



THE KAISER COMMISSION ON **Medicaid and the Uninsured**

BRIEFING NOTE

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Dual Eligibles in Nursing Facilities and Medicare Drug Coverage

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In a focus group of Medicaid directors conducted by HMA for the Commission on October 26, participants noted that coordination of the proposed Medicare prescription drug benefit and the current Medicaid drug benefit for dual eligibles residing in nursing facilities “requires far more attention.” Among the issues they identified were the potential disruption to existing arrangements between nursing facilities and institutional pharmacies, which could have implications for the prices paid by facility residents and Medicaid for their drugs and the effectiveness of current clinical reviews in monitoring quality and utilization.¹ This Briefing Note explores the issues presented for the design and administration of a new Medicare drug benefit by dually eligible nursing facility residents.

Dual Eligibles in Nursing Facilities

An estimated 1.6 million Americans who are dually eligible for Medicare and full Medicaid coverage reside in a nursing facility. Of these 1.6 million, about 1.25 million are elderly.² The amount spent by Medicaid on prescription drugs for this population is not available, but it is likely to be a large number. On average, nursing home residents receive 6.7 routine prescription medications per day.³ In Georgia, 14 percent of Medicaid spending on prescription drugs is done on behalf of nursing home residents, who represent 2 percent of that state’s Medicaid beneficiaries; in Indiana, the corresponding figures are 25 percent and 7 percent, respectively.⁴ Nationally, Medicaid prescription drug spending totaled roughly \$28 billion (federal and state) in FY 2003.

Current Practice

The dispensing of prescriptions to nursing facility residents involves a supply chain that differs from the one used by noninstitutionalized patients. While some nursing facilities use community pharmacy or retail drug chains to supply prescriptions to their

¹ Vernon Smith, Sandy Kramer, Jocelyn Guyer, *Coordinating Medicaid and Medicare Prescription Drug Coverage: Findings from the Focus Group Discussion with Medicaid Directors* (November 2003), p. 13, www.kff.org.

² Judy Kasper, Barbara Lyons, and Risa Elias, *Dual Eligibles: Medicaid’s Role in Filling Medicare’s Gaps* (forthcoming).

³ Dan Mendelson, Rajeev Ramchand, Richard Abramson, and Anne Tumlinson, “Prescription Drugs in Nursing Homes: Managing Costs and Quality in a Complex Environment,” *NHPF Issue Brief* No. 784 (November 12, 2002), p. 3, www.nhpf.org.

⁴ *Ibid.*, p. 7.

residents, the large majority – over 80 percent of all nursing home beds in the country – use “institutional” pharmacies that specialize in long-term care facilities.⁵ They supply intravenous and infusion therapies as well as prescription drugs. They specialize in providing each resident’s prescriptions in individual blister packs, referred to as “unit dose” packages, which are designed to avoid errors in administration of the medications as well as diversion of narcotics by nursing facility staff. Institutional pharmacies offer 24-hour delivery of prescriptions and furnish “e-carts” of drugs to nursing facilities on consignment to be used in emergencies.⁶ In addition, institutional pharmacies provide consultant pharmacist services, which include monthly reviews of each resident’s medications to avoid adverse drug interactions.⁷ Commonly, institutional pharmacies maintain formularies (lists of drug products from which they dispense prescriptions) and negotiate price discounts with manufacturers in exchange for including the manufacturer’s product in the formulary.

Current Law

Both Medicare Part A and Medicaid cover nursing facility services, although the nature of the coverage is quite different. Medicare is the first dollar payor – i.e., Medicaid does not pay until Medicare coverage (if any) is exhausted. Thus, dual eligibles residing in a nursing facility are either in a Medicare Part A stay or, more commonly, in a Medicaid stay. Coverage for prescription drugs varies by payor.

Dual Eligibles in a Medicare Part A Stay. Medicare covers up to 100 days of skilled nursing facility (SNF) care per spell of illness for beneficiaries admitted within 30 days of a hospital stay of at least 3 days. There is no coinsurance during the first 20 days. The average length of covered stay is less than 30 days. Drugs prescribed for use during the covered stay are covered. Payment for covered prescription drugs is included in the prospective SNF per diem payment amount. There is no separate cost-sharing requirement for prescription drugs; like all other SNF services (i.e., nursing care, room and board, physical and occupational therapy, supplies, appliances, and equipment), they are subject to the general SNF coinsurance requirement (\$109.50 per day for the 21st through 99th day). State Medicaid programs are required to pay this coinsurance requirement on behalf of dual eligibles unless the State’s payment rate for nursing facility services is lower than the amount of the Medicare Part A payment less the coinsurance requirement.

Dual Eligibles in a Medicaid Stay. Dual eligibles could receive Medicaid nursing facility benefits following upon the expiration of Medicare Part A coverage or without any prior Medicare Part A coverage. In either case, states generally pay for drugs prescribed for eligible nursing facility residents separately from the payments they make to the nursing facility itself. (New York, which includes the costs of many drugs in its prospective daily rate, is the most prominent exception to this; Medicaid director focus

⁵ *Ibid.*, p. 4.

⁶ Long Term Care Pharmacy Alliance, www.ltcpa.org.

⁷ American Society of Consultant Pharmacists, www.ascp.com/MedicareRx.

group participants noted that “some” states have folded drugs into the per diem rate). Whether drugs are paid for separately or as part of the facility payment, residents are exempt from any copayment or other cost-sharing requirements that states apply to prescription drugs. States may, however, apply prescription drug cost containment strategies to nursing facility residents; for example, Florida exempts residents from its preferred drug list but applies its prior authorization requirement (after four brand-name prescriptions per month) to both nursing facility residents and beneficiaries in the community.⁸

Medicare Drug Benefit: Potential Issues

The Medicare outpatient drug benefit now under consideration in Congress is a voluntary, stand-alone benefit under Medicare Part D delivered through private risk-bearing plans. In geographic areas with fewer than two such plans, among the options under discussion is that the Medicare program would provide fall-back coverage through non-risk bearing federal contractors. This benefit design raises a number of issues for dual eligibles residing in nursing facilities. Some of these are specific to beneficiaries in a Medicare Part A stay, others are specific to individuals in a Medicaid stay, and some are common to all institutionalized dual eligibles, whether their nursing facility care is covered by Medicare Part A or by Medicaid.

Dual Eligibles Residing in Nursing Facilities. Whether a dually eligible individual is in a Medicare Part A stay or Medicaid stay, there are some common threshold issues:

- Must the beneficiary enroll in a Part D plan to receive Medicare drug benefits?
- If so, who makes the choice as to which Part D plan: the beneficiary, or the nursing facility?
- If the beneficiary makes the choice, how does enrollment (or re-enrollment) occur in the case of a beneficiary who is incompetent, whether as a legal or practical matter?
- If the beneficiary makes the choice and enrolls in a Part D Plan that does not include the nursing facility’s pharmacy in its distribution network, will the facility be required to enter into a supply relationship with the Plan’s pharmacy? Will the Part D plan be required to enter into such a relationship with the facility?
- Will all Part D Plans be required to have the capacity to deliver prescriptions to nursing home residents on a 24-hour basis, and to furnish prescriptions in individual “unit dose” packages?

Dual Eligibles in a Medicare Part A Stay. In addition to those listed above, a number of questions arise in connection with dual eligibles during a post-hospitalization Medicare Part A stay:

- Which Part of Medicare covers the beneficiary’s prescription drug costs, Part A or the new Part D?

⁸ Mendelson, op. cit., p. 10.

- If Part A continues to cover, is the government's payment to the Part D plan adjusted to reflect Part A's assumption of the cost burden? How does the Part D plan learn when the Part A stay has ended and the plan's responsibility starts?
- If, on the other hand, the new Part D covers during a Part A stay, how is the facility's Part A per diem payment adjusted to avoid duplication of payment for drug coverage?
- If the new Part D covers, and the Part D plan's benefit is narrower in scope than that of the state Medicaid program, and the state Medicaid program wraps around the Part D benefit, how will the "wrap" be administered? Will the facility supply the drug and then seek reimbursement from either the Part D plan or Medicaid? How will the facility know what drugs are covered by any particular Part D plan? How will the state Medicaid program know?
- If the new Part D covers, and the Part D plan's benefit is narrower in scope than that of the state Medicaid program, and the state Medicaid program does not wrap, how will the nursing facility fulfill its legal and professional responsibility to ensure that its residents receive necessary medications?
- If the new Part D covers, and the new Part D requires copayments, are state Medicaid programs obligated to pay the copayments on behalf of the dual eligibles? If not, how would residents, who are required to apply almost all of their income to the cost of nursing home care, be expected to pay the copayments? If state Medicaid programs are obligated to pay any Part D copayments, how would such a subsidy system be administered?

Dual Eligibles in a Medicaid Stay. In the case of dual eligibles who either never had a Medicare Part A stay or have completed it and continue to reside in the nursing facility, there are a number of design issues in addition to those listed above. These issues are common to states like New York that include payments for prescription drugs in their nursing home rates as well as to states that reimburse separately for prescription drugs, with one exception. In New York and similar states, the nursing facility would presumably be responsible for coordination of benefits with the Part D plan, since the state is not making separate payment for drugs for these beneficiaries. In other states, the state Medicaid agencies rather than the facilities themselves would have to coordinate coverage with the Part D plans.

By definition, all dual eligible beneficiaries must be sufficiently poor to qualify for Medicaid in the state in which they reside. However, dual eligibles residing in nursing facilities for more than 30 days face an additional financial constraint. They are required to apply almost all of their monthly Social Security, private pension, and other income to the cost of their nursing home care, thereby reducing the amount that the state Medicaid program must pay the facility. By federal law, individual residents are allowed to retain a personal needs allowance of at least \$30 per month; state Medicaid programs are allowed to increase this amount, and some do. The personal needs allowance is intended to pay for clothing, toiletries, hair care, and other items and services not covered by the Medicaid payment for nursing facility services. In the case of an individual with a spouse in the community, an additional portion of the individual's income must be reserved for the spouse in order to avoid the spouse's impoverishment. Because most

dually eligible nursing facility residents are already applying most of their incomes to the cost of care, they are currently exempt from any copayments or other cost-sharing with respect to prescription drugs. These circumstances raise a number of issues about the ability of residents to afford drugs not covered by their Part D plan as well as any new cost-sharing requirements imposed on the drugs that are covered.

- If the resident's Part D plan offers a benefit that is narrower in scope than that of the state Medicaid program, and the state Medicaid program is required to wrap around the Part D plan's benefit, how will the wrap be administered? Will the facility supply the drug and then seek reimbursement from either the Part D plan or Medicaid? How will the facility know what drugs are covered by any particular Part D plan? How will the state Medicaid program know?
- If the resident's Part D plan's benefit is narrower in scope than that of the state Medicaid program, and the state Medicaid program does not wrap, how will the nursing facility fulfill its legal and professional responsibility to ensure that its residents receive necessary medications, given that most of the resident's income is being applied to the cost of care?
- If the new Part D plan imposes copayments, would state Medicaid programs be obligated to pay the copayments on behalf of the duals? If not, how would residents, who are required to apply almost all of their income to the cost of nursing home care, be expected to pay the copayments? If state Medicaid programs are obligated to pay the copayments, how would such a subsidy system be administered? How would the state Medicaid programs know what copayments each Part D plan imposed on any particular drug, particularly if different plans use different tiered copayment schemes?

Implications

The implementation of a Medicare drug benefit has the potential to disrupt current administrative and commercial arrangements among Medicaid, Medicare, nursing facilities, institutional pharmacies, and consultant pharmacists. The resulting disruption could degrade patient care for residents dually eligible for Medicare and Medicaid. For example, assume there are two Part D plans in an area; that some dually eligible residents in the same nursing facility select one of these plans and some another; that the nursing facility uses an institutional pharmacy and consulting pharmacist that do not contract with either of the Part D plans; and that both Part D plans have formularies and dispensing procedures that are different from one another and different from that those of the facility's institutional pharmacy. How will the nursing facility staff keep track of where to access needed medications for any given patient?

One option for minimizing the disruption of current arrangements and pharmacy services for dual eligible nursing home residents is to specify that Medicare Part A continue to cover drugs during a Part A SNF stay and that the state Medicaid program continue to cover drugs during a Medicaid stay. The Medicaid portion of this option could be accomplished in a number of ways. One would be to designate the state Medicaid agency (or its subcontractor) as the Part D plan for each dual eligible during the

portion of the institutional stay covered by Medicaid, with Medicare paying the state Medicaid agency what it would have paid a private Part D plan for the same individual. Another approach would be to leave the dual eligible enrolled in a private Part D plan, but to require each Part D plan, upon the institutionalization of an enrollee who is also eligible for Medicaid, to transfer all payments received from the Medicare program on behalf of that enrollee for the period of institutionalization to the state Medicaid agency. In either case, the federal government should reimburse the state Medicaid agency for 100 percent of the administrative costs it incurs in connection with this coordinating activity.

The principal advantage of this option is that it would not require any significant change in the current administrative arrangements among nursing facilities, institutional pharmacies, consultant pharmacists, and the state Medicaid program, thereby minimizing the risk of a disruption in pharmacy services to dually eligible nursing home residents. These residents would continue to be entitled to the current Medicaid drug benefit, without copayments. They would also be entitled to the Medicare Part D benefit (assuming they enroll), but the benefit in their case would take the form of a payment directly (or by transfer through the Part D plan) from Medicare to the state Medicaid agency offsetting the Medicaid agency's cost.