MEDICARE PART D FROM THE MEDICAL DIRECTOR PERSPECTIVE

Daniel Haimowitz, MD, FACP, CMD
History of Medical Directors in LTC

- OBRA (1987) required for all NFs by October, 1990
- Medical Directors met in 1988: described 4 major roles, 9 broad functions & over 100 tasks
“The Medical Director shall ensure that residents receive necessary nursing, medical & other services to maintain the highest possible levels of mental & physical function & well-being, as defined by the comprehensive care plan.”
MEDICAL DIRECTOR
RESPONSIBILITIES

• Physician leadership
• Patient care—Clinical leadership
• Quality of Care
• Education, Information, and Communication
Roles and Responsibilities of Medical Directors

- Physician Leadership
- Quality of Care
- Education, Information, Communication
- Clinical Leadership
MEDICAL DIRECTORS AND MEDICARE PART D

• Patient Care- Clinical Leadership
  “Participate in administrative decision-making and the development of policies and procedures related to patient care”

• Education, Information, Communication
  “ Maintain knowledge of the changing social, regulatory, political, and economic factors that affect medical and health services of LTC patients”
TYPES OF MEDICAL DIRECTORS

- Full time
- Part time
- Corporate
- Rural, etc.
Who is the average medical director?

- 62% part time
- 80% serve as attending in their facility
- 71% have practices outside the facility
- Most serve more than one facility
- Average number of hours/month = 18
F-501 TAG

• Issued June 2005 (effective November)
• Clarifies requirements, defines medical director’s essential responsibilities
• Ensures that facilities have licensed physician medical director to provide clinical guidance and oversight regarding quality standards of practice
• Coordination of medical care and implementation of resident care policies
WORKING DAY OF A MEDICAL DIRECTOR

• Facility responsibilities (meetings, survey issues, physician coverage, etc.)
• Direct patient care concerns in facility
• Private practice (office, hospital, assisted living, house calls, etc.)
• Hundreds to thousands of calls, forms, e-mails, faxes, mail, paperwork
CONSULTANT PHARMACIST/MEDICAL DIRECTOR INTERACTIONS

• Quarterly meetings
• Pharmacy reports
• Collegial, respectful, in an atmosphere of mutual trust and admiration!
• Suspicions of conflict of interest
PHYSICIAN AWARENESS OF MEDICARE PART D

- Earlier than community-based
- American Medical Directors Association (AMDA)
- Concerns about time and effort
PART D TIMELINE

• Late 2005: Physician education, meeting with administration, talking to families
• January 3, 2006: Calm!
• Spring 2006: Real problems begin
WHAT MEDICARE PART D IN LTC REALLY IS

• …saving money?
• …ability to prescribe medications?
• …way to ensure quality?
• FORMULARY!!
PROBLEMS FROM PHYSICIAN PERSPECTIVE

• Time
  38% AMDA members spend 4-7 uncompensated hours/week
  13% spend 8+ hours/week
  Frequent or very frequent problems with prior authorizations (70%) and exceptions (55%)
Timeframe for Coverage Determinations

**Plan**

- **Enrollee or physician requests exception**
  - **Request normal review**
    - 72hr
      - Decision in 72 hrs
      - Request granted: receive coverage
      - Request denied
        - Redetermination
          - 7 days std
          - 72 hrs exp
          - Request denied
            - Appeal leaves plan
          - Request granted: receive coverage
  - Expeditied review rejected
    - In 24 hrs
    - Decision in 72 hrs
    - Request denied
      - Redetermination
        - 7 days std
        - 72 hrs exp
        - Request denied
          - Appeal leaves plan
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- **Request expedited review**
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          - Appeal leaves plan
        - Request granted: receive coverage
Timeframe for Coverage Determinations

*Beyond the plan*

1. **Independent Review Entity (IRE)**
   - Request denied
   - Request granted: receive coverage
   - 72 hrs

2. **Administrative Law Judge (ALJ)**
   - Request granted: receive coverage
   - Request denied

3. **Medicare Appeals Committee (MAC)**

4. **Judicial Review**
PROBLEMS FROM PHYSICIAN PERSPECTIVE (con’t)

• Particular drugs or types of drugs
  -- Alzheimer’s disease (23%)
  -- non-generics (“almost anything…a problem”)
  -- inexpensive drugs
  -- emergency meds (influenza outbreaks)
PROBLEMS FROM PHYSICIAN PERSPECTIVE (con’t)

• Lack of standardized forms
• No access to chart
• Patient history often unknown
• Requirement for personal contact to plan
• Seem designed to deter physicians from requesting prior approvals or exceptions
Medicare Part D Coverage Determination Request Form

This form cannot be used to request:
- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- Biotech or other specialty drugs for which drug-specific forms are required. [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCoverage/downloads/04_formulary.asp]

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<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Prescriber Information</th>
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<tbody>
<tr>
<td>Patient Name:</td>
<td>Prescriber Name:</td>
</tr>
<tr>
<td>Member ID#:</td>
<td>NPI# (if available):</td>
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<td>Address:</td>
<td>Address:</td>
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<td>DOB:</td>
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<tr>
<td>M/F</td>
<td>Contact Person:</td>
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</table>

Diagnosis and Medical Information

- Medication:
- Strength and Route of Administration:
- Frequency:
- New Prescription OR
- Expected Length of Therapy:
- Date Therapy Initiated:
- Height/Weight:
- Drug Allergies:
- Diagnosis:
- Prescriber’s Signature:
- Date:

Rationale for Exception Request or Prior Authorization

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure)
  - Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);
- Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
  - Specify below: Anticipated significant adverse clinical outcome
- Medical need for different dosage form and/or higher dosage
  - Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason
- Request for formulary tier exception
  - Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome
- Other:__________ → Explain below

REQUIRED EXPLANATION:

__________________________________________________

__________________________________________________

Request for Expedited Review

- REQUEST FOR EXPEDITED REVIEW (48 HOURS)
  - BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER’S ABILITY TO REGAIN MAXIMUM FUNCTION
DRUG PLAN CALL CENTER PERFORMANCE

• CMS: 92% answered within 5 minutes
• GAO: accurate/complete info 1/3 of time
different answers to same question

“CMS took issue with the report, faulting it for
asking the wrong questions or not phrasing the
questions more precisely”
PROBLEMS FROM PHYSICIAN PERSPECTIVE (con’t)

• Myriad drug plans and drug plan options
• Requiring a form to get a form
• Lack of critical information about the PDP (formulary alternatives)
• Omission of all forms and doses (liquid, ODTs)
• Formulary choices inappropriate for the elderly
• Surveyor concerns (unnecessary medications, F329 tag)
CASE STUDY

• “Mrs. Casper”
• “The hurdles created are resulting in a lower level of care being provided for nursing home patients. They are now less likely to be prescribed uncovered medicines...because it takes too much time and effort for everyone involved.”
BROADER PROBLEMS

- LTC input to PDP formularies
- Evidence-based/data driven decisions
- Physician knowledge of drug availability
- CMS responsiveness to concerns
- Long term effect on quality and patient care
ASSISTED LIVING (AL)

- More AL than nursing home beds
- Increasing acuity of care for AL residents
- Not typically a medical director in an AL facility
- No mandated pharmacist review
- Regarded as same as community-dwelling
- Problem with dual-eligibles required to make Part D co-payments
NF & ALF Projections

Source – HSG, 7/02
A comparison of ADL dependency among ALF and SNF residents

- **Eating**: 23% (ALF) vs. 47% (SNF)
- **Transferring**: 36% (ALF) vs. 73% (SNF)
- **Toileting**: 41% (ALF) vs. 78% (SNF)
- **Dressing**: 57% (ALF) vs. 86% (SNF)
- **Bathing**: 72% (ALF) vs. 94% (SNF)

Source: Natl. Center for Assisted Living, 2001
CENTER FOR EXCELLENCE IN ASSISTED LIVING (CEAL)

• 2006 Quality Summit
  November 30 to December 1, 2006
  Arlington, VA
AMDA

• Represents more than 7000 medical directors, attending physicians and others in LTC
• Average physician sees 100 NH patients per month (42% of total in 2000)
• Majority of members maintain a private practice outside of their LTC responsibilities
AMDA (con’t)

- Has been part of weekly CMS conference calls and frequent e-mails
- Part D task force
- Susan Pettrey
- AL involvement (AL workgroup, CEAL Advisory board)
SOLUTIONS

- SIMPLIFICATION!
- Mandate uniform procedure and forms for exceptions, prior authorizations and appeals
- Prohibit prior authorization requirements for all meds in a class
- Greater CMS oversight with quarterly public reports, prompt sanctions against non-compliant PDPs
WORKING WITH THE MEDICAL DIRECTOR

• Discuss use of “problem” medications
• Develop protocols
• Educate staff about automatic substitutions (PPIs, cholesterol meds)
• Educate physician staff (medical staff meetings)
WORKING WITH THE MEDICAL DIRECTOR (con’t)

• Use of common CMS exception form
• Use medical director as a resource (pharmaceutical companies)
• Improve communications (discourage fax as be-all and end-all)
• Develop strategy to identify common Part D problems
DEALING WITH THE NON-COMPLIANT PHYSICIAN

• Education
• Communication
• Use of the medical director as a resource
STRENGTH IN NUMBERS

• Develop relationships with interested organizations (ASCP, AMDA, Alzheimer’s Assoc., etc.), and tell them specific problems

• Put political pressure on CMS
"Remember when the most difficult thing about getting a prescription filled was figuring out what the doctor wrote?"
## Sources of Additional Information

<table>
<thead>
<tr>
<th>Governmental</th>
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<th>Non-governmental Organizations</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>American Society of Consultant Pharmacist</td>
<td>Kaiser Family Foundation</td>
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<tr>
<td>– 1-800-MEDICARE</td>
<td>– American Geriatrics Society</td>
<td>– <a href="http://www.kff.org">www.kff.org</a></td>
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<tr>
<td>Social Security Administration</td>
<td>American Medical Directors Association</td>
<td>– <a href="http://www.medicarerxmaters.org">www.medicarerxmaters.org</a></td>
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<tr>
<td>State Medicaid</td>
<td>American Health Care Association</td>
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<td>– <a href="http://www.shiptalk.org">www.shiptalk.org</a></td>
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<td>Insurance Assistance Programs (SHIPs)</td>
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Access to Benefits – www.accesstobenefits.org

Medicare –1-800-MEDICARE


Social Security Administration – www.socialsecurity.gov

State Medicaid – www.shiptalk.org

State Health Insurance Assistance Programs (SHIPs) – www.shiptalk.org


社会保障机构 – www.socialsecurity.gov

州医疗救助 – www.shiptalk.org

州健康保险援助计划（SHIPs） – www.shiptalk.org

Kaiser Family Foundation – www.kff.org

医疗保险 Rx 权益 – www.medicarerxmaters.org

医疗保险今天 – www.medicaretoday.org

Access to Benefits – www.accesstobenefits.org
Region V
Chicago (IL, IN, MI, MN, OH, WI)

Centers for Medicare and Medicaid Services
312-886-6432
ROCHIDMO@cms.hhs.gov

Social Security Administration
312-575-4053
RESOURCES

• American Medical Directors Association  
  www.amda.com
• Susan Pettey  spettey@verizon.net
• www.assistedlivingconsult.com
• Richard Stefanacci  r.stefan@usip.edu
• www.theceal.org
CONTACT ME

- 1 Gardenia Road Levittown PA 19057
- Phone 215-943-2222
- E-mail geridoc1@comcast.net
THANK YOU!

QUESTIONS?