Medicare Prescription Drug Coverage:
How Does It Affect Long-Term Care Residents in Iowa?

1. What Will Fully Dually-Eligible Long-Term Care Facility Residents Pay for Prescription Drugs under the Medicare Prescription Drug Benefit?

- Full dual-eligible residents who live in certain long-term facilities are "deemed eligible" for the maximum low-income subsidies. Moreover, they are the *only* low-income individuals who are not required to pay *any* cost sharing *but only if*:
    - they are auto-enrolled into (or select) a Medicare Prescription Drug Plan with a monthly premium subsidy low enough to be entirely covered by the premium subsidy;
    - the long-term care pharmacy that their long-term care facility contracts with is in the network of the Medicare Prescription Drug Plan into which they are enrolled, and
    - their prescribed medications are in the formulary of the Medicare Prescription Drug Plan into which they are enrolled, or they have obtained a *Coverage Determination* or *Exception* to the formulary to include their medications in the plan formulary. (See HAP's document *Help: I Couldn't Fill My Prescription* for more information about formulary appeals or exceptions available from HAP's Medicare Appeals Resource Center.)

2. Which Types of Long-Term Care Facilities Must Full Dual-Eligibles Reside in to Not Pay for their Medicare-Covered Prescription Drugs?

- For the purpose of the Medicare prescription drug benefit, fully dually-eligible residents will *not* pay any cost sharing amounts to their Medicare Prescription Drug Plans if they reside in the following long-term care facilities:
    - skilled nursing facilities,
    - nursing facilities,
    - inpatient psychiatric hospitals, or
    - intermediate care facilities that are residential facilities for developmentally disabled adults (called "ICF/MR")
- Medical Assistance (or Medicaid) can pay these institutions on a per diem basis for caring for individuals when they reside in the institution for a month or more.

3. How Will the Medicare Prescription Drug Benefit Affect Residents of Assisted Living Facilities, Group Homes, and Board and Care Homes?

- While these facilities often restrict prescription drug purchases to a designated long-term care pharmacy, *all* residents in these types of facilities will be subject to some cost sharing in accordance with their income and resources.
- Residents in these facilities who receive full Medical Assistance services through a home and community-based (HCBS) waiver will qualify as full dual-eligibles and therefore will be eligible for the maximum subsidies.
    - However, unlike full dual-eligibles residing in long-term care facilities as defined by the Medicare prescription drug benefit (see Question 2), they will be required to meet the cost-sharing requirements in accordance with their income and resources.

(Preamble, 70 Federal Register 4200, 4236; Regulation, 70 Federal Register 4572-4573, January 28, 2005.)

4. What Will Other Long-Term Care Facility Residents Pay for Prescription Drugs under the Medicare Prescription Drug Benefit?

- These residents will pay some amount of cost-sharing.
  - If eligible for the low-income subsidies, they will pay the cost sharing amounts associated with the levels of subsidies to which they are entitled, based upon their income and resources.
  - Long-term care facility residents whose income is 150% or more of the Federal Poverty Level ($1,197 for an individual and $1,604 for a married couple until March 2006) and/or whose resources exceed $10,000 for an individual or $20,000 for a couple will follow the standard cost sharing rules. (See HAP's chart, "Medicare Part D: Standard Beneficiary Cost sharing.")

(Preamble, 70 Federal Register 4388, January 28, 2005)

5. Are There Any Drugs That Are Excluded from Medicare Prescription Drug Coverage?

The new Medicare Prescription Drug Benefit cannot cover prescription drugs that are covered by Medicare Part A or Medicare Part B. Additionally, a standard Medicare Prescription Drug Plan may not cover certain drugs. They are:

- weight-loss and weight-gain drugs,
- drugs for symptomatic relief of coughs and colds,
- prescription vitamins, with the exception of prenatal vitamins and fluoride,
- over-the-counter drugs, with the exception of insulin,
- drugs to promote hair growth,
- fertility drugs,
- cosmetic drugs,
- drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications,
- barbiturates (drugs used to control seizures or used for sedation or anesthesia such as Phenobarbital or Nembutal®), and
- benzodiazepines, often referred to as minor tranquilizers, used to treat anxiety or insomnia (such as Xanax®, Valium® and Ativan®).

(Preamble, 70 Federal Register 4228, January 28, 2005)

6. Are There Other Prescription Drug Payment Sources for Long-Term Care Residents Besides a Medicare Prescription Drug Plan?

- Residents of long-term care facilities whose care is being covered under the Medicare skilled nursing facility (SNF) benefit have their prescribed medications a*nd* over-the-counter medications paid under the Part A SNF *per diem* payment to the facility. Part B-covered drugs remain coverable under Part B and are *not* covered under the Medicare Prescription Drug Benefit. These include:
  - drugs not commonly self-administered that are administered incident to a physicians services,

  - certain anti-cancer drugs, and
  - certain anti-nausea medications taken with anti-cancer drugs.

- Drugs specifically excluded by the Medicare Prescription Drug Benefit (see Question 5 above) *could* be covered, at state option, by the state Medical Assistance program. These include medications often prescribed for nursing home residents such as:
  - benzodiazepines,
  - over-the-counter (OTC) medications such as those to redress pain, constipation or indigestion,
  - medications to prevent weight loss, particularly for people with cancer, HIV and AIDS, and
  - barbiturates, such as sleeping pills.
- Residents whose stay is covered by Medicare or Medical Assistance should *not* be charged for over-the-counter (OTC) drugs, personal hygiene items, or incontinence care items (42 CFR Section 483.10(c)(8)(i)(E): http://www.gpoaccess.gov/cfr/retrieve.html). OTC drugs are included in the per diem reimbursement rate that a NF receives from Medicare or Medical Assistance.
- Full dual beneficiaries with a Medical Assistance "share-of-cost" could apply their "excess income" to the cost of drugs specifically excluded from the Medicare Prescription Drug Benefit instead of to the cost of the nursing home *per diem* charges.
- TRICARE covers prescribed drugs at a skilled nursing facility (SNF). TRICARE also covers prescription drugs for patients who are transferred from a SNF to a nursing home, though the nursing home may not allow the patient to use a TRICARE pharmacy.
- The Veterans Administration (VA) provides care for veterans at VA nursing homes, state nursing homes, and domiciliary care homes for those who do not need acute care or skilled nursing care, and might provide some prescription drug coverage, depending upon the veteran's status with the VA.
- Group health plans may also provide some prescription drug coverage for stays at long-term care facilities. Check with the beneficiary's plan for more information about which drugs are covered during a stay at a SNF or NF.

(Preamble, 70 Federal Register 4228, January 28, 2005)

7. What About Pharmacy Access?

- Plans must ensure "convenient" access to long-term care pharmacies for LTC residents and must contract with "any willing" LTC pharmacy in their region that can meet the standard LTC pharmacy terms and conditions that CMS has established in an operational LTC Guidance released on March 16, 2005. (http://www.cms.hhs.gov/pdps/LTC_guidance.pdf)
- CMS has stated that it expects that long-term care facilities will continue to contract with a limited number of long-term care pharmacies, or with only one long-term care pharmacy. (See LTC Guidance, p. 3, March 16, 2005, http://www.cms.hhs.gov/pdps/LTC_guidance.pdf)
- CMS anticipates that "LTC facilities will likely select LTC pharmacies that meet Part D standards and participate in the largest number of Part D plan LTC networks" (Preamble, 70 Federal Register 4251 January 28, 2005).

  - Because there are numerous plans available to Medicare beneficiaries in Iowa, LTC facilities will likely have residents enrolled in many different plans each with its own formulary and pricing structure.
- Residents will not be able to obtain prescriptions through out-of-network pharmacies.
  - It will be important for residents to be enrolled in a plan that includes the facility's long-term care pharmacy in its network.
- Medicare Prescription Drug Plans may reimburse long-term care pharmacies for the special packaging of drugs as part of the dispensing fee.
- Certain supplies associated with some kinds of drug administration, such as IV solutions and nebulizers and spacers, are not covered under the Medicare Prescription Drug Benefit.
  - *But*, some of these may be covered as supplies or durable medical equipment under Medicare or Medical Assistance.

(Preamble, 70 Federal Register 4236, 4251, 4438, January 28, 2005)

8. How Can Residents Select a Plan That Will Meet Their Unique and Individual Needs?

Selecting a Plan

- The first step will be to determine which long-term pharmacy or pharmacies the resident's facility uses.
  - Note: Some states do *not* allow long-term care facilities to restrict drug purchases to an exclusive long-term care pharmacy.
- The second step will be to determine which Medicare Prescription Drug Plans have those long-term care pharmacies "in-network."
- Third, make sure all (or most) of the medications prescribed are in the plan's formulary.
  - Plans are permitted to design their own formularies, but are required to form an independent pharmaceutical and therapeutic committee (P&T) to develop and review the formulary.
    - Residents and their medical care providers will have to use the *Coverage Determination and Formulary Exception* process to request Medicare coverage for non-formulary drugs.
  - Alternatively, plans may choose to use the model formulary guidelines designed by the United States Pharmacopoeia (USP).

(Preamble, 70 Federal Register 4255-4259, January 28, 2005)

Plan Enrollment

- Full dual-eligibles will be automatically and randomly assigned to a Medicare Prescription Drug Plan in October of 2005. Enrollment in the assigned plan will be effective on Jan. 1, 2006 *if* they do not choose and enroll in a different plan by Dec. 31, 2005.
  - They will be able to switch Medicare Prescription Drug Plans at anytime, effective the first day of the month following the switch.

- Other beneficiaries found eligible for the low-income subsidy (or "extra help") must choose and enroll in a Medicare Prescription Drug Plan by Dec. 31, 2005 in order to have drug coverage on Jan. 1, 2006.
  - Those who do not select and enroll in a Medicare Prescription Drug Plan by the end of the Initial Enrollment Period on May 15, 2006, will be automatically and randomly assigned to a plan, effective on June 1, 2006. They will have an opportunity to change plans.
- Other beneficiaries must choose and enroll in a Medicare Prescription Drug Plan.
- People moving into (and out of) LTC facilities will have a special enrollment period (SEP), during which they will be able to switch Medicare Prescription Drug Plans.
  - An individual who moves into a long-term care facility has a continuous SEP for as long as s/he resides in the facility.
  - An individual who moves out of a long-term care facility has a SEP for up to 2-months after moving out of the facility.

(Preamble, 70 Federal Register 4210-4212, January 28, 2005; PDP Guidance, Eligibility, Enrollment, and Disenrollment, CMS, August 30, 2005)

9. Who Can Help LTC Residents Make Their Medicare Part D Decisions?

- Many LTC residents will need help understanding their options under the Medicare Prescription Drug Benefit, as well as help making the decisions they must make about their Medicare Prescription Drug Plan.
- Authorized representatives can assist residents by educating them, helping with the application for the low-income subsides, and helping them enroll in a preferred plan. Authorized representatives are:
  - persons designated under state law (Preamble, 70 Federal Register 4350, January 28, 2005),
  - persons listed on low-income subsidy applications as helpers (Preamble to the proposed SSA Regulations, 70 Federal Register 10559-60, March 4, 2005), and
  - persons "acting responsibly" on behalf of an individual (Preamble, 70 Federal Register 4378, January 28, 2005).

10. How Will Residents Get Access to Prescriptions They Need?

- CMS is required by law to review formularies and must ensure they do not discriminate against certain populations, including beneficiaries in LTC facilities.
  - CMS will institute formulary review criteria for the institutionalized beneficiary population.
- All Medicare Prescription Drug Plans are to establish a system for formulary exceptions and appeals for drugs not found by the plan to be "reasonable and necessary," and an exceptions process to assist beneficiaries whose physicians prescribe non-formulary or non-preferred drugs.
  - There is not an expedited process available to the LTC pharmacy for payment of an excluded drug by the plan if the drug has already been dispensed.

  - If a coverage appeal is denied, the LTC pharmacy would have to bill the resident and/or the facility.

- For more information, see HAP's document, *Help! I Couldn't Fill My Prescription.*

(Preamble, 70 Federal Register 4261-62, 4364, 4473, January 28, 2005)

11. What Are Specialized Medicare Advantage Plans and How Do They Apply To Institutionalized Individuals?

- These are Medicare Advantage (MA) plans that limit enrollment to certain populations with special needs, such as institutionalized individuals.
- These plans must limit enrollment to persons expected to reside in a nursing facility or a skilled nursing facility for at least 90 days.
- All such Medicare Advantage plans *must* offer Medicare prescription drug coverage.
- They may not be available in your region.

(Preamble to the Medicare Advantage Final Regulations, 70 Federal Register 4596, January 28, 2005)

Sources:

"Final Rule; Medicare Program; Medicare Prescription Drug Benefit,"70 Federal Register 4193, January 28, 2005.
http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1321.pdf

"Final Rule; Medicare Program; Establishment of the Medicare Advantage Program," 70 Federal Register 4588, January 28, 2005.
http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1322.pdf

"Proposed Rule; Social Security Administration; Medicare Part D Subsidies," 70 Federal Register 10558, March 4, 2005.
http://www.healthassistancepartnership.org/site/DocServer/SSA_Regs_on_Low-Income_Subsidies.pdf?docID=5221

"PDP Guidance: Eligibility, Enrollment, and Disenrollment," CMS, August 29, 2005.
http://www.cms.hhs.gov/pdps/PDP_enrollmentguidance+exhibits_FINAL_8-29-05.pdf