – Medical at home with special pharmacy services identical to long-term care

Source: NCPA Advocacy Center
Still despite the challenges, Ladwig says the only option is for pharmacy to push forward. “We have to persevere, that’s what we do,” he says. “It’s often through the greatest times of stress that you see the most innovation.”

A BOOMING SEGMENT EMERGES
According to the AARP, 10,000 baby boomers are turning 65 every single day, and this is expected to continue into the 2030s. This means that nearly seven baby boomers are turning 65 every minute.

For GeriMed President Christopher Mangione, that’s a stark reminder that our population is aging, and with it will come more demand for senior care.

“Obviously there are a lot of people aging into the demographic,” he says. “These folks at home – a lot of them are boomers – don’t want to go into nursing homes.”

Even in the best of times, nursing homes are not always desirable destinations, and assisted living facilities are often out of reach financially for many. Add a COVID-19 pandemic to the mix, and it gets even more complicated. That’s why Mangione says medical at home is a concept whose time has come.

“Medical at home as we see it is just another emerging segment of long-term care that’s in a lower-cost environment, and it is better medically for these patients to remain at home,” he says. “That’s why it’s so logical for us when we say to CMS, ‘You just have to marry up the pharmacy service.’ You would be paying so much more for patients if they were in a skilled facility, in contrast to them just getting the same pharmacy services at home.”

Susan Rhodus, RPh, GeriMed senior vice president, contracts and advocacy, says, “We definitely think it’s more important than before. It’s all about trying to take care of patients who don’t have a mechanism to get their medications at a retail pharmacy on their own. They are like nursing home patients in all regards except they don’t want to go there, or can’t afford to be there. It’s taking care of people who can’t take care of themselves.”

GeriMed, based in Louisville, Ky., was established in 1983 to support independent pharmacies servicing LTC and home care patients. Founded by 1985-86 NARD (now NCPA) president Joseph Schutte, and still privately-owned by the Schutte family, the company was built by pharmacists for pharmacists to assist independent pharmacies in maximizing profitability.

“It was started to help independent pharmacies be more efficient in purchasing. Then when Part D was enacted it began to assist pharmacies in getting better reimbursement,” says Rhodus, who has 37 years of experience in LTC and has been with GeriMed for 30 years. “We cater to independent pharmacies. That’s our business.”

As with other medical at home advocates, Mangione and Rhodus say that the message constantly conveyed to CMS is that more people prefer to stay in their home, that it reduces costs, and by including pharmacists skilled and experienced in long-term care, medication errors will be reduced and adherence numbers will improve.

“The point is, CMS basically agrees with this and says OK, it should be location neutral, and they should be able to get this benefit everywhere,” Mangione says. “That’s nice to say, but you have to codify that. You need to modify the manual that recognizes this population in order for PBMs to negotiate in good faith for these folks to get essentially this LTC benefit in the home environment, and for the pharmacies to get the benefit of the enhanced reimbursement.”
As with any venture, educating others to help them advocate for you is vital. Mangione admits that the process is “arduous” for a variety of reasons.

“Long-term care is the most poorly understood class of trade just because of the numbers,” he says. “We have millions in contrast to hundreds of millions. We deal with PBMs, health plans, and manufacturers, and the body of knowledge is tribal. You might be dealing with somebody who knew the business and then they leave. That person’s replacement might have a retail mentality, and they don’t understand the segment, and all the nuanced regulations that govern it.

“It’s a complicated class of trade, and if you don’t know it, we are speaking two different languages when you are trying to accomplish anything. It just makes it very difficult.”

Still, Mangione is bullish on medical at home’s prospects.

“I think we are in a perfect storm of need right now,” he says. “I just think about the isolation of these patients and the opportunity to provide service to them. We’ve never seen more stakeholders advocating for the medical at home segment. There’s a lot of people on board right now, even in the last 18 months, that I think also helps the cause.”

HEALTH CARE WHEREVER YOU ARE
When discussing medical at home, Michelle Templin, senior vice-president of product management and legislative affairs with Managed Health Care Associates, Inc., likes to use a personal anecdote. Her 82-year-old father had knee replacement surgery. Afterward, being otherwise healthy, he insisted on recovering at home. Being stubborn, Templin says, he won the battle.

The other, more traditional route might have been in a nursing home or other type of facility.
“At home he received the same protocols that he would have received at the nursing home,” Templin says. “It wasn’t any different, it was just the four walls around him that were different.”

That’s why Templin says that organizations such as MHA are trying to change the mindset about dictating reimbursement and care quality. Should it be based on the walls around you, or dictated by the needs you have as a patient?

“With medical at home, there’s a lot of people like my father who could get the same care in a non-nursing home setting,” she says.

MHA, with corporate headquarters in Florham Park, N.J., is a health care services and software company that offers a growing portfolio of services and solutions to support the diverse and complex needs of the alternate site health care provider.

“Part of what we do on behalf of our members is provide best-in-class network rates, along with significant discounts in purchasing and rebates as part of core GPO function,” says Russell Procopio, MHA executive vice president for long-term care pharmacy. “We also do a lot with legislative affairs and advocacy.”
Templin says that there is a subset of people for whom medical at home makes sense, and that LTC pharmacies are perfectly positioned to offer that service.

“Our argument is that pharmacy is doing the exact same amount of work for them as if they did it in a nursing home – doing all the specialized packaging, the delivery, the drug regimen review – and it should be recognized and they should be compensated for their professional services,” she says. “They are providing services that save the Medicare trust fund a lot of money. My dad was a lot cheaper at home than he would have been for the trust fund. Again, it’s appropriate for certain people, and for those people let’s do it. Because it makes sense all around. It’s a better quality of life and you lower the costs.”

It’s been pointed out by medical at home supporters that one reason why CMS has been hesitant to provide recognition is because of concerns about return on investment figures. Procopio references a recently released MHA report titled “The Value of the Long-Term Care Pharmacist in the Delivery and Continuum of Care” that has a section about a study commissioned for MHA member pharmacy ExactCare. Procopio says the study yielded impressive results in the pharmacy’s per-patient-per-month reduction in costs for care.

“In the ExactCare study the medication adherence rate for their population was all above 90 percent and consistent with assisted living facilities, and their per-member-per-month study showed up to a $980 reduction on a per-member-per-month cost, based upon an ExactCare model which was a long-term care at home model versus assisted living. So there is some data out there regarding return on investment. That’s just one study, but it’s encouraging.”

Procopio says MHA is focusing on showcasing that all the residences of care, including long-term care at home, have positive impacts on portions of days covered, net adherence, total cost of care, patient satisfaction, and retention (determining if patients are happy in their setting). The goal is to meet health care effectiveness data and information set (or HEDIS) measures published by the National Committee for Quality Assurance. Procopio notes that HEDIS is important as it is one of health care’s most widely used performance improvement tools.

**What pharmacy services constitute medical at home?**

To participate in Medicare Part D sponsor LTC pharmacy networks, Chapter 5 of the Prescription Drug Benefit Manual requires that the pharmacy have the capacity to provide the following minimum performance and service criteria:

- Comprehensive inventory and inventory capacity
- Pharmacy operations and prescription orders
- Special packaging
- IV medications
- Compounding/alternative forms of drug composition
- Pharmacist on-call service
- Delivery service
- Miscellaneous reports, forms, and prescription ordering supplies

LTC pharmacies may additionally provide the below services to a patient in their home:

- Medication management services
  - Medication therapy management
  - Medication reconciliation – discrepancies discovered are documented and corrected with current prescribers
  - Medication synchronization
  - Consulting services
  - Medical chart reviews
- Transition of care management – pharmacists and health care professionals collaborate to evaluate hospitalizations and aim to decrease readmissions
- Physician, caregiver, and family engagement and education
- Nursing home services (in concert with other health care providers)
  - Occupational and physical therapy
  - Activities of daily life (toileting, transferring, eating, bathing, and dressing)

*Source: NCPA Advocacy Center*
“Health plans and the PBMs use HEDIS to make sure that the plans and the PBMs are creating the right incentives to drive those behaviors,” Procopio says. “If we can prove to CMS that those things are positive to the system, not just for us and the plans, I think we are going to make some headway. If we can prove that a pharmacy like ExactCare has a care model where everything that they do for the patient is directly linked to positive HEDIS outcome scores, that’s in line with what CMS wants to see.”

In Procopio’s view, the more success stories that can be pushed out, the better. “We have to show facts and data associated with the cost of care and the outcomes,” he says. “I don’t think anything will happen if we don’t do that.”

Templin says that constant education is critical. “We need to talk to people and let them know what we are trying to accomplish,” she says. “We’re not trying to open the retail market to make it something it’s not, we’re not trying to put a square peg in a round hole. Let’s not penalize the providers because of the way that the system is set up today, to recognize based upon the four walls that you are in. Let’s set them up for success so they can provide the care that they need to provide for patients wherever they may be.”

Chris Linville is America’s Pharmacist® managing editor.

<table>
<thead>
<tr>
<th>NCPA’s LTC Division: Your resource and advocate for long-term care pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently, more than 10,000 “boomers” are turning 65 every day, and it is projected that by 2020 the number of Americans age 65 or older needing long-term care services will be 12 million. What does this growing LTC market mean for pharmacy owners? <strong>Opportunity.</strong></td>
</tr>
<tr>
<td>Most insurers reimburse pharmacies—whether closed-door or not—a higher dispensing fee when providing LTC compliance packaging. In addition, there are no pharmacy DIR clawbacks when dispensing to an LTC facility.</td>
</tr>
<tr>
<td>If you provide prescriptions for residents in group homes, adult day care centers, continuing care retirement communities, residential care homes, assisted living centers (ALF), or hospice facilities, it makes business sense for you to belong to NCPA’s LTC Division.</td>
</tr>
<tr>
<td>LTC Division members have exclusive access to:</td>
</tr>
<tr>
<td>• <strong>Business resources</strong> such as sample LTC/ALF consultant pharmacist provider services agreements.</td>
</tr>
<tr>
<td>• <strong>Tips on how to acquire new business</strong> and create your personalized LTC marketing plan.</td>
</tr>
<tr>
<td>• <strong>NCPA LTC experts</strong> to guide you through the first steps in opening a “closed door” LTC pharmacy.</td>
</tr>
<tr>
<td>• <strong>Monthly newsletter</strong> providing timely updates on legislative and regulatory issues such as medical at home LTC nurse-as-agent; fair and reasonable reimbursement; MAC pricing; provider status; and much more.</td>
</tr>
<tr>
<td>• <strong>Special networking opportunities</strong> at events like the NCPA Annual Convention.</td>
</tr>
<tr>
<td><strong>Join the LTC Division Today</strong></td>
</tr>
<tr>
<td>Membership in the LTC Division is open to NCPA members and is only $195 per year. An online application form is available at <a href="http://www.ncpa.co/pdf/NCPA-LTC-Membership-Application.pdf">www.ncpa.co/pdf/NCPA-LTC-Membership-Application.pdf</a>.</td>
</tr>
<tr>
<td>For more information on the NCPA LTC Division, visit <a href="http://www.ncpa.org/ltc">www.ncpa.org/ltc</a>.</td>
</tr>
</tbody>
</table>