MEDICARE PART D CASE STUDIES

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PASSING THE BUCK

THE CASE

Nancy is a Social Worker that works in a long-term care facility (LTCF). On average, the typical resident takes about eight different medications each month. The Medicare Modernization Act of 2003 (MMA), which introduced Part D, changed the way prescription drugs are financed in the LTCF setting, and Nancy continues to have several concerns as to how the facility can best serve its residents' needs.

Pharmacy services in the long term care environment have been shaped by the extensive drug needs of residents and the complex regulatory environment in which the homes operate. Long Term Care Pharmacies (LTCPs) have evolved to provide specialized services and supplies to meet these unique needs.

Most nursing homes have historically relied on one single Pharmacy vendor to provide all Pharmacy related services. Potential advantages include increased efficiency, predictability, and standardization. Additionally, the consultant Pharmacists of the LTCP offer comprehensive drug management services, including quality assurance and improvement activities.

Because of their control over the formulary, LTCPs were able to effectively negotiate rebates and large volume purchase prices with drug manufacturers. Additionally, the consultant Pharmacists could ensure a high degree of compliance with formulary prescribing.

Before Part D, Medicaid played a substantial role in the financing of LTCF residents' drug coverage. Accounting for about two-thirds of the residents, drug coverage for this population was paid by Medicaid to the Pharmacy on a fee-for-service basis over and above the rate paid to the home. In contrast, drug costs of Medicare Part A residents were bundled into the per-diem rate, with the LTCF paying the LTCP from these proceeds. Private pay patients would pay either out of pocket or through other existing coverage.

Nancy has found that her dually eligible residents have seen the biggest change as a result of MMA. Nancy currently has 70 residents in her facility and many of the residents use different plans for prescription drug coverage. There are about 50 drug plans offered in her state, each with varying coverage, cost sharing, formulary design, and utilization management. The expectation is that individuals chose a plan based on their personal needs. However, Nancy finds that she is often expected to help recommend a plan.

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WHAT WOULD YOU DO?

Part D Trivia Question

Which state had the highest number of Medicare Part D beneficiaries reach the donut hole in 2007?

A. Alaska
B. Hawaii
C. New York
D. Wyoming

THE STUDY

The advent of Medicare Part D created the most significant changes in prescription drug coverage for LTCF residents who are dually eligible. Enrollment of these individuals into a private Part D plan shifted their coverage from Medicaid to Medicare. By comparison, drug coverage for those under Medicare Part A remains unaffected. The impact of private pay residents depends on whether or not they enrolled in a Part D plan.

Dually eligible residents with both Medicaid and Medicare are auto-enrolled into a plan with premiums at or below regional benchmark values. Nancy is justifiably concerned because the random enrollment system inevitably places some residents into plans which may not have the most advantageous coverage. Additionally, as a healthcare professional, she is not allowed to steer a beneficiary into a particular plan.

Clinically, Part D introduced significant variation in the nursing home pharmacy environment. Residents may be enrolled in as many plans as are offered in the market, each with a different formulary and different utilization management requirements. LTCFs and their Pharmacies no longer function primarily under the singular policy of the state Medicaid preferred drug list. Instead, there is a renewed complexity to negotiated drug pricing and formulary design across different plans.

Because of the MMA legislation, prescription drug plans – and not the LTCP – now have the authority to create and maintain drug formularies. This can have significant revenue implications for LTCPs. Additionally, unlike Medicaid payments, payments to LTCPs under Part D are not set administratively, but rather, are subject to the negotiation between the Pharmacy and each of the plans.

Non-covered drugs and the price of specific medications remain a large concern for both LTCPs and LTCFs. These two groups have, since the advent of Part D, needed to collaborate closely to keep a check on costs. Shouldering the financial burden appears to depend on the contractual arrangements set up between these parties, yet both parties, as well as the resident, always have a vested interest.

Nancy, and other healthcare professionals, may provide "education" regarding Medicare Part D. They are not, however, permitted to choose a plan for the resident or direct a resident toward any plan in particular. Much of what lies in the middle of these extremes is difficult ground for a professional to negotiate, even in an environment where beneficiaries may change plans monthly.

Part D Trivia Answer

Nationally, about 3.4 million people, or 26% of Medicare Part D beneficiaries hit the donut hole in 2007. **Hawaii**, at 36%, had the highest percentage of any state reaching the donut hole. Diabetes, which occurs at a rate about 3-5 times greater in this island state than for the rest of the United States, might be a major factor.

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