



PRIMER ON MEDICARE PART D  
**Admitting Medicare Residents  
and Obtaining Their Medications**



## Acknowledgements

The idea for this Primer came about during a meeting of one of the many teams working under the 501(C)(3), all-volunteer educational organization called the Health Industry Collaboration Effort, better known by its acronym, “ICE.”

ICE was formed in 1998 to educate the public regarding common concerns of health plans and provider organizations relative to the implementation of the Federal Balanced Budget Act of 1997.

The founders of ICE recognized that the collaborative and consistent development of educational materials by health plans would be a sound approach to promoting compliance with industry requirements. ICE has a proven track record and is nationally recognized as a collaborative working group.

The particular ICE team under which the Primer and attending materials were drafted is called the ICE Part D Implementation Team. The members of the work group formed under the Part D Implementation Team should be recognized for their efforts in putting together an exemplary educational tool about the intricacies of the Part D program:

- Peggy Goldstein, Vice President/COO, CA Association of Health Facilities
- MaryLou Gradisek, Chairperson, Medicare Part D Leadership Team, Omnicare, Inc.
- Lee Meyer, Pharm.D., CGP, FASCP, Dir Pharmacy Services Golden Clinical Services
- R. Paige Talley, Executive Director, Long Term Care Management Council
- Art Whitney, R.Ph., CEO & President, Pacific West Pharmacy, Inc.
- Sheri Zapp, R.Ph., Executive Director, Medicare D Contracting, PharMerica

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The composition of the work group – made up of representatives from a variety of health care industry organizations -- illuminates the ideals and standards upon which ICE was built and is the very essence for which it stands.

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Information contained in this publication is intended to provide a general introduction for long-term care facility staff and pharmacies to the Medicare Part D prescription drug benefit.

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## PRIMER ON MEDICARE PART D Admitting Medicare Residents and Obtaining Their Medications



### Introduction

Since the inception of the new Medicare Part D prescription drug benefit, nursing facility residents, long-term care pharmacies and facility staff have faced a number of challenges.

While some aspects of the program have become clear, a report released in June 2007 by MedPAC (the federal Medicare Payment Advisory Commission), titled “Medicare Part D, Nursing Homes, and Long-Term Care Pharmacies,” highlights the increased tension between facilities and pharmacies, the issues surrounding cost-savings strategies used by PDPs (prescription drug plans) and the burden these processes can place on clinical and pharmacy staff.

The facilities and LTC pharmacies must react quickly and work closely together to ensure that residents receive the medications they need.

This *Primer on Medicare Part D* has been developed in coordination with LTC pharmacies, health plans, professional groups and government agencies. It is intended to help facility staff in determining the appropriate actions to take at the time of admission, or when a facility resident becomes eligible for Medicare.

### Medicare Part D in brief

When they turn 65, almost all citizens become eligible for Medicare, which includes Parts A, B, C and/or D.

While seniors are automatically enrolled in Part A, they *must* elect Part B and may choose either straight Medicare or Medicare Part C (managed care.) Medicare Part D, however, is a *voluntary* drug-coverage program which relies on private plans to administer the benefit and which emphasizes consumer choice of plans.

Unless seniors choose a Part D plan at the time they become eligible, they will pay an increasingly higher premium until the time they do enroll into a drug plan. Only those beneficiaries who previously had some type of qualified prescription-drug coverage – and who elect to enroll in a Part D plan at, or some time after, they become eligible – will be exempt from this penalty. This is called “creditable coverage” (see Appendix A: Glossary of Terms.)

**Dual-eligibles** – A resident on Medi-Cal (Medicaid) who is also Medicare-eligible – that is, “dual-eligible” – will no longer have a drug benefit under Medi-Cal. In order to receive a pharmacy benefit, a dual-eligible beneficiary must be enrolled in a Part D plan.

For these residents, there is an automatic enrollment process in a randomly assigned PDP whose monthly premiums are at or below regional benchmark premium rates.

Dual-eligible residents of nursing facilities may switch to a different plan, at or below the benchmark, up to once per month. “Non-dual” nursing-facility residents are not auto-enrolled and must choose a plan, but they too may switch to a different plan up to once per month.

This new reimbursement environment obligates nursing facilities and their LTC pharmacies to work with multiple plans and no longer function primarily under a single state Medi-Cal policy. Generally, each of these plans has different types of coverage, cost-sharing, formulary design and utilization management. Therefore, strong communication about plan choice, plan enrollment and changes to those choices is essential from the first moment a resident enters a nursing facility or becomes age 65 and eligible for the Medicare Part D benefit.

Federal guidelines restrict the ability of providers (including facility staff, pharmacies and physicians) from directing residents to particular plans. Providers may offer objective information, including how well drug plans cover medications needed by the resident, but the final choice is still left to the resident.

This presents a challenge to both the pharmacy and the facility, as more often than not, the resident and/or family actively seek guidance from the provider and are confused by the array of choices facing them among Part D plans.

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### Communication a key factor

As described in the MedPAC report, “Prescribing in nursing homes depends on a series of communications between four parties – the prescribing physician, the nursing home, the LTC pharmacy and the PDP.”

Facilities receive orders for medications from a resident’s attending physician, and that order typically is faxed to the pharmacy. The pharmacy then reviews the order for coverage against the PDP formulary. It is at this point that the pharmacy is totally dependent upon the facility to have good information about which plan the resident is enrolled in.

The first critical responsibility of the facility is to obtain information upon admission about applicable Medicare Part D plan enrollment and to communicate that information to the pharmacy. Typically, the facility sends the resident’s “face sheet,” which should have the necessary information for dispensing the drug and billing the correct payer. The pharmacy has the ability to verify Part D coverage through an online eligibility check which returns the Part D plan and the beneficiary’s identifying information.

If the medication is covered, it is ordered and sent to the facility. If the drug is covered but requires prior authorization or some type of step therapy, the pharmacy or facility contacts the physician to obtain the necessary information and clinically appropriate intervention. The pharmacy may also provide covered formulary alternatives under the plan and then present these options to the physician.

In the past, with Medi-Cal, these processes were primarily handled by the pharmacy. But the new world of Medicare Part D makes it necessary for close collaboration between facility and pharmacy, with the intervention of the facility medical director if necessary.

If a medication is not on the resident's Plan's formulary, the facility or pharmacy contacts the physician to determine if there is an appropriate alternative therapy. If there are no approved alternative therapies, the patient the physician may initiate the prior authorization process and/or exceptions process. However, the patient may choose to pay out of pocket for the off-formulary drug. The PDP communicates with the physician as to the approval of a request, and the physician then contacts the facility and/or pharmacy. If the request is denied, the resident or the physician may initiate an appeal to the PDP.

All these activities must occur within a set time-frame consistent with regulatory requirements and resident care needs. It is a daunting process which is not easily managed and because of federal regulations cannot simply be turned over to the pharmacy for resolution.

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### Proactive steps facilities can take: **Suggested best practices for Part D coverage**

A decision tree delineating various scenarios with suggested processes is attached as Appendix B of this material. However, in all cases there are several essential steps that need to be taken in order to facilitate communication and to obtain Part D coverage.

#### Information collection

First gather as much data as possible at, or prior to, admission. Place that information on the facility face sheet (including enrollment in a Part D plan) and send that face sheet to the pharmacy. Subsequent changes in payer status, physician and other information that could impact Part D billing should be sent to the pharmacy as soon as the change occurs.

#### To enroll or not to enroll

Provide educational materials to new residents relating to enrollment in a Part D plan that suits their medication needs. Your LTC pharmacy can give you some information to share with residents and their families. Remember the pharmacy cannot enroll the resident – the resident or family must do so, and you can assist in this process.

While they await final Medi-Cal approval, individuals whose Medi-Cal eligibility is pending should be encouraged to enroll in a Part D plan that is at or below the regional bench-

mark premium. This will help mitigate costs and minimize any disruption in service when they do become Medi-Cal eligible.

If they choose not to enroll in a Part D plan pending Medi-Cal eligibility, residents will be auto-enrolled into a regional benchmark plan once they do become eligible. While this auto-enrollment will be retroactive, the resident may still be responsible for some drug costs during the pending period, and when she or he first becomes eligible.

#### LIS, the low-income subsidy

Encourage all families, especially those of Medi-Cal residents who are obligated to a share of cost, to apply for the “low-income subsidy,” or LIS, through their local Social Security Administration office or online at [www.socialsecurity.gov](http://www.socialsecurity.gov). Even if they believe they do not qualify, it is better to check. Do not wait for a determination from Medi-Cal.

SSA reported that in 2006, all dual-eligible residents were erroneously given LIS. This is no longer happening, so all residents should apply.

Individuals whose Medi-Cal eligibility is pending should apply for the LIS as they are responsible for premiums, deductibles and co-pays while they are waiting for Medi-Cal eligibility approval. This will help to reduce their out-of-pocket expenses and may be reimbursed by the PDP when coverage is awarded retroactively.

#### Problem-solving around co-payments

In general, nursing facility residents who are dual-eligibles should not have co-payments for their Medicare Part D-covered drugs. If the pharmacy is receiving notices of co-payments due, the facility can assist in getting the correct information to the plan. Part D plans are required by the federal Centers for Medicare & Medicaid Services (CMS) to accept the best available evidence from the resident, the facility or pharmacy proving Medi-Cal eligibility and status as a resident of a nursing facility or other institution. Institutionalized status is obtained when a resident has been in a nursing facility for a calendar month under a Medi-Cal-paid stay.

CMS sent a memo to the Part D plans in December 2006, outlining the type of documentation that can be submitted by providers as proof of Medi-Cal status. This includes any of the following:

- ✓ A copy of the resident’s Medicaid card which includes the member’s name and an eligibility date during the discrepant period.
- ✓ A report of contact including the date a verification call was made to the state Medicaid agency and the name, title and telephone number of the state staff person who verified the Medicaid status during the discrepant period.
- ✓ A copy of a state document that confirms active Medicaid status during the discrepant period.
- ✓ A printout from the state electronic enrollment file showing Medicaid status during the discrepant period.

- ✓ A screen print from the state's Medicaid systems showing Medicaid status during the discrepant period.
- ✓ Other documentation provided by the state showing Medicaid status during the discrepant period.

Proof that can be provided to the plan to verify institutionalized status includes:

- ✓ A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period.
- ✓ A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual.
- ✓ A screen print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

There is a natural delay in getting this information to the PDPs from the state and CMS, so the facilities need to be aggressive in providing evidence. Remember, however, institutionalized status applies after a full 30/31-day Medicaid paid stay in a nursing facility, so some co-pays may be appropriate in the first partial month after admission. These expenses can be paid from the share of cost or by the family as appropriate.

### Changing plans

Residents who voluntarily choose a plan with a premium higher than a benchmark plan and who are (or become) eligible for Medi-Cal benefits will be responsible for paying the difference in the premium between the two plans. Residents need to be aware that failure to pay the difference in the premium will result in disenrollment from the plan. Also important is the knowledge that if they are dually eligible and in a SNF, they may change to a benchmark plan within the next month.

### Formulary changes

Remember that formularies can change at anytime, so while a plan may cover a particular drug today, it may not do so tomorrow. For any formulary changes, the plans are required to give 60-days notice to the resident, physicians, pharmacies and other providers – which may or may not include facilities. Constant communication with your LTC pharmacy will help avoid delays or unnecessary billing for non-covered drugs.

### More communication

From the beginning, families should be encouraged to communicate with the facility and to share any correspondence they receive from Medicare and the Part D plans. Only in that way can the facility and the pharmacy help the family navigate these difficult processes.

## Appendix A: Medicare Part D Acronyms and Glossary of Terms



*Many of the terms found within this glossary are not within the text of the guide or the decision tree, but the reader will find the definition of terms helpful when working with residents in long term care facilities.*

**Benchmark plan** – A Medicare Part D Plan whose premium rates are at a CMS approved level for that region. Dual eligibles entering a nursing home may be automatically enrolled in one of these (if they are not otherwise covered) and residents in nursing homes should consider voluntarily choosing a “benchmark” plan to avoid the cost of premiums and high co-pays.

**Catastrophic coverage** – This is the phase in the Medicare prescription program that begins when the beneficiary satisfies the TrOOP requirement.

**CMS** - Centers for Medicare and Medicaid Services - CMS is the federal government agency that administers Medicare and the prescription drug benefit, as well as Medicaid.

**Co-insurance** – The percentage of the cost of the drug a beneficiary pays to get a prescription.

**Co-payment** - A specified dollar amount that a beneficiary must pay out-of-pocket for a specified service at the time the service is rendered, also called a co-pay.

**Cost-sharing** - The out of pocket contribution a beneficiary makes to their cost of care. This includes deductibles, premiums, co-insurance and co-payments.

**Coverage gap** – The phase in the Medicare prescription program that the beneficiary will pay 100% of the cost of the drugs until their total out-of-pocket costs reach a designated amount, qualifying them for catastrophic coverage, which is the next phase.

**Creditable coverage** – Documented health care coverage beyond the dates a person is eligible to enroll in Medicare Part D, such as health care through employment. Creditable coverage is necessary to be exempt from the normal penalties applied for late enrollment in Part D.

**Deductible** - A flat dollar amount a beneficiary must pay before Medicare will pay for his or her prescription drug costs.

**De Minimis** – Premium Policy for Low-Income Subsidy Eligibles was established to eliminate the need to move low-income subsidy beneficiaries to new plans simply because their existing plan’s premium exceeded the low-income premium subsidy by a de minimis amount. Annually, CMS may establish the “de minimis” range that would apply for the next plan year. De minimis is a Latin expression meaning about minimal things.

**Dual eligible** - A beneficiary who is eligible for both Medicare and Medi-Cal.

**Employer-Sponsored Plan** - An employer-sponsored group prescription drug plan can operate either as or under contract with a PDP or MA-PD plan, or can provide retirees with drug coverage as part of the normal retiree health plan.

**FBDE** - Full-Benefit Dual-Eligible - Persons who are eligible for both Medicare and Medicaid (California’s Medicaid program is called Medi-Cal).

**FFP** - Federal Financial Participation - The process by which the federal government pays a portion of the costs of services provided to Medicaid recipients in the states. Each state receives its own percentage of the cost of covered services based on a specific formula.

**FPL** - Federal Poverty Level - A benchmark used to determine eligibility for various federal programs including Medicare and Medicaid.

**HICAP** - Health Insurance Counseling and Advocacy Program - A statewide program funded through both state and federal dollars to assist elderly individuals with questions regarding their health insurance benefits and resources.

**HICN** - Health Insurance Claim Number - The identifying number on the Medicare card you will need to enroll in Part D and/or access beneficiary specific information on the Medicare Prescription Drug Plan Finder on-line tool.

**HMO** - Health Maintenance Organization - A type of managed care plan in which a group of doctors, hospital, and other health care providers agree to deliver health care for a set reimbursement every month. If an individual is enrolled in an HMO, he or she generally receives care from the providers in the HMO’s network.

**IRO** - Independent Review Organization - An independent review organization is selected by Medicare. For MMA Part D that independent review organization is MAXIMUS Federal Services.

**LIS** - Low-Income Subsidy - Also known as extra help. A benefit through which the government pays for part or all of the Part D premiums for all Medicare Part D beneficiaries who have incomes that are below 150 percent of the federal poverty level (including all dual eligibles).

**LTCP** - Long Term Care Pharmacy - MMA describes the requirements of a long term care pharmacy which contracts with a PDP or MA-PD and refers to them as NLTCP. Requirements include all of the traditional services of a long term care pharmacy including drug utilization review, special packaging, on-call and delivery services. Plans are under an “any willing provider” requirement with respect to the NLTCP, but must have at least one contract to service long term care residents.

**MA-PD** - Medicare Advantage Prescription Drug Plan - MA-PDs are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans.” They are not supplemental insurance.

**MAXIMUS Federal Services** - Center for Health Dispute Resolution, is a group of experts on appeals. Medicare hired MAXIMUS Federal Services to look at denied appeals and decide if the health plan made the right decision. MAXIMUS Federal Services works for Medicare, not the Medicare health plan.

**Medi-Cal** - The California name for the federal Medicaid health program for low income individuals.

**Medicare HMO** - An HMO that has contracted with the federal government under the Medicare Advantage program (formerly called Medicare+Choice) to provide health benefits to persons eligible for Medicare who choose to enroll in the HMO, instead of receiving their benefits through the traditional Medicare fee-for-service program.

**MSPs** - Medicare Savings Programs - Beneficiaries of these programs are known as “partial dual eligibles” as they have slightly higher incomes than people who are full dual eligibles, and Medicaid only pays for cost-sharing associated with Medicare. MSP beneficiaries are automatically deemed eligible for the low-income subsidy.

**MTMP** - Medication Therapy Management Program - PDPs are required to develop and report details on their respective MTMPs to CMS. CMS asserts that MTMP will help to identify best practices that will evolve into industry practice standards and could eventually be adopted as CMS standards.

**MMA** - Medicare Modernization Act of 2003 - The federal law passed in 2003 establishes the Medicare Part D benefit and specifies many elements of the program, including how dual eligibles are treated.

**Part D** - The new prescription drug benefit component of the Medicare program. The prescription drug benefit will begin on Jan. 1, 2006.

**Part D Drugs** - A drug that is only available by prescription, approved by the Food and Drug Administration, used and sold in the United States and prescribed for medically acceptable conditions. Part D drugs include biological products, insulin, syringes, needles, gauze and alcohol swabs associated with the injection of insulin, and vaccines not covered under Part B. Following is a link to the list of all Part D drugs: [http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts\\_03.09.07.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf) However, if this link is not working, you may find the drug formulary list at the CMS website: <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Download>.

**Premium** - Regular monthly payments made to a health plan by beneficiaries for health care coverage.

**PDP** - Prescription Drug Plan (or Part D plan) - A private insurance plan that offers coverage for prescription drugs under Medicare Part D.

**RDS** - Retiree Drug Subsidy - The MMA establishes a 28% retiree drug subsidy. The subsidy payments reimburse plan sponsors for drug coverage they provide to retirees in lieu of Medicare drug coverage, encouraging them to continue offering the high quality coverage they have offered in the past.

**SEP** - Special Enrollment Period – Special Enrollment Periods are circumstances in which Medicare Beneficiaries are given an opportunity to enroll in a Part D plan outside of the Annual enrollment period. Full-benefit dual eligibles have a continuous Special Enrollment Period. They can change their Medicare prescription drug plan at any time.

**SHIP** - State Health Insurance Assistance Program - a state and federal funded program to provide assistance on questions relating to health insurance for the elderly and disabled.

**SSA** - Social Security Administration - The federal agency in charge of determining eligibility for the low-income subsidy.

**Step Therapy** – A series of drug or therapy choices required to be tried and shown to be ineffective before certain medications will be approved by a PDP. Each Plan has its own rules on step therapy.

**TrOOP** - True Out of Pocket – Costs for the prescription drug expenditures that count toward the annual out-of-pocket threshold that beneficiaries must reach before catastrophic drug coverage begins.

**TrOOP Facilitator** - Computer data base that tracks the out-of-pocket costs of Part D participants and provides information on which beneficiaries are enrolled in which Plan.



# Pharmacy/LTC Facility Medicare Part D Decision Tree

**ADMISSION**

1. Obtain medical and financial information from acute hospital, family, potential resident or representative prior to admission.
2. Prepare face sheet with Part D plan enrollment indicated, Medicare, Medi-Cal, Social Security number and date of birth.
3. Have family or help family apply for LIS (low-income subsidy.)
4. Send any update on insurance plans to LTC pharmacy.
5. Send copies of all insurance cards to pharmacy, including Medicare, Medi-Cal, any other insurance.

**MEDICARE/MANAGED CARE (Part A or skilled level)**

1. Send face sheet – include Part D enrollment information to pharmacy.
2. Note expected length of Medicare Part A coverage.
3. Identify secondary payer (family, insurance, Medi-Cal, Part D, other.)
4. Send copy of Medicare card to pharmacy.

**PENDING MEDI-CAL**

1. Ensure family applies for LIS.
2. Direct family to local county office for Medi-Cal application.
3. Send face sheet to pharmacy.
4. Talk to family about enrollment in a Part D "benchmark" plan (see list of plans.)
5. Talk to pharmacy about providing information to share with family/resident on Part D plans available.

**MEDI-CAL ONLY (for residents approaching Medicare eligibility)**

1. Meet with family to prepare for enrollment in a Part D plan.
2. Determine whether any other prescription coverage is in place (for example, retirement benefits.)  
**Note:** Co-pays will apply.
3. Determine approximate date of Medicare eligibility.
4. Track Part D enrollment process with family/resident.
5. Transmit information to LTC pharmacy.

**PRIVATE**

1. Determine Medicare eligibility.
2. Talk with family about choice of Medicare Part D plan **or**
3. Determine whether other creditable coverage is available (for example, retirement medical benefits.)
4. **If** also applying for Medi-Cal, inform pharmacy.
5. Send copy of Medicare card to pharmacy.

**IF PRIVATE RESIDENT APPLIES FOR MEDI-CAL**

**CURRENT RESIDENT**

Current residents may change billing status from skilled level) Medicare Part A or managed care) to custodial (Medi-Cal or private.) In addition, a resident may become eligible for Medicare on his/her 65th birthday.

**CHANGE OF BILLING STATUS**

1. Notify pharmacy when Medicare Part A days expire or when managed-care/skilled-level days are exhausted.
2. Notify pharmacy upon discharge/expiration of resident.

**RESIDENT TURNS 65 YEARS OF AGE**

1. Determine date resident becomes eligible for Medicare.
2. Meet with family to review PDP choices.
3. Send PDP choice information to pharmacy 30 days prior to status change.
4. Send information on date of status change.

**PRIVATE PAY TO MEDI-CAL**

1. Determine time frame of the switch.
2. Ensure resident enrolls in a benchmark plan (see list.)
3. Inform LTC pharmacy 30 days prior to switch.
4. Direct family to local welfare office for assistance.
5. Ensure resident applies for LIS.

**MEDICARE RESIDENT IS BILLED AS CO-PAY**

1. Determine when resident will have been in facility for 30 calendar days from admission.
2. Contact pharmacy provider whenever a co-pay bill is received, determine why co-pay billed.
3. Contact PDP and provide face sheet, admission information.
4. Request that PDP change resident to **full-benefit dual-eligible (FBDE)** with zero co-pay (see manual.)

