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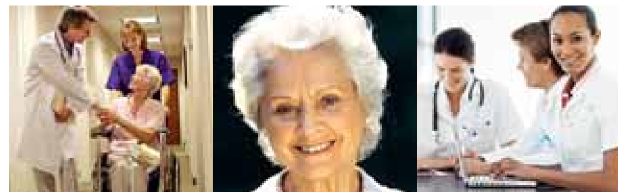
Medicare Part D



Questions to Ask in Evaluating Part D Plans for LTC Facility Residents

Nursing homes, assisted living communities and other long-term care facilities are being asked by their residents and the residents' responsible parties for help in choosing a Medicare Part D prescription drug plan. Given the complicated nature of the new Part D benefit, the numerous plans being offered (generally more than 40 PDP alternatives, plus MA-PDs) and the many differences between the various plans, we understand that the information can be overwhelming and raise many questions.

The CMS marketing guidelines for Part D plans state that "To the extent that a provider (defined to include long-term care facilities) can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs, ***providers are encouraged*** *to do so. To this end, providers may certainly engage in discussions with beneficiaries when they seek information or advice from their provider regarding their Medicare plan options."*

In order for long-term care facilities to help their residents understand the best Part D plan for them, below are some questions facilities and their residents should consider.

1. Is the plan honored by the pharmacy that currently serves the facility?

If a given Part D plan is not honored by the facility's pharmacy, that plan will not pay for drugs provided by that pharmacy. Most facilities want to utilize a single pharmacy for all of their residents, to allow use of a single packaging and administration system, ensure consistent pharmacy policies and procedures and otherwise avoid operational problems which may result from use of multiple pharmacy providers. Pharmacies are providing lists of the Part D plans that they honor to the facilities they service.

2. If the resident is Medicare/Medicaid dual eligible (or may become dual eligible in the future), does the plan accept dual eligibles with no premium?

For dual eligibles, CMS will pay the premium which would otherwise apply, so long as the plan's premium is at or below the "premium subsidy amount" for the given PDP region. If dual eligibles enroll in a different plan, they will be obligated to pay the portion of the premium in excess of the premium subsidy. Given that most dual eligibles lack the funds to pay anything towards a plan premium, they will generally want to pick from the plans that accept dual eligibles with no premium.

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3. Does the plan have appropriate policies for residents who are prescribed non-formulary medications?

The basic rule under Medicare Part D is that Part D plans can deny coverage of drugs which are not on the Part D plan's formulary, unless an applicable exception applies. Part D plans have substantial discretion with respect to their exception policies for non-formulary medications, and Part D plans which adopt narrow exceptions criteria will leave residents responsible for the costs of non-covered medications. Facilities may also be exposed to potential financial responsibility for non-covered drugs provided to residents who cannot pay for the medication themselves (e.g., dual eligibles); some CMS officials have stated that facilities will bear responsibility for these costs. Residents and their families should specifically ask whether the Part D plan will provide coverage of non-formulary drugs in the following situations:

- **Does the plan cover non-formulary medications from E-Boxes?**
  Some plans may deny coverage of non-formulary medications from an E-Box.

- **Does the plan provide coverage of first fills of non-formulary drugs for a 30-day supply?**
  While CMS requires plans to provide coverage of a first fill of a non-formulary drug, some may provide coverage of only a few days' supply of medications.

- **Does the plan provide coverage of non-formulary medications during the full 90-180 day transition period recommended by CMS?**
  CMS has recommended, but not required, that Part D plans provide coverage of non-formulary drugs which the resident is currently taking for a 90-180 day transition period, during which the resident will be transitioned to medications on the Part D plan's formulary. This period is intended to allow appropriate time to monitor therapeutic efficacy and assess any adverse effects of the new medication, among other things. Since this is a recommendation, but not a requirement, some Part D plans may try to move patients off of non-formulary drugs in a shorter period, with potentially greater risks to residents' health.

4. Does the plan allow for "split billing"?

Skilled nursing facilities will remain responsible for the costs of drugs provided during a Part A-covered stay. Where a 30-day dose was dispensed during the Part A stay, but 20 days of that supply will be consumed after Part A coverage ends and coverage by the Part D plan begins, will the plan pay for those drugs to allow for a credit to the facility?

5. Does the plan pay for delivery and specialized packaging for residents of assisted living communities?

CMS has "encouraged" (but did not require) Part D plans to appropriately reimburse long-term care pharmacies for providing these services to ALF residents who need them. Some plans will pay for the services of an institutional pharmacy for ALF residents, while others will provide the same reimbursement they pay retail pharmacies—which is much lower, and insufficient to allow for the added services many ALF residents currently receive.

6. How does the plan handle prior authorization requirements for long-term care facility residents?

Part D plans are allowed by CMS to include drugs on their formularies, but make coverage subject to “prior authorization” by the plan. When prior authorization is denied by the Part D plan, the prescription is not covered. Some Part D plans relax these restrictions for long-term care facility residents because of the drug care planning, screening and reviews performed in long-term care which are not present in the retail pharmacy setting. Other plans apply the same prior authorization requirements for long-term care facility residents and ambulatory patients purchasing their drugs at a retail pharmacy. This results in red tape and increased potential for non-covered drugs being charged to the resident or the facility.

7. Does the plan modify its refill policies and other adjudication edits for long-term care residents?

Other restrictions on coverage may be imposed by Part D plans which can create problems for facilities and their residents. The following questions are relevant to residents of long-term care facilities:

Does the plan’s refill policy allow for:

- **“Spitter” doses?**
  Many long-term care facility residents have trouble swallowing their medications and may spit pills out on the floor. This may result in some plans denying coverage on the basis of “refill too soon” when a refill is ordered 25 days after the previous 30-day supply was dispensed, even though the reason for the early refill was that the resident had difficulty swallowing and spit some of the pills out onto the floor.

- **New Admissions?**
  Some Part D plans may deny coverage of a refill on the basis that a script was filled at a retail pharmacy for the beneficiary prior to admission .

- **Re-Admissions?**
  Where the resident is discharged (e.g., to the hospital) and subsequently re-admitted to the facility, some Part D plans may deny coverage because a script for the medication was filled during the prior stay.

- **Leave of Absence?**
  Residents leaving the facility to stay with family for a weekend, holiday or other absence may request a take-home supply of their medications, frequently in vial form. Some plans may deny coverage of these medications on the basis of a “refill too soon” adjudication edit.

- **Cycle Fills?**
  For facilities using a cycle fill system, some Part D plans may deny coverage due to “refill too soon” or “minimum quantity” edits.

8. Does the plan allow narcotics and other DEA Schedule 2, 3 or 4 drugs to be dispensed in limited quantities?

   Plans which require such drugs to be dispensed in a 30-day supply can create burdens on facility nursing staff with respect to accounting for such medications at the end of each shift.

9. Does the plan deny coverage due to “length of therapy” restrictions, despite the intensive utilization review which occurs within LTC Facilities?

   Some plans have modified these restrictions on coverage for long-term care facility residents, while others will apply controls designed for retail pharmacies to long-term care facility residents.

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