Determining the Best ALF Prescription Drug Plans

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

Any day now, the Centers for Medicare and Medicaid Services (CMS) will announce the prescription drug plans (PDPs) that have been approved to administer the Medicare prescription drug benefit. However, assisted living facilities should begin planning now to evaluate these plans and prepare to identify and recommend the best plans for their residents.

Each plan differs on premiuns charged and administrative processes (eg, prior authorization). They also have their own pharmacy network and benefit designs with regard to medications access as well as coverage for such services as medication therapy management services.

Prescription Drug Plan Evaluation

To evaluate plans, residents, family members, and other can utilize the CMS PDP tool finder through www.cms.gov. This tool is expected to be up and running by October 15. It first asks for some basic demographic information, including:

- Medicare claims HICN #
- Last name
- Date of birth
- Part A or B effective date
- Zip code

- Medications
- Preferred pharmacy

Using this information, the tool finder produces a comparative list of plans based on the total cost of listed medications and preferred pharmacy information (see Table 1).

Assisted living facilities that wish to consider what would be the best PDPs for their residents should look at several aspects of the plans. These include:

- *Administrative processes.* How simple is the prior authorization process? What kind of transitional period does the plan have to provide new enrollees access to non-formulary drugs for a period of time?
- *Formulary.* Does the formulary include medications that are most commonly used by your resident population? Are there many drugs on the formulary that are considered inappropriate for elderly patients?
- *Packaging.* The availability of special packaging, such as bubble packs, will be required for beneficiaries who are nursing facility residents. However, these are not required for ALF residents. However, some PDPs are providing coverage for special packaging as an incentive to enrollment. This is a useful consideration for ALFs.
- *Pharmacy networks.* Is the plan connected to the pharmacy or pharmacies your facility uses? If not, what pharmacies are in their network? How convenient are they? What services do they offer?

Table 1.
Plan-Find Worksheet

Plan	Best Plan	Worst Plan
Premium		
Common ALF Medications		
Medication Therapy Management Services		
Special Packaging		
Pharmacy Network		
Comments		

While facilities can't mandate that their residents enroll in any specific plan, they can—and should—offer some guidance and information. This may involve partnering with a local aging/senior organization and arranging for individual counseling sessions. It also will be useful to organize lunches for residents and/or family programs with guest speakers talking about how to choose a PDP. If they haven't done so already, facilities should send out letters to residents and family members alerting them about what they should watch for in the mail and the timeline for the new prescription drug benefit and PDP enrollment.

While facilities can't mandate that their residents enroll in any specific plan, they can—and should—offer some guidance and information.

An announcement about the CMS-approved prescription drug plans on October 1, 2005, marks the first public look at the plan designs. The agency also will begin a massive educational campaign at this time which will target beneficiaries through national and regional/local grassroots efforts. This will be accompanied by plans marketing their unique characteristics to Medicare beneficiaries, who can enroll in their chosen plan on November 15. Dual eligibles (those who get both Medicare and Medicaid) will be auto-enrolled in a plan; however, they can switch plans without penalty at any time. However, non-duals, whose enrollment in the prescription drug plan is voluntary, only can enroll without penalty until May 15, 2006.

While there is much work for ALFs to do as the plans roll out and the drug benefit nears its January 1, 2006, effective date, these facilities should know that they don't have to reinvent the wheel or function in isolation. Rather, they can utilize several excellent resources, including a number of useful Web sites such as:

- Medicare (1-800-MEDICARE) *www.medicare.gov* & *www.cms.gov*
- Social Security Administration *www.ssa.gov*
- State Health Insurance Counseling And Assistance Programs (SHIPs) *www.shiptalk.org*
- Kaiser Family Foundation *www.kff.org*

- Medicare Today
  www.medicaretoday.org
- Access to Benefits
  www.accesstobenefits.org
- American Society of Consultant Pharmacist
  www.ascp.com
- American Geriatrics Society
  www.americangeriatrics.org
- American Medical Directors Association
  www.amda.com

Action Plan for ALFs

With all the confusion circulating regarding Medicare prescription drug plans, it often is lost how significant the financial benefit is for Medicare beneficiaries may be. With the average Medicare beneficiary spending $1,457 per year, the White House, Congressional Budget Office, and other sources suggest that seniors—especially those with high monthly drug costs—will experience savings of 10-20% or even more.[1] However, these savings are less certain if a senior chooses a plan that does not meet his or her needs.

ALFs that take the lead on working with their residents to help them make the best PDP choice are likely to have happier seniors in their residences. When residents can afford their drugs, they also are likely to be healthier and more compliant with therapies.

There is no doubt that the new Medicare prescription drug benefit is confusing, that it requires time and effort to understand, and that it will require more time, effort, and extensive coordination to implement. However, by taking a proactive and positive approach to Part D, ALFs ultimately will benefit their residents. ALC

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is Editor-in-Chief of *Assisted Living Consult*.

Reference

1. The Kaiser Family Foundation. Actuarial Research Corporation Analysis for The Kaiser Family Foundation. Washington, DC: The Kaiser Family Foundation 2003, 2004.

Exercise and Fall Reduction in Assisted Living

(continued from page 19)

Services. *Physical Activity and Health: A Report of the Surgeon General*, 1996.

9. Evans WJ. Exercise training guidelines for the elderly. *Medicine and Science in Sports and Exercise* 1999; 31: 12-17.

10. National Institutes of Health. *Consensus Development Conference Statement, Physical Activity and Cardiovascular Health*, December 1995.

11. Frank JS, Patla AE. Balance and mobility challenges in older adults: Implications for preserving community mobility. *American Journal of Preventive Medicine* 2003; 25: 157-163.

12. IMPACT. *Preventing Falls and Fall-Related Injuries in Manitoba: A Review of Best Practices*, March 2005.

13. Lord SR, Castell S, Corcoran J, Dayhew J, Matters B, Shan A, Williams P. The effect of group exercise on physical functioning and falls in frail older people living in retirement villages: a randomized, controlled trial. *Journal of the American Geriatrics Society* 2003; 51: 1685-1692.

14. Carter ND, Khan KM, McKay HA, Petit MA, Waterman C, Heinonen A, Janssen PA, Donaldson MG, Mallinson A, Riddell L, Kruse K, Prior JC, Flicker L. Community-based exercise program reduces risk factors for falls in 65- to 75-year-old women with osteoporosis: randomized controlled trial. *Canadian Medical Association Journal* 2002; 167: 997-1004.

15. American Geriatrics Society, British Geriatrics Society, American Academy of Orthopaedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. *Journal of the American Geriatrics Society* 2001; 49: 664-672.

16. Province MA, Hadley EC, Hornbrook MC, Lipsitz LA, Miller JP, Mulrow CD, Ory MG, Sattin RW, Tinetti ME, Wolf SL. The effects of exercise on falls in elderly patients. A preplanned meta-analysis of the FICSIT Trials. Frailty and Injuries: Cooperative Studies of Intervention Techniques. *Journal of the American Medical Association* 1995; 273: 1341-1347.

17. Shivonen S, Sipila S, Taskinen S, Era P. Fal incidence in frail older women after individualized visual feedback-based balance training. *Gerontology* 2004; 50: 411-416.

18. Campbell AJ, Robertson MC, Gardner MM, Norton RN, Buchner DM. Falls prevention over 2 years: a randomized controlled trial in women 80 years and older. *Age and Ageing* 1999; 28: 513-518.

19. Robertson MC, Campbell AJ, Gardner MM, Devlin N. Preventing injuries in older people by preventing falls: A meta-analysis of individual-level data. *Journal of the American Geriatrics Society* 2002; 50: 905-911.

20. Delbaere K, Crombez G, Vanderstraeten G, Willems T, Cambier D. Fear-related avoidance of activities, falls and physical frailty. A prospective community-based cohort study. *Age and Ageing* 2004; 33: 368-373.

21. Wolf S, Sattin R, Kutner M, O'Grady M, Greenspan A, Gregor R. Intense tai chi exercise training and fall occurrences in older, transitionally frail adults: a randomized, controlled trial. *Journal of the American Geriatrics Society* 2003; 51: 1693-1701.

22. Sattin RW, Easely KA, Wolf SL, Chen Y, Kutner MH. Reduction in fear of falling through intense tai chi exercise training in older, transitionally frail adults. *Journal of the American Geriatrics Society* 2005; 53: accessed August 8, 2005 at: www.blackwellpublishing.com.

23. Li F, Harmer P, Fisher KJ, McAuley E, Chaumeton N, Eckstrom E, Wilson NL. Tai chi and fall reductions in older adults: A randomized controlled trial. *Journal of Gerontology, Medical Sciences* 2005; 60A: 187-194.

24. Avidan A, Freis BE, James ML, Szafara KL, Wright GT, Chervin RD. Insomnia and hypnotic use, recorded in the minimum data set, as predictors of falls and hip fractures in Michigan nursing homes. *Journal of the American Geriatrics Society* 2005; 53: 955-962.

25. King AC, Oman RF, Brassington GS, Bliwise DL, Haskell WL. Moderate-intensity exercise and self-rated quality of sleep in older adults. A randomized controlled trial. *Journal of the American Medical Association* 1997; 277: 32-37.

26. Myers AM, Malott OW, Gray E, Tudor-Locke C, Ecclestone NA, Cousins SO, Petrella R. Measuring accumulated health-related benefits of exercise participation for older adults: the Vitality Plus Scale. *Journal of Gerontology, Medical Sciences.* 1999; 54: M456-M466.

27. Colcombe S, Kramer SF. Fitness effects on the cognitive function of older adults: A meta-analytic study. *Psychological Science* 2003; 14: 125-130.

28. Weuve J, Kang JH, Mason JE, Breteler MM, Ware JH, Grodstein F. Physical activitiy, including walking, and cognitive function in older women. *Journal of the American Medical Association* 2004; 292: 1454-1461.

29. Li F, Fisher KJ, Harmer P, McAuley E. Falls self-efficacy as a mediator of fear of falling in an exercise intervention for older adults. *Journal of Gerontology, Psychological Sciences* 2005; 60B: P34-P40.

30. Jones CJ, Clark J. National standards for preparing senior fitness instructors. *Journal of Aging and Physical Activity* 1998; 6: 207-221.

31. Saelens B, Sallis J, Black J, Chen D. (2003). Neighborhood-based differences in physical activity: an environmental scale evaluation. *American Journal of Public Health* 2003; 93: 1552-1558.

32. Dunlap J, Barry HC. Overcoming exercise barriers in older adults. *The Physician and Sports Medicine.* 1999; 27. Accessed August 8, 2005 at www.physsportsmed.com/issues/1999/10_15_99/oct99.htm.

33. Centers for Disease Control. Missed opportunities in preventive counseling for cardiovascular disease: United States: 1995. *Morbidity and Mortality Weekly Report* 1998; 47: 91-95.