



## **ADVOCACY NEEDED TO ASSURE PRESCRIPTION DRUG COVERAGE FOR NURSING HOME RESIDENTS**

When the Part D program goes into effect on January 1, 2006, dually-eligible nursing home residents will lose Medicaid coverage for prescription drugs and will be required to get their prescription drugs through Medicare, using a Medicare Part D prescription drug plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD) instead. The Medicare Modernization Act (MMA) and final regulations give PDPs and MA-PDs considerable discretion to decide which specific drugs to include in their formularies. Formulary decisions made by PDPs and MA-PDs may leave many residents without coverage for the prescription drugs that they need. For private-pay residents, tier-pricing decisions may appear to make prescription drugs unaffordable. A variety of strategies undertaken now may help residents get non-covered prescription drugs.

**The Nursing Home Reform Law**, enacted in 1987, establishes a high standard of care for residents, requiring facilities to “provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care.” Regulations and guidance implementing the Reform Law make clear that facilities must provide needed prescription drugs regardless of whether there is a source of payment. Educating residents and their family members of this requirement will provide them with information necessary to assure continued drug coverage while avenues of payment are pursued.

**The MMA** creates both an exceptions process and an appeals process that residents can use to challenge the denial of coverage for a particular prescription drug.

In addition, between now and January 1, 2006, advocates can work at the state level to assure appropriate payment from other sources for necessary prescription drugs for residents:

- **Medicaid** program: The MMA explicitly excludes from coverage under Part D a list of drugs that are currently *optional* under Medicaid. These drugs include drugs for weight loss, barbiturates, and benzodiazepines, which are prescribed for many nursing home residents for seizure disorders, acute anxiety, panic attacks, and muscle spasms. Since a state’s Medicaid program can cover prescription drugs that are explicitly excluded from coverage under the MMA, advocates should first determine whether the state currently covers such drugs. If so, advocates can encourage continued coverage; if not, advocates can press for new coverage of these prescription drugs. States receive federal financial participation

for MMA-excluded prescription drugs that they cover under their Medicaid programs.

- **State Pharmaceutical Assistance Program (SPAP):** Thirty-one states have SPAPs to provide state-funded drug coverage to individuals without such coverage. State SPAP laws could be amended to provide wrap-around drug coverage for nursing homes residents losing their prescription drug coverage under Medicaid.
- **Incurred medical expense deduction:** In calculating the amount of money that a nursing facility resident must contribute to the cost of her nursing home care (i.e., “share of cost”), federal Medicaid law *requires* that the state program allow the resident to deduct the out-of-pocket cost of medical services that are recognized by state law but not covered by the Medicaid state plan. This “incurred medical expense deduction” allows a resident to purchase non-covered prescription drugs and to deduct their cost from her share of cost. A resident can use the incurred medical expense deduction to purchase a needed drug while requesting an exception for coverage of a non-covered drug or appealing denial of coverage of a non-covered drug, or after her appeal has been denied.

Some states that have not implemented the incurred medical expense deduction might develop a program, with prompting and encouragement; in other states, litigation may be necessary. (See *Johnson v. Rank*, No. C-8405979-SC (N.D. Cal. Dec. 7, 1984) (preliminary injunction requiring California to implement the incurred medical expense deduction)).

**Note also** that the Medicare and Medicaid programs pay for **over-the-counter drugs** as part of the *per diem* payment for nursing home care. As a result, the fact that the MMA expressly precludes PDPs and MA-PDs from paying for over-the-counter drugs is irrelevant for nursing home residents in a Medicare- or Medicaid-covered stay. Nursing homes must provide residents with non-prescription drugs that are typically stocked in bulk at the nursing station. They cannot charge residents for them (42 C.F.R. §483.10(c)(8)(i)(E)).

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