RECOMMENDATIONS

7A The Congress should direct CMS to identify selected overlap drugs and direct plans to always cover them under Part D. Identified drugs should be:

- low cost
- covered under Part D most of the time.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

7B The Congress should allow plans to cover a transitional supply of overlap drugs under Part D under the same conditions as the general transition policy applied by CMS.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

7C The Congress should permit coverage for appropriate preventive vaccines under Medicare Part B instead of Part D.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Vaccines and Part D

Physicians report that coverage of preventive vaccines under Part D is problematic for them. By statute, under Part B Medicare covers preventive vaccines for influenza, pneumonia, and hepatitis B for patients at high or intermediate risk. Medicare covers other vaccines under Part B if they are administered to treat an injury or direct exposure to a disease. For example, Part B covers rabies vaccine for beneficiaries bitten by animals. However, Medicare covers any other preventive vaccines under Part D. Currently, PDPs are paying for few preventive vaccines. Interviewees mentioned that the most likely new vaccine to be covered under Part D is a vaccine for shingles licensed by the FDA in 2006. However, if more vaccines become eligible for Part D, physicians are likely to have a problem billing plans. Like most Part B drugs, physicians purchase vaccines and provide them in their offices, but most have no direct way of billing PDPs.

Currently, CMS is seeking to clarify how plans intend to pay for vaccines under Part D. Plans would also have to develop a method to pay providers to administer the vaccines. To date, plans have suggested a variety of methods to pay for Part D-covered vaccines including:

- delivering vaccines directly to the physician's office,
- providing vaccines to network pharmacies,
- reimbursing patients after administration of the vaccine, and
- developing a web-based tool that allows physicians to submit claims electronically (Banner 2007).

These methods are largely untested. Recognizing this concern, the Academy of Managed Care Pharmacy notes that physicians do not have the appropriate information systems to bill under Part D (AMCP 2007). They endorse moving all vaccines to Part B.

If beneficiaries have to pay the full payment rate for vaccines and then seek reimbursement from their plans, physicians are concerned that the out-of-pocket cost will discourage beneficiaries from seeking preventive care when appropriate vaccines are available. Public health agencies—for example, the Centers for Disease Control and Prevention (CDC) and the National Vaccine Program Office in the Department of Health and Human Services (HHS)—share this concern. Beneficiaries without Part D coverage might also be unable to receive recommended vaccines unless they are able to pay the full payment rate.

Before implementation of Part D, Medicare covered preventive vaccines only if they were listed in statute. The Congress could simplify the process for coverage. For example, Medicare carriers could decide on coverage for preventive vaccines based on medical evidence as they do with other Part B services. Medicare payment for vaccines, like other Part B drugs, would be based on the average sales price methodology.

One source of information about Part B coverage for vaccines could be the recommendations of the Advisory Committee on Immunization Practices (ACIP), which consists of 15 experts in fields associated with immunization who have been selected by the Secretary of HHS to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the CDC on the most effective means to prevent vaccine-preventable diseases. The Committee develops recommendations for the administration of preventive vaccines to the pediatric and adult populations, along with schedules regarding the appropriate time frame, dosage, and contraindications applicable to the vaccines. ACIP recommendations are currently used to determine vaccines covered under the Vaccines for Children program. ACIP could develop similar recommendations for the Medicare population. Medicare could use this source of information for help making coverage decisions.

Although this section relates only to preventive vaccines, beneficiaries might have better access to some other drug products under Part B than under Part D.[6] CMS is studying whether some drugs should be moved from one part of the program to the other. The Commission also will study potential cases in future work. Any significant shift of drugs from one part of the program to the other should consider the time needed for drug plans to take the changes into account before submitting their bids to CMS for the following year.

RECOMMENDATION 7C

The Congress should permit coverage for appropriate preventive vaccines under Medicare Part B instead of Part D.

RATIONALE 7C

Since physicians have no direct way to bill Part D plans, they face administrative barriers to providing appropriate preventive care to beneficiaries. Under Part B, physicians

would be able to administer new vaccines in their offices as they do current covered vaccines and beneficiaries would have more access to preventive care.

IMPLICATIONS 7C

Spending

- This recommendation would increase spending by less than $50 million for 1 year and by less than $1 billion over 5 years.

Beneficiary and provider

- This recommendation would improve beneficiary access to preventive care and reduce the administrative burden for physicians.

Delivering Part D benefits to residents of long-term care facilities

The overall fit between Part D and the nursing home pharmacy sector is a matter of debate. Some stakeholders characterize the Part D benefit as a better fit for community-based beneficiaries who fill prescriptions in retail pharmacies than for institutionalized beneficiaries because the latter often have cognitive as well as physical impairments. However, current law states that Medicare beneficiaries in nursing facilities (NFs) should have the same freedom as community-based beneficiaries to choose among Part D plans. Here we examine how the introduction of Part D is affecting pharmacy services for residents of NFs and other stakeholders. We also describe several approaches policymakers can consider for delivering Part D benefits in this care setting but do not offer recommendations.

Medicare beneficiaries in NFs

According to data from the Medicare Current Beneficiary Survey (MCBS), in 2003, about 5 percent of all beneficiaries lived in long-term care facilities.[7] This group is made up disproportionately of individuals age 85 or older (43 percent vs. 12 percent of the entire Medicare population), and they are much more likely to be widows or to have never married (only 14 percent remain married vs. 52 percent overall) (CMS 2006b). More than half of beneficiaries in long-term care facilities did not complete high school compared with 30 percent overall, and about half have incomes of $10,000 or less compared with 22 percent overall. Individuals who reside in NFs often are there because they are in a weak physical state with difficulty performing activities of daily living. About two-thirds of the institutionalized are also mentally or cognitively impaired (Table 7-1).

TABLE 7–1 **About two-thirds of institutionalized Medicare beneficiaries are mentally or cognitively impaired**

	Dual eligibles	Nondual eligibles	All
All institutionalized beneficiaries	56%	44%	100%
Percent who are mentally or cognitively impaired			
Aged	32	26	58
Disabled	8	1	10
Total	40	28	68

Note: Dual eligibles are individuals who receive both Medicare and Medicaid benefits. Mentally or cognitively impaired includes beneficiaries who have dementia, mental illness, or mental retardation. Sums may not add to totals due to rounding.

Source: MedPAC analysis of Cost and Use files, 1999–2001 Medicare Current Beneficiary Surveys.

The population of beneficiaries in long-term care facilities is made up disproportionately of individuals who are dually eligible for Medicare and Medicaid.[8] In 2003, 19 percent of duals lived in long-term care facilities compared with about 2 percent of nondual Medicare beneficiaries. More than half of all institutionalized Medicare beneficiaries are duals (Table 7-1). Definitions of institutionalization can vary, but this result corresponds roughly with other data. As of April 2007, data from CMS's On-line Survey, Certification, and Reporting system suggest that nearly 14 percent of residents at certified NFs were on a Medicare Part A stay, 65 percent were on a Medicaid stay, and the remaining 21 percent either had another source of coverage or paid out of pocket (CMS 2007b).

Providing prescription drugs to NF residents before and after Part D

The distribution system for drugs dispensed to residents of NFs is quite different from that for beneficiaries living in the community, and Part D has affected how providers operate. NFs and the LTCPs with which they contract have always had to interact with multiple insurers because residents with individual or employer-sponsored supplemental drug policies had coverage through different