

Medicare Modernization Act

DHS MMA Project

The Impact of the New Medicare Prescription Drug Benefit on Long term Care Facilities in Oregon

The purpose of this fact sheet is to provide guidance to licensed foster home, residential and nursing facility providers who administer medications on how to address problems that may occur with the implementation of the Medicare Prescription Drug program. Providers should contact the relevant Program Coordinator listed under Resources if they have specific questions.

Background

The new Medicare prescription drug program will go into affect on January 1, 2006. All individuals with Medicare are eligible to participate but will need to enroll in a Prescription Drug Plan or Medicare Advantage-Prescription Drug (plan) to receive benefits. People with both Medicare and Medicaid will face the biggest changes. However, this new federal program will impact most of your residents.

Under the Medicaid program, the Oregon Health Plan Plus, Oregonians with both Medicare and Medicaid (dual eligibles) have not had to deal with copayments for prescription drugs, nor have they had to worry about being denied pharmacy services. However, when these people are transferred to the Medicare drug program they will need to pay copayments to get their prescriptions filled. **If they do not pay, pharmacies do not have to provide their prescription drugs.**

Those individuals with Medicare only who choose to enroll in a prescription drug plan will have to face complex cost sharing arrangements (e.g., graduated premium payments and deductibles).

The Role of the Provider in Medicare Prescription Drug Program

Facilities are urged to address co-payment/cost sharing arrangements for Medicare prescription drug coverage in their policy and procedures. The facility should review these with new residents at the time of admission. The policies should address the following medication related issues:

- **Representative-payee.** A representative payee is recommended for everyone who has limited money management skills. If there are no legal guardians or

family members willing to become a representative payee and the facility administrator is willing to assume this role they should call the relevant SPD Program Coordinator for guidance. Facilities should always follow DHS standard representative payee rules and regulations.

- **Pharmacy Drug Plan (PDP) Coordination.** Facilities may offer pharmacy coordination services to their residents. However these are optional services and **cannot be a mandated condition of residence**. Facilities may offer:
 - To collect funds from residents through monthly billing statements, or other means, and then make necessary co-payments/cost share payments directly to pharmacies or plans on behalf of the resident as part of their Medication Administration service.
 - Offer assistance to residents regarding enrollment or reenrollment in a Medicare Plan that provides a more compatible formulary, a better cost share arrangement or uses a preferred pharmacy. .
- **Responsibility for co-payments.** Medicare rules clearly state that the payment of co-payments or cost share payments is a beneficiary responsibility and that plan/pharmacies do not have to provide drugs in the absence of these payments. SPD does not expect licensed nursing home, residential or foster home providers to cover these costs.
- **Responsibility for “safe medication systems.”** Providers must inform applicants of additional medication administration fees that the facility may charge if the resident is enrolled in a plan that does not contract with the Providers “pharmacy of choice.” Providers may not make enrollment in certain drug plans a condition for residence, however providers may educate applicants and/or residents of the beneficial services that the pharmacy of choice provides and which plan contracts with this preferred pharmacy.

Guidance on Steps to Take on Non-Payment of Copayments

There may be instances when a resident cannot or will not pay the required copayments. This could mean that the facility cannot ensure a resident’s safety or well-being. When a provider is notified that a resident has not paid a copayment and the pharmacy will not provide the prescription drug without the copayment, the provider should:

1. Contact the family member, representative or other responsible party to ask if they can assist with copayment management.

2. Use the CMS website or toll-free phone center to see if another plan will provide the medications at a lower cost. Dual eligible residents (those with Medicare and Medicaid) can change plans monthly. Others will be “locked in” the entire year.
3. For private pay residents, plans may be willing to lower the cost sharing responsibility.
4. Contact the physician, or other prescriber, to request a medication review to determine the health impact to the client if the client stops taking the medication.
 - a. As part of this review, the prescriber, resident (and/or legal representative) and the facility nurse or administrator should have a care conference.
 - b. The prescriber should be asked to either modify the medication regime to reduce drug costs so that the resident can resume medication payments and/or inform the resident and provider of the medical consequences if the resident no longer takes the recommended medication.
5. If the Provider can continue to meet the residents care needs, including those changes that the prescriber anticipates as a result of the medication refusal, then the provider can document that the resident is refusing medication and that the prescriber has been informed. Providers should obtain clear instructions from the prescriber on what change in the residents condition would warrant notification to him/her.
6. If the care conference identifies that the resident’s health either has deteriorated or has a substantial likelihood of deteriorating to the degree that the resident meets the involuntary move-out criteria contained in the facility’s governing administrative rules, the provider should follow normal move-out protocol.