The Coalition of Geriatric Nursing Organizations

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Representing 18,500 Nurses

American Academy of Nursing (AAN) Expert Panel on Aging

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American Association of Nurse Assessment Coordinators (AANAC)

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The John A. Hartford Foundation Institute for Geriatric Nursing New York University

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National Conference of Gerontological Nurse Practitioners (NCGNP)

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National Gerontological Nursing Association (NGNA)

The Medicare Modernization and Improvement Act: The Medicare Part D Drug Benefit

Tips for Nurses

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A survey of older adults showed that 60% of these individuals reported taking 5 or more medications, and 16% reported taking 10 or more medications[3]. Approximately 20% of older individuals reported that they restricted the use of their medications because of the prohibitive cost of these drugs[4].

In response to these concerns among others congress passed legislation which set up Medicare Part D to help meet the individual needs of the beneficiary. One thousand one hundred sixty two pages of final regulation were published in the Federal Register on January 21, 2005 to describe the details of the Medicare Prescription Drug Benefit and includes the expectation that private entities (e.g. insurance plans) will form Prescription Drug Plans (PDPs).

This document has been prepared to assist nurses to help older adults make informed decisions about Medicare Part D coverage.

The Medicare Part D Drug Benefit: Tips for Nurses

Eligibility

All persons with Medicare Part A and/or Part B coverage will have the option to enroll in one of these plans. They will select from the plans that are available in their area, pay a premium and receive a limited amount of support for their drug costs. This change affects all persons who are enrolled in Medicare, regardless of their secondary insurance (Medigap) or place of residence e.g. nursing home.

Persons who are dually eligible (also have Medicaid): Persons dually eligible must enroll in one of the plans; Beginning in October of 2005 these individuals will be arbitrarily placed in a PDP. They will incur no costs associated with this and will be able to change plans during the special enrollment period (SEP) as long as there are other PDPs available to them. Also newly admitted residents to long term care facilities will be able to change PDPs at the time of admission if they would like. All PDPs must cover enrollees in all nursing homes in their regions.

Notification to Medicare Beneficiaries

People with Medicare and Medicaid ("dually insured" persons), Supplemental Security Income, and Medicare Savings Program coverage: Starting at the end of May through June, CMS is mailing notices to people who are automatically eligible for extra help paying for a Medicare prescription drug plan. The notices let these people know that Medicare prescription drug coverage is coming, and that they will get extra help without needing to apply for it. The notices can be viewed at: http://www.cms.hhs.gov/medicarereform/lir.asp.

People who do not automatically quality for extra help: This summer, SSA is mailing a different letter to other people who do not automatically qualify for the extra help, but may be potentially eligible for the drug plan (limited assets and incomes <$14,355 individual and $19,245 couple). The letter will include an application that people can fill out and return to find out if they qualify for extra help paying for a Medicare prescription drug plan. This letter can viewed at: http://www.ssa.gov/organizations/medicareoutreach2/ on the web. Select "Application for Help with Medicare Prescription Drug Plan Costs." Beneficiaries may complete and submit these forms at either SSA and/or their state Medicaid agencies.

People with Medicare who do not qualify for extra help: In October CMS will mail every beneficiary the "Medicare and You Handbook," which describes the Part D program. By mid-October, beneficiaries can begin to compare plans in preparation for enrollment.

Enrollment

There will be a very short window for the enrollment of Medicare recipients. Many people will need help determining which plan covers more of the medications they take and which pharmacies in their area are associated with which plan.

While individuals can begin to find out if they qualify for "extra help" with the costs of medications as early as July 1, details of the available plans will not be available until October. Beneficiaries cannot begin applying for the actual benefits until November 15, 2005. Open enrollment will then continue until May 15, 2006. Persons who enroll after that time will probably have higher premiums (1% per month for every month they wait to join). This penalty remains in effect for as long as they have prescription drug coverage. If they enroll by the 1st of the year they can immediately begin accruing benefits, but for those who enroll later there will not be retroactive benefits.

Costs of the Benefit

The standard Medicare drug benefit premium in 2006 will be about $37 a month and can be deducted from the beneficiaries social security check or paid directly to the plan. There is an annual deductible of $250. After the person has spent $250, Medicare will cover 75% of the cost of the approved drug up to $2000 or a co-pay of 25% (Medicare pays $1500, individual pays $500). The next $2850 in costs are paid entirely by the individual. When the total costs have

reached $5100 ($3600 out-of-pocket) then Medicare will pay 95% (5% co-pay) of all drug costs for the year.

Table of Coverage Based on Annual Deductible

$ Coverage (annual deductible)	Government %($)	Beneficiary %($)
0-250	0	100% ($250)
0-2000	75%($1500)	25% ($500)
2001-5099	0	100% ($2850)
		Total cost: $3600 Plus annual average premium of $450 (12moX@$37)
5100 to all drug costs	95%	5%

If the person is dually eligible for Medicare and Medicaid, there are no premiums or co-pays as is the current system in most states. The costs for persons enrolled in HMO or Managed Care Plans with drug benefits will be determined by their health plans.

What Drugs will be covered?

The formularies are expected to cover most classes of drug but the choice of drugs may be limited, perhaps with more variety in some classes than is currently available in some private drug plans. (see NY Times, June 15, 2005 Robert Pear, “Medicare Insists on Wider choice in Drug Benefits”) Practitioners will have to stay abreast of current and future changes in the program). Covered drugs must be available only by prescription, approved by FDA, used and sold in the US, and used for a medically-accepted indication.

What Drugs will be not be covered?

Drugs or classes of drugs or their medical uses, which are excluded from Medicare coverage, will be excluded, except for smoking cessation agents. At the current time it is anticipated that the following will be drugs excluded from coverage:

*drugs for anorexia, weight loss or weight gain
*drugs prescribed for cosmetic reasons or hair loss
*drugs for the symptomatic relief of coughs or colds
*prescription vitamins and mineral supplements
*non prescription or over the counter drugs
*barbiturates and benzodiazepines

Drugs will not be covered under Part D if they can be paid for under Parts A or B (including the limited drug benefit covering drugs furnished "incident to" a physician's service, pneumococcal pneumonia vaccines, hepatitis B vaccines, and influenza virus vaccines). State Medicaid programs may elect to cover drugs that are not covered under Part D.

Who will decide what drugs are included in the formularies?

Each drug plan will have considerable flexibility in developing its own formulary, with guidance provided by the USP Model Guidelines. The USP Model Guidelines consist of a listing of 146 types of medications in 41 therapeutic classes. USP specified that at least two drugs should be offered in each category, and suggested that at least one product within each subclass be covered. USP also recommended that drug plans should be required to justify exclusion of drug subclasses by providing "substantial clinical, scientific, or other rationale." The Model Guidelines may be found at http://www.usp.org/druginformation/mmg.

CMS is also requiring that a formulary include at least two drugs in each category. CMS emphasized that it will be the final arbiter of the kinds of drugs covered in a drug plan, as it will review each plan's proposed drug covered. CMS requires an up-to-date formulary. Plans may include e-prescribing subject to be determined regulations.

Medication Therapy Management Plans (MTMP)

Each drug plan must have an MTMP to assure appropriate drug regimens for targeted individuals (those with multiple chronic diseases who are taking multiple covered drugs and are likely to have covered drug costs that exceed an amount to be set by CMS). The regulation provides considerable flexibility as to responsibilities of MTMPs, citing lack of consensus as to best ways to provide such a service. MTMP will be considered an administrative cost of drug plans. CMS expects it to "become a cornerstone of the Medicare Prescription Drug Benefit."

Provision for Emergency Access

Emergency access standards are established to assist beneficiaries in obtaining prescribed drugs in emergency situations. Drug plans must ensure adequate access to non-network pharmacies when network pharmacies are not available.

Coverage Determinations, Re-determinations, Appeals, and Grievances

A complex process provides for re-determination by the drug plan, reconsideration by an outside organization, hearing before an administrative law judge, review by the Medicare Appeals Council, and finally, litigation in federal district court. Coverage determinations must be made within 72 hours, with expedited coverage decisions within 24 hours. Providers will be required to provide supporting statements for coverage decisions, expedited coverage decisions, exceptions, expedited re-determinations, and reconsideration by an independent reviewing entity.

Challenges and Concerns for Providers

While Medicare D will offer new and helpful benefits there will considerable challenges for both the beneficiary and the prescribing health care provider. Between October (when plans are available for review) and January (when benefits begin) the health care provider must determine their patients' drug plan and adjust medication regimes accordingly. Primary challenges include the following:

1. **Helping people make decisions about plans**: Decisions about coverage are complex and many individuals in the community, but especially in long term care facilities, may not be able to fully make these decisions. Significant health care resources will go into helping these individuals understand and decide on coverage. (See Guidelines for Selecting a Part D Plan at www.medicareadvocacy.org/FAQ_PrescDrugs.htm)
2. **Drugs not covered on plans:** There will many commonly used and useful medications that will not be covered. These include, as noted previously, barbiturates, weight loss medications, drugs covered by Medicare Part A or B and over the counter medications such as laxatives, skin creams, and medications to decrease gastric acid production or pain killers. Providers will need to decide to stop these medications, submit an appeal, or consider alternative payment or treatment options.
3. **Submitting appeals:** Appeals can be done in an attempt to get coverage for non-formulary medications. Routinely these appeals will be responded to within 72 hours, and within 24 hours for an emergency situation. This contradicts the long term care requirement that mandates medication be given on time.
4. **Issues specific to long-term care** facilities: In addition to helping people make choices, there are issues related to the costs of services to long term care facilities, which has been bundled into long term care pharmacy contracts, no longer will be covered. This includes: drug carts, consultant pharmacy services, emergency boxes, stat and off-hours deliveries, fax machines, medication administration records and other forms, med-pass observations, attendance at quality assurance and care plan meetings, and participation during surveys. It has not been clarified who will pay for the dispensing fees for medications administered in the long term care setting. Facilities that are currently used to working with a single formulary may have to understand and know multiple different formularies.

Resources

For an overview of Medicare D there is a taped video conference that can be viewed at www.publicconnect.com/medicareeducation created by the combined efforts of AGS, Pfizer and CMS. For other information, stay tuned to www.cms.hhs.gov

Law with citations *and* on pages 12 and 13, find excellent "Guidelines for Selecting a Part D Plan" at www.medicareadvocacy.org/FAQ prescdrugs.htm

Over 100 national and voluntary organizations and 56 local coalitions have joined for the purpose of helping CMS implement the Medicare Part D. Drug plan. Nursing organizations are welcome to join. Find at www.accesstobenefits.org

Medicare fact sheets and other resources at www.kff.org

New website created by 40 national organizations to help make the transition to Medicare part D at http://www.MedicareRxEducation.org

The John A. Hartford Foundation Institute for Geriatric Nursing http://www.Hartfordign.org

References

1. Coalition of Geriatric Nursing Organizations: American Academy of Nursing: Expert Panel on Aging; American Association of Nurse Assessment Coordinators; National Conference of Gerontological Nurse Practitioners; National Gerontological Nursing Association.
2. The John A. Hartford Foundation Institute for Geriatric Nursing, New York University Division of Nursing, www.hartfordign.org.
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4. Sharkey JR, Ory MG, Browne BA. Determinants of self-management strategies to reduce out-of-pocket prescription medication expense in homebound older people. J Am Geriatr Soc. 2005, 53(4), 666-74.