Experts' Roundtable

In each issue of *ALC*, we will ask a panel of experts to comment on a pressing issue of the day. Watch for this roundtable, and let us know if you have any suggestions regarding experts you would like to hear from or questions you would like to see addressed.

Now that the Part D plans have been announced, what do you think? Are there any surprises for ALFs?

Albert Riddle, *MD*
National Corporate Medical Director, NeighborCare
President of Riddle Medical Group, LLC
Corporate Medical Director, Northern Services Group of Rockland County
Garnerville, NY

There are no real surprises but many concerns. My main concern is that you have AL residents who—if you look at them—really aren't much different from those you see in a typical skilled nursing facility in terms of comorbid and chronic medical conditions. But when you look at the number of medications AL residents take compared to nursing facility patients, the AL folks are taking more medications on average to treat the same conditions.

It's hard to pinpoint a single reason for this. One contributing factor is that regulations are much different in assisted living, and there isn't the same type of collaboration between attending physicians and consultant pharmacists to manage residents' drug regimens and address polypharmacy and other drug-related issues (such as the use of antipsychotics). There also is less influence of the Beers criteria and other components of the survey process that are designed to oversee medications.

We know that elderly institutionalized residents require special packaging that may not be required for younger, healthier populations. When the Medicare Modernization Act was finalized, however, AL was not included in the definition of long term care; so we're left to wonder how ALFs are going to deal with the fact that they are excluded from some of the benefits that nursing facilities have, even though their residents are very similar in terms of medication needs. I think you will see ALFs making deals with pharmacy providers to get some of their special needs met. Otherwise, they will run the risk of getting hit with additional dispensing fees that pharmacies will require to get the drugs residents need in the forms that they need.

We need to do whatever we can to increase the sensitivity of prescription drug plans and to communicate to PDPs that AL residents have many of the same special needs as skilled nursing facility (SNF) residents. This will take a certain amount of education, and it won't be easy.

In terms of formularies, there isn't much difference between ALFs and SNFs. As primary care providers, we will have to be prepared to deal with additional administrative processes involved in ensuring necessary access to non-formulary medications. This will require prompt action by physicians, coordination between physicians and pharmacies, and everyone's commitment to navigating the appeals process as needed. As physicians work with residents and their families, particularly at the start of Part D implementation, these practitioners will need to make themselves fully aware of what plans will be available to their patients. Physicians will need to learn about the formularies, which ones offer the broadest therapeutic range, and which ones will make it the easiest for physicians to access drugs not on the formulary.

I'm concerns about some of the drugs that are not covered under any circumstances. I understand that we need to be careful about the use of benzodiazepines in the elderly. However, we have residents who have been on these medications for a long time; and we need to consider now how we will wean them off of these drugs or make arrangements to pay for these medications another way. It is important that we not wait until next year and end up making fast, rapid, or sudden changes that would be detrimental to our residents.

In some ways, Part D presents a wonderful opportunity to take advantage of medication management therapy services to look at medication regimens, outcomes, and the potential for adverse events. Maybe we can use this as a chance to reduce polypharmacy and document what we are getting from medications in terms of outcomes.

Alec Pruchnicki, *MD*
Instructor of Medicine, New York Medical College
Attending Physician, St. Vincent's Hospital
New York, NY

I haven't seen the specific plans, but the overall plan is pretty poor for my patients, 90% of whom are dual eligibles. The entire program is overly complicated and subsidizes HMOs, drug companies, and private corporate insurers, thus siphoning off funds from the main Medicare trust fund. How restrictive the formularies will be is also unclear.

There may not be surprises, since many of these problems are clearly predictable. Many ALFs that I am familiar with use a single pharmacy that supplies all of the residents. This makes it a lot easier for the nursing staff to handle orders, deliveries, billing, and monitoring. If residents or their families start signing up with various drug plans, chaos could ensue—as not all plans may be tied into the facility's preferred pharmacy.

Furthermore, some of these plans may require HMO enrollment, which could disrupt established patient-

doctor relationships. Many of both the pharmacy and HMO plans have lock-in provisions, and patients cannot easily disenroll if problems arise. This could produce medical problems for residents and significant administrative problems for the nursing staff.

As an onsite ALF physician, this could be a major problem for me. My practice survives partially because my overhead is low. Having 90% of my patients enrolled in the same insurance program, ie, Medicare/Medicaid, makes billing very easy and avoids most pre-approvals, authorizations, restrictive vendors or consultants, and so on. If many of my patients start to enroll in different pharmacy plans—or, worse still, in different HMOs—my practice may no longer be viable.

Are there solutions? My facility, myself, and our present pharmacy have started to develop a plan to avoid these problems. The pharmacy is reviewing all the available plans and is trying to identify just a few that best meet our residents' need. Then the administrative and nursing staff, the pharmacy representative, and myself will sit down and try to pick just one plan based on formulary, preauthorization, prices, and other factors. We then will present this choice to the residents and try and convince them to enroll in this one plan. We also will have to have a back-up plan for those who want to choose an alternative or if our choice turns out to be problematic for certain residents. We're hoping this will minimize possible problems. Wish us luck.

Diane Crutchfield,
PharmD, CGP, FASCP
President
Pharmacy Consulting Care
Knoxville, TN

It is difficult to evaluate the potential impact of the prescription drug plans (PDPs) and Medicare Part D on ALFs because regulations overseeing these facilities vary widely from state to state. For many residents, especially those who pay for medications privately, Part D will offer a significant benefit. In addition, it will be a huge advantage for low income individuals who previously weren't able to afford the medications that they needed (although there are traditionally fewer of these patients in ALFs than in SNFs).

Clearly, some issues have yet to be fleshed out; and we will have to watch for developments in these areas. For example, some state Medicaid programs have indicated that they are willing to pay for medications not covered by Part D; but we don't know yet which states will do this and what drugs they will cover or exclude. All of this will have implications for facilities and the pharmacies with which they work. The pharmacies, for example, will have to pull these drugs out separately and bill the state for them, while billing PDPs for the others. There remains the possibility that some PDPs will opt to cover some of these "excluded" medications to avoid the possibility of physicians ordering other, more costly medications.

While CMS didn't change the definition of long term care to include assisted living, the agency has clarified that PDPs can provide reimbursement for special packaging to long term care pharmacies serving ALFs. Of course, this kind of thing is harder to track in ALFs, where some residents use the facility's preferred provider, while others use a community or mail-order pharmacy. More than ever, it will be important for facilities and practitioners to know what physicians residents are seeing, what medications they are taking, and where they are getting their prescriptions filled in order for them to take full advantage of the Medicare drug benefit.

ALF residents, including those who are dual eligibles, are not exempt from prescription drug copayments. Only the dual population residing in an institutional facility is exempt. This may cause some confusion among beneficiaries. However, this special population of duals can change PDPs at any time, whether they reside in an ALF or SNF. Non-duals only may change plans annually during the open enrollment period.

Another area in which I've encountered some confusion regards the automatic enrollment of dual eligibles. It is my understanding that duals will be randomly auto-enrolled to a PDP by CMS if they do not choose a plan by December 31. Facilities should work closely with the pharmacy to assure that all dual eligible residents are signed up for a plan because Medicaid will no longer pay for medications as of January 1, 2006.

Education will be key to how effective the new Medicare prescription drug benefit is. The CMS Web site (www.cms.hhs.gov) has a great deal of helpful information, both for the patient and for the provider. You may have to dig a little, but it's there. Recently, the agency posted two slide decks that you can download and use for educating staff and residents/families. In addition, national organizations such as the American Society of Consultant Pharmacists (www.ascp.com) have excellent information and materials available for their members and others.

We need to remember that this information can be overwhelming and a little intimidating for our residents. We toss around phrases like "dual eligibles" all the time, but they generally don't even know what this means. We have to take the time to talk with them, patiently listen to their concerns and answer their questions, and help them find a plan that they are comfortable with and that best meets their needs, while following the marketing guidance requirements. ALC