As the MMA Storm Moves Toward Us...

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

In the first issue of *ALC* we described a brewing storm with an uncertain future. Now with the release of the final rule for the Medicare Modernization and Improvement Act (MMA) on January 21, 2005, the storm path is a little clearer. There are still many questions to resolve, but we finally have some answers. So while the storm is still a ways off shore, it is easier to picture where the rain will hit; and we can begin to envision clearer skies in the future.

CMS Changes the Definition...Maybe

Historically, when the Centers for Medicare and Medicaid Services (CMS) talked about long-term care (LTC), the agency really meant skilled nursing facilities (SNFs). Now, in the final MMA rule, CMS may have opened the door to include some ALFs by expanding the definition of a LTC facility to include a medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid. Still, CMS insists that ALFs are not LTCFs—particularly when it comes to issues involving payment or reimbursement. Fortunately, this is by no means the end of the issue. Several national organizations are working with CMS to find a way to get assisted living included in this definition.

So what's in a name? The expanded definition of a LTC facility has many implications because of the special rules that apply to LTC residents and the pharmacy providers that support LTC facilities. First, LTC residents are allowed a special enrollment period (SEP), which allows them the ability to change prescription drug plans (PDPs) (see sidebar on page 16) at any time. This is critical in maintaining the relationship between LTC residents and LTC pharmacy providers, who may or may not have been a networked provider in their community-based plan.

Important Dates for Medicare Part D Plans

Notice of Intent to Bid	2/18/05
Application	3/23/05
Formulary	4/18/05
Bid	6/06/05
Plan Announcements	9/01/05
Marketing	10/01/05
Enrollment begins	11/15/05
Part D Benefit Begins	1/01/06

Fitting the definition of a LTC resident also is important because of the financial benefit low-income beneficiaries receive. Copayments are waived for those with incomes less than 100% below the federal poverty level and reduced for those with incomes 135% or more below the federal poverty level.

Consider the real-life implication of these savings. A resident eligible for nursing home placement chooses instead to take a community-based waiver and move into an ALF where he or she is subject to these copayments. These costs easily

could add up to $600 per year (10 branded medications x $5 x 12); whereas if this individual resided in a SNF, he or she would have no out-of-pocket expenditures. While $600 may seem like a small amount, it will be enough to move residents from an ALF to a SNF. What sense does this make when residents have to leave their homes and the state ends up paying much more than $600 to foot the bill for the move and the services the individuals will receive in the SNF?

With regard to LTC pharmacy providers, there are unique standards that differentiate them from community-based pharmacies. CMS currently is developing these standards, but the agency already has stated that it will include performance and service criteria that are uniquely required in LTC. And while ALF pharmacies deliver under similar standards, they will not be viewed any differently than community-based pharmacies—unless they come to fall under that definition of LTC.

Unbundling Benefits LTC, Not AL

CMS, by limiting the definition of dispensing, has forced pharmacy providers to unbundle, that is, separate billing for their services from costs for drug products. While LTC pharmacies will get some of these services covered under their unique agreements with Medicare drug plans, ALFs will not have this ability. ALF pharmacies still will need to unbundle their services and products. However, they then will have to hope that facilities or patients will be able and willing to pick up the bill for the services. Otherwise, they will have to eat the costs or hope that the facility will foot the bill.

In an ideal world, the facility would charge a medication therapy management service (MTMS) fee—covered by Medicare—to their residents and pass this through to their pharmacy provider. Provision for such a MTMS is included in the MMA and the Medicare Part D drug benefit. However, again, because ALFs are not considered long-term care facilities, they cannot benefit from this provision.

Instead, ALF pharmacies will need to demonstrate in real terms that they are different than community-based pharmacies and, therefore, deserving of additional payments. In looking at how they can voice this differentiation, pharmacists should consider the criteria the government has established for patients eligible to receive MTMS under the MMA:

- Have multiple chronic diseases
- Take multiple prescription drugs
- Are likely to incur high drug costs

Pharmacists need to outline the unique services they provide with these residents that are designed to maximize adherence, ensure safety, prevent medication-related problems, and reduce costs when possible.

Putting Up the Plywood

It is clear that ALFs need to prepare to weather this storm. To do this, they first should determine if they meet the definition of a LTC facility. If the answer is yes, they need to work with their pharmacy providers to make sure that they are networked with at least one Prescription Drug Plan (PDP) that is appropriate for ALF residents. If the answer is no, then the pharmacy provider needs to be networked with many PDPs to assure continuity of care (since residents cannot change from their community-based plan). For these non-LTC ALFs, it is important that the initial PDP selection is consistent with the facility.

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Introducing the PDPs...

A new entity—the Prescription Drug Plan (PDP)—is being established to administer the new Medicare prescription drug benefit. With the implementation of these new PDPs, the drug benefit goes from being a government program (as it was under Medicaid) to a private initiative. Congress believes that the free market nature of private PDPs will increase competition and drive down prices.

It has yet to be determined precisely how the PDPs will function. Congress left it to CMS to establish the details of the programs. And the agency is giving the PDPs tremendous leeway and flexibility regarding the design of their plans.

PDPs will be at risk only for medication costs. Patients will pay their premiums directly to the PDP, and the PDP will provide whatever medications those patients need as part of the drug benefit program.

In addition to the PDPs, there are two other options for implementing the drug benefit:

- **Medicare Advantage Plans (formally Medicare+Choice)**. Up to 13% of beneficiaries are expected to end up in these plans, which likely will be more popular with younger beneficiaries.
- **"Fallback" plans**. These plans, which CMS will set up and contract with Pharmacy Benefit Managers (PBMs) or other private companies to manage, will be used only in regions of the country where there aren't two or more choices of plans. To date, CMS does not anticipate the need for these fallback plans.

At Congress' direction, CMS has divided the country into regions for the purposes of implementing the drug benefit. There are 34 regions for the PDPs and 26 for the Medicare Advantage Plans. Consumers must have at least two choices per region—either two PDPs or one PDP and one Medicare Advantage Plan.

In either case, residents and staff will need education about what options are available, what use of the PDPs will mean, and how these plans will work.

Ultimately, this storm preparation really comes down to three elements: education, planning, and collaboration. You already are working on the education piece by reading articles in *ALC* on MMA. Planning begins with providing resources to your staff and residents so that they can operate in an efficient and effective manner. Lastly, collaboration—including communication and cooperation between the full care team—will enable everyone to work together to ensure that residents have access to the medications they need.

Strategies for weathering this storm are becoming clearer as we learn more about the final plans for the MMA and the prescription drug benefit. Facilities that begin preparing now are more likely to come through the turmoil safely; they then will be able to focus on what they do best—providing a safe, healthy, and happy home for millions of our nation's seniors. ALC

Special Treatment for LTC

Residents	Special Enrollment Period Copayments Waived for dually eligibles
Pharmacy Providers	Unique Any Willing Provider Standards PDPs required to include LTC pharmacies in their network
Plans	Special risk adjuster for institutionalized enrollees

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For a listing of special MMA-related Web sites, please see Suggested Resources on page 34.

Negotiating the Complexities of the Long-Term Care Continuum
(continued from page 14)

The Future of ALFs in the LTC Continuum

For ALFs, advancing better understanding of quality and affordability requires study to develop and test systems of care designed to optimize outcomes. Such research includes exploring innovative team and financial models to address the housing and care needs of all seniors.

ALFs face a particularly difficult task of juggling the need for consumer choice and autonomy while keeping costs in check. At the same time, they need to provide these services to a medically disparate and often frail or failing aging population that will continue to accumulate disabilities with advancing age.

A variety of allied health care professionals, most prominently physicians trained and skilled in the care of aging patients, can provide consultation and direction to aid ALFs in developing appropriate and effective systems of screening, evaluation, and ongoing care.

Overcoming the challenges, establishing effective systems and processes, ensuring that residents are safety and comfortable, and providing effective staff education will go a long way toward making ALFs a powerful and enduring part of the long-term care continuum. And effective and innovative facilities, staff, and practitioners can see to it that the continuum is smooth and seamless. ALC

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