The Impact of Medicare Part D

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In the preceding article, Dr. Stefanacci has done an excellent job of summarizing the status of Medicare Part D as of May 15, 2006. What do these changes mean to institutional pharmacies and our assisted living (AL) customers? What will the impact be on senior living options going forward? As with any ambitious undertaking that affects a large number of people, there are numerous details that need to be worked out. There are also portions of the Medicare-eligible population that have special needs that are not being addressed by Medicare Part D. Governmental support for the high cost of prescription medications utilized by seniors is a great idea. However, as with many broad programs, the devil is in the details.

The impact of the implementation of Medicare Part D has been enormous. Our pharmacy had been attempting to prepare for this program for over 2 years. We had been educating AL providers, residents and their families, and health care providers. A significant investment had been made in systems, training, and adding personnel to cope with the myriad of issues that we could predict. Yet, the confusion, lack of clear guidelines, miscommunication, lack of education, variation in state policies, added administrative burdens and, worst of all, interruptions in appropriate drug therapy have overwhelmed even the most prepared. Also, it has diverted *all of us* who are trying to take better care of seniors from quality initiatives to administrative logistics and survival.

Specifically, the impact on assisted living can be viewed from 4 perspectives:

- Residents (and their families)
- AL communities
- Health care providers
- Pharmacies

Let's start with the impact on AL residents and their families. The scariest consequences of Medicare Part D are the problems created when an individual's care transitions from one setting to another. A typical scenario would be a senior falls at home and fractures a hip, thus resulting in a hospitalization. After hospitalization, the patient is transferred to a rehab unit either in a skilled nursing facility or rehab hospital. Upon discharge, the patient may then move into an AL community because they can no longer function independently at home. All the while, the medications are changing and the formularies are different, depending on what is covered, by who, and where? Does this sound like safe continuity of care for our frailest population?

The complexity of the Medicare Part D Prescription Drug Plans

(PDPs), especially given their target audience, is almost mind-boggling. Expecting seniors to enroll online is only part of the absurdity. In AL communities, some degree of cognitive impairment is prevalent in over 50% of the residents and yet, giving guidance to these residents and their families in the selection of their PDP is not allowed. The majority of seniors surveyed stated that they would look to their physicians for advice on these issues. Yet, we have just learned that 94% of physicians remain confused about Medicare Part D, especially with regard to access for specific medications. It's not hard to understand why everyone is confused.

There have been numerous problems with interruption in therapy due to requirements (such as prior authorizations, quantity limits, step therapy, and changes in formularies) imposed by the PDPs in an effort to restrict access to higher-cost prescriptions. When Medicare beneficiaries change their PDP, these problems can then be compounded further.

At the end of the day, most of the complaints from AL residents are related to the coverage gap. Residents are frustrated over the savings being less than expected, particularly as they are hitting the "donut hole."

While initially most AL providers thought Medicare Part D was a pharmacy issue, most now recognize the significant impact on their operations. Their staff is spending inordinate amounts of time answering residents' questions and coping with the resulting confusion. The administrative burden related to prior authorizations alone takes time away from resident care, poses regulatory threats, and increases AL providers' liability related to medications always being available when they are needed. This often results in the AL community having to pay for emergency supplies of medications. While the relationship between a skilled nursing facility and its pharmacy is viewed as important, that is not the case in AL communities. Therefore, AL residents suffer under retail PDPs that promote 90-day medication supplies in vials—the least appropriate packaging for this population—which has been shown to reduce efficiency, increase the potential for medical errors and, again, take time away from other resident care activities.

Health care providers also are impacted negatively. As previously cited, 70% of physicians are spending 20% or more of their time on administrative tasks. This is time that is taken away from direct patient care, and obviously a tremendous waste of a valuable resource. Health care providers are confronted by new and customized procedures and formularies, and are finding it progressively harder to ensure optimal drug therapy for their patients. These issues could be reduced significantly if there was standardization of procedures and reporting.

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However, the greatest impact of Medicare Part D has been on pharmacies. Many of the institutional pharmacies had been focused on improving care, improving outcomes, and lowering costs. Now, they are distracted by the numerous Medicare Part D-related economic and administrative burdens placed upon them. The confusion has dictated that the organization that I am affiliated with hire an additional 6 full-time equivalents. This represents a staffing increase of almost 4% just to manage the questions, confusion, billing issues, prior authorizations, and changing PDP information. Additionally, this does not include the time our field nurses spend on answering Medicare Part D questions, rather than improving the medication management programs onsite.

Increased salary expense is not the only problem. The economic impact on cash flow and increased interest expenses related to slower collections has significantly impacted pharmacy operations. The number of denied claims has risen, and we now have staff who monitor inaccurate reimbursements from the PDPs on a full-time basis. It is becoming almost impossible to provide a range of services, such as compliance packaging and delivery, in an economically viable way. There are numerous pharmacies, mostly the smaller independents, that have been forced out of business, leaving communities and residents frantically searching for appropriate pharmacy services.

The AL population is among several disenfranchised stakeholders of the Medicare Part D debate. Those over 85 years of age comprise the fastest-growing segment of our population. The Centers for Medicare and Medicaid Services (CMS) should recognize this fact and be more responsive to its needs. Unfortunately, Medicare Part D was not designed to accommodate or promote any alternatives to skilled nursing. By making dually eligible beneficiaries residing in skilled nursing facilities exempt from copayments, CMS has created a significant disincentive for these seniors to live in alternate settings. Certain state waiver programs have offered AL communities as an alternative for nursing home-eligible individuals. Based on its lower cost and

more residential appeal, there has been a significant reduction in nursing home occupancy in these states. Numerous diversion programs in Oregon, Florida, and New York have demonstrated this.

Despite all the challenges, confusion, and chaos, I remain cautiously optimistic. Hopefully, many of the proposed legislative and regulatory changes will improve the current situation, particularly as it relates to AL residents. It is incumbent on pharmacies to prove the value of their added services. By documenting cost-savings from therapeutic interventions and drug regimen reviews and demonstrating better outcomes as measured by adherence to the Beers criteria, improving quality of life indicators, and decreasing lengths of stay, institutional pharmacies could better justify charging for additional clinical services.

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Pharmacies may need to explore new business practices, such as using credit cards to pay for products and services, rather than mailing statements. Technology can be utilized to create greater efficiencies, but requires significant capital investments. The most disturbing factor is that all the time spent on dealing with the issues created by Medicare Part D could have been better spent on improving care models. ALC

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Integrated Solutions Mean New Independence for Residents

(continued from page 10)

environmental change from the traditional continuing care center that residents previously occupied to that of the Kipnes Centre. Researchers are observing ways the veterans, their families, and the staff use the public spaces in the center, how residents adapt to the home-like features, whether they find the buildings user-friendly, and if mealtime atmosphere has a positive impact on consumption and nutrition. Because it is rare to move an entire group of people from one facility to another that's so different, and be able to observe the changes and implement positive results elsewhere, researchers consider this a unique opportunity to develop a comparative analysis.

The CAPITAL CARE *Group* is uniquely positioned to accomplish this feat. The public company, a wholly owned subsidiary of Capital Health, is among the few continuing care providers in Canada with a dedicated research unit. Its experience in building modern continuing care centers started in 1995 with McConnell Place North in Edmonton (Canada's first residential care center for people with Alzheimer's disease) and has culminated in the Dianne and Irving Kipnes Centre for Veterans as its most recent endeavor.

In keeping with its decade-long drive to become the Western Canadian leader in practice-based research, on-site student training, and evidence-based practice, *The* CAPITAL CARE *Group* is planning a continuing care teaching center in downtown Edmonton, in collaboration with the University of Alberta and NorQuest College. It envisions a center of excellence that integrates clinical care with education and research for seniors in continuing care and supportive living environments. Historically in Canada, teaching and research have not been intentionally incorporated into continuing care settings, despite the obvious need—continuing care beds outnumber those found within acute care facilities, where most of the research has taken place. In contrast, within the teaching nursing homes developed and evaluated in the United States, Hempel says significant positive outcomes have been documented, including improved quality of care for residents, as well as benefits for the health care professionals and researchers affiliated with these settings.

Integrated technology systems enable residents to wander freely in secure areas, including all common areas.

"Our model has been replicated in a number of places in Canada," says Hempel. "It's a model that really makes residents feel at home." ALC

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