Medicare Reform’s Impact on Long-Term Care

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In late June of last year, both the House and the Senate passed the most meaningful Medicare reform legislation since Medicare’s inception in 1965. As luck would have it, this occurred just days before I joined Centers for Medicare and Medicaid Services (CMS) as a Health Policy Scholar. This role provided me not only a front row seat, but a place on the playing field as CMS works to operationalize the Medicare Modernization Act of 2003 (MMA). It is this perspective of MMA with attention to its impact on long-term care (LTC) residents and providers that I analyze here.

To start, there will be two major points of impact felt by LTC as a result of MMA: pharmaceutical access and the expanded role of managed care. Pharmaceutical access became a major issue for LTC when, in the concluding hours of this legislation, the pharmacy benefit was moved from Medicaid to Medicare significantly affecting the dually eligible beneficiary. “Dually eligible” refers to those Medicare beneficiaries who have full Medicaid benefits, including fairly unlimited pharmaceutical access. As a result, the vast majority of LTC residents will be forced from the Medicaid pharmacy benefit to the new Medicare Part D pharmacy benefit, which starts in 2006. This program will be offered through private risk-taking prescription drug plans (PDP) that can either operate within fee-for-service Medicare or as part of a Medicare managed care program. It is important to realize that LTC to the federal government is very different than what most of us involved in senior care think; LTC is only nursing facilities and not assisted living or other nonnursing home settings. As a result, all of these nonnursing home settings are instead considered in the same manner as any community-dwelling senior with no special consideration given despite their increased needs.

The second point of impact will be felt by the addition of specialized Medicare Advantage (MA) plans. Medicare Advantage is the new term for all Medicare managed care programs, which all include managed Medicare plans such as Medicare+Choice organizations as well as Preferred Provider Organizations (PPO). New types of MA plans now available as a result of MMA are specialized MA plans. Specialized MA plans offer the opportunity to expand managed care into nursing homes in a way not previously available. This is the result of allowing managed care plans to focus solely on institutionalized seniors within a particular facility rather than having to serve the entire population in a large geographic region.

PHARMACEUTICAL ACCESS
LTC is treated differently than community-based seniors. This differentiation arose from the fact that the authors of the Medicare legislation recognized that LTC is very different from community care. The characteristics of nursing home residents differ greatly from the average Medicare beneficiary. Nursing home residents are more likely to be widowed, indigent females with an average age of 85. They take 10 medications on average per day for a range of comorbid conditions and often report their health to be fair to poor. As a result of these unique demographics, nursing home delivery systems have evolved to care for residents’ specific needs. One such system that the legislation seems intent on maintaining is the specialized nursing facility pharmacy provider.

Currently, specialized nursing home pharmacy providers deliver the majority of pharmaceutical services to nursing home residents. The need for specialized services in nursing facilities is based in part on federal regulations, which are very much outcome-oriented. This is, in part, the result of such regulations as FTAG 332/333, which states that the facility must ensure that it is free of medication errors and that its rates be less than 5%. As a strategy to meet this medication error outcome requirement, pharmacists have used unit-dose or special packaging, which are not commonly available through community pharmacies. In addition, these systems of delivery have improved the efficiency of medication nurses by reducing the time needed to administer medications. Another example, FTAG 425, requires the facility to provide routine and emergency drugs to its residents, and this has evolved into a 24/7 access standard that is met through nursing home pharmacy providers. As a result of these regulations, as well as state regulations and standards of practice that govern...
nursing facilities, specialized nursing home pharmacy providers provide the majority of medications to nursing home residents. Because of these mandates, which are based on quality-of-care concerns, MMA has found it necessary to maintain this unique relationship through a provision in the legislation titled convenient access in LTC facilities. CMS has an obligation to safeguard this current practice of care.

How exactly the final regulation will be written is still up for debate. To help provide guidance into the regulation writing process, CMS is mandated by MMA to provide a review and report on current standards of practice for pharmacy services provided to patients in nursing facilities. The specific matters reviewed include assessment of the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in nursing homes and evaluation of the impact of these standards with respect to patient safety, reduction of medication errors, and quality. This report is to guide policy in this area, although the late delivery of this report to Congress in mid-2005 will make its impact on the initial regulations minimal. One option being promoted now by several pharmacy-consulting and nursing home pharmacy provider associations calls for a certification of necessity for Medicare beneficiaries in need of these services. The benefit of this certificate is that it could apply outside the walls of the nursing facility and touch seniors in the community and assisted living facilities who currently receive and benefit from this specialty pharmacy service.

Although the new Part D Medicare Pharmacy Benefit will not be available until January 2006, the first portion of the Medicare pharmacy program to be implemented is the Medicare Endorsed Discount Card Program. This began as a benefit in June 2004. As noted, the Medicare legislation recognizes the uniqueness of LTC pharmacy management and, as a result, has provided for the endorsement of three nursing home specialty providers through a competitive process. Unlike the general discount cards, which promise to offer seniors who sign up an estimated 15% to 20% reduction off of market rates for the purchase of medications, these nursing home discount cards only need provide the transitional assistance. The transitional assistance refers to a $600 annual benefit as being provided to low-income beneficiaries. Those below 135% of the federal poverty level who are Medicaid beneficiaries are excluded from the transitional benefit. However, it is anticipated that nursing home residents that are spending down assets to qualify for Medicaid will take advantage of this benefit. This $600 benefit is not restricted by any plan sponsors formulary but does have some Medicare-imposed restrictions.

This raises the issue of restrictions in pharmaceutical access secondary to formularies. PDPs can choose to follow a formulary with therapeutic categories as described by U.S. Pharmacopeia or design their own formulary classes provided they do not discriminate against any group of Medicare beneficiaries. As pharmaceutical benefit managers have done in the past, formularies will force some level of restriction on the access to pharmaceutical products that are not commonly felt through the Medicaid pharmacy programs. In addition to the PDP-imposed restrictions, and because of the very restrictive man-
pharmacy benefit should be no different than the Medicaid benefit for LTC residents. However, although pharmaceutical access from a financial standpoint might not change, there could be some restrictions for LTSS residents and the continued availability of specialized LTC pharmacy services, the exact level of which will not be fully understood until we get closer to the program’s implementation on January 1, 2006.

SPECIALIZED MEDICARE ADVANTAGE PLANS

Although the prescription benefit received the majority of the attention in the legislation, another area of focus is managed care or rather, as it is now to be referred, Medicare Advantage. MMA has provided for a means for managed care to have a major impact on nursing facilities through the provision on specialized MA plans. Specialized MA plans can serve one of three groups: institutionalized seniors, dually eligible, or a disproportionate share of those with chronic illnesses. There were two programs specifically identified in the MMA conference report, United Healthcare’s EverCare and the Wisconsin Partnership. These models have demonstrated their ability to produce improved outcomes over fee-for-service. Because of the specialized needs of nursing home residents, as well as the need for dually eligible to enroll with a PDP to receive their pharmacy benefits, it is likely that many more nursing facility residents will become part of an MA organization. Now all MA organizations, including United Healthcare’s EverCare and the Wisconsin Partnership, will begin to be paid based on risk adjustment, which means they will no longer receive the same Medicare reimbursement for their healthiest members as they do their sickest. Instead, based on diagnosis information submitted by physicians and collected by Medicare, a specific risk factor will be applied to all Medicare beneficiaries. As a result of this new system of payment, MA plans will move from trying to attract the healthiest members to attempting to attract those members who can have the greatest impact in controlling costs.

Although the major impact of MMA involves pharmaceutical access and the expanded role of managed care, there are other provisions that will affect nursing home patients and their care providers. Those specific provisions are the following:

- Physicians will see a 1.5% increase in Medicare reimbursement rather than the mandated 4.5% decrease for 2004. In 2005, an additional 1.5% increase will be applied to the Medicare reimbursement. The concern is in 2006 when an adjusted payment formula is applied that additional decreases of upward of some 5% will be realized.

- All rural providers will see an increase in Medicare reimbursement. This is in part an attempt to reconcile the significant disparity that exists currently between rural and urban providers.

- A small provision is in place to provide for criminal background checks for nursing home employees. Four states will pilot this new process, which could involve Medical Directors, because it will deal with direct patient care staff, including staff physicians and nurse practitioners.

- Physical therapy caps have once again been removed, although it is highly likely that this issue will be reintroduced in the future. Medicare’s need in the future to control spending could once again make these types of caps a reality.

- Nurse practitioners can now be recognized as attending care providers for hospice patients. This is a continuation of the expanded scope of practice for nurse practitioners, a trend that is likely to continue.

HEALTH SAVINGS ACCOUNTS

Lastly, it is noteworthy to mention the only portion of the legislation that does not have immediate impact on seniors but promises to affect how seniors in the future pay for their care: Health Savings Accounts (HSA). HSAs are available to any person who is insured solely by a high deductible cata-
strophic policy. As a result, Medicare beneficiaries are excluded. Dollars are put away in HSAs up to the deductible limit; these funds enter, grow, and exist without being taxed provided they are used for medical expenses. It is thought that HSAs will allow individuals to build a reserve of funds to pay for services not covered by Medicare such as long-term care facility costs. CMS expects these accounts to cover a significant portion of healthcare services for Medicare beneficiaries in the future. This could allow a larger percentage of non-Medicaid beneficiaries to occupy nursing facilities.

CONCLUSIONS

In the end, MMA could offer some positive impact for nursing facilities. If, for example, we are able to move to specialized MA programs based on an integrated multidisciplinary team approach, the result would be an efficient and effective system that promotes preventative measures using medications appropriately and gets away from the inefficient acute-care silos that currently exist. One thing is true; we will experience a major impact on how care is delivered in nursing homes. Perhaps it is no coincidence that soon after President Bush signed this legislation into law, Roto Rooter announced the purchase of the nation’s largest hospice provider; indeed, we are entering a strange new world.15

REFERENCES

7. MMA Section 107(b). Review and Report on Current Standards of Practice for Pharmacy Services Provided to Patients in Nursing Facilities.