MANAGED CARE IN 2017
WHAT THE NEW CHANGES IN HEALTHCARE MEAN FOR THE ELDERLY POPULATION

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Disclosure Statement

I do not have a vested interest in or affiliation with any corporate organization offering financial support or grant money for this continuing education program, or any affiliation with an organization whose philosophy could potentially bias my presentation.
OBJECTIVES FOR PHARMACISTS

- Describe how value-based reimbursement will impact the future of health care provided to the geriatric population.
- Discuss the Centers for Medicare & Medicaid (CMS)’s Star ratings system
- Define Medication Therapy Management (MTM), Comprehensive Medication Reviews (CMR), and Targeted Medication Reviews (TMR)
- Analyze strategies to assist elderly patients through the “donut hole” period of Medicare Part D coverage.
- Discuss how MTM and Star ratings work together synergistically and how this provides an opportunity for pharmacists.
- Identify common mistakes that patients make when applying and using Medicare.
OBJECTIVES FOR PHARMACY TECHNICIANS

▪ Describe how value-based reimbursement will impact the future of health care provided to the geriatric population.

▪ Discuss the Centers for Medicare & Medicaid (CMS)’s Star ratings system

▪ Define Medication Therapy Management (MTM), Comprehensive Medication Reviews (CMR), and Targeted Medication Reviews (TMR)

▪ Identify strategies to assist elderly patients through the “donut hole” period of Medicare Part D coverage.

▪ Discuss how MTM and Star ratings work together to provide opportunities for pharmacy.

▪ Identify common mistakes that patients make when applying and using Medicare.
WHAT IS MEDICARE?

- Federally funded program offered to patients over 65 years and over along with other specifically qualified individuals
  - Benefits are funded greatly by payroll taxes from US citizens
  - Medicare accounts for 14% of the US federal budget\(^1\)
- Began in 1965 by President Lyndon B. Johnson
  - 50% of US citizens over 65 were not insured before 1965
  - Accounted for 5% of US economy
- Leading health care insurance program for American seniors\(^2\)

\(^2\)Medicare.gov.
MEDICARE AND THE UNITED STATES

- In 2016, CMS (Centers for Medicare and Medicaid) estimated that the national health spending (federal and state government, private sector, and individuals) has increased to 18% use of the economy.
- Projected to reach 19.9% by 2025\(^3\)
- \$4 Trillion spent on healthcare in the United States\(^4\)

MEDICARE

Part A

- Hospital Insurance
- SNF medication coverage
- Hospice

Part B

- “Limited” outpatient drugs and immunizations
- Injectable and infusion drugs given in office
- Supplies such as nebulizers and infusion pumps
- Certain anti cancer medications
- Treatments in ESRD
MEDICARE ADVANTAGE

- Commonly known as MA-PD or Part C
  - Medicare Advantage + Prescription Drug

- Provides medical coverage and prescription drug coverage

- Monthly premiums required

- Emergency and urgent care coverage

- Usually includes, but not limited to:
  - Private Fee-for-Service Plans (PFFS)
  - Preferred Provider Service Plans (PPOs)
  - Health Maintenance Organization Plans (HMOs)

MEDICARE PART D

- Commonly referred to as PDP
  - Prescription drug plan that is ran by private insurance companies
- Flexible and offers a standard level of prescription drug coverage
- Benefits and costs can change every year
- Set guidelines mandated by CMS
- Drug formulary specific to each plan and coverage will vary per plan as well

- Every Part D and MA-PD plan has **steps** and **tiers**
- Plans can change tiers of medications **yearly**
MEDICARE PART D AND ADVANTAGE ELIGIBILITY

- Already enrolled in Part A and/or Part B
- Residence in service area
- What can I tell my patient?⁶
  - If they join **three months before** they turn 65 years old
    - Drug coverage begins on their birthday
  - If they join **during the month** they turn 65 years old
    - Drug coverage begins the following month on the 1ˢᵗ
  - During the **three months after** they turn 65 years old
    - Drug coverage begins first day of the month after the application was finished

ASSESSMENT

A patient comes to your pharmacy and lets you know that they are turning 64 next week. Even though they are not quite 65 years old, they would like to get a head start on their third party enrollment and would like ask you a few questions.

The patient states, “I’m basically turning 65 year old in a year. I may move to another town near here depending on where my children move. I was told by another pharmacist that when I enroll for Medicare that I should be ‘ok’ as long as I always keep my third party informed of where I live that I should be able to stay on that plan”.

How should you, as a pharmacy team member, respond:
ASSESSMENT

A. “That’s very true, you should be fine”

B. “If it is the ‘original’ Medicare (A and B) then it is federally funded nationwide. I believe Part C and D follow the same rules as well, so you should be fine”

C. “No, if it is the ‘original’ Medicare (A and B) then it is federally funded nationwide. Part C (MA-PD) and D are offered by private companies that vary by area. So, if you move, your plan may change”.

D. “No, all parts of Medicare are the same and will travel with you wherever you until you die”.
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D. “No, all parts of Medicare are the same and will travel with you wherever you until you die”.
• Yearly deductible must be paid by patient **before** your plan shares your costs
• In 2016 it was $360 and 2017 it was $400
• $**405** in 2018

**Step 1**

**Step 2**

• Co-payment or co-insurance
• Until the patient reaches the **cost threshold**
• 2018 Cost threshold is **$3750**

**Step 3**
• Donut Hole
• The patient is responsible for 44% of generic drugs and 35% of brand name drugs
• Under brand name drugs the patient receives an $85 credit towards their out-of-pocket costs

Step 3

Step 4
• Out-of-pocket costs amount to a threshold of $5,000 in 2018
• In 2017 the out-of-pocket threshold was $4,950

Step 5
• Catastrophic Coverage
• Patient only pays 5% of retail price of medications for the rest of the year
OUT OF POCKET THRESHOLD

What can you tell a patient about their out of pocket costs or their TrOOP (True Out-Of-Pocket Costs)?

The technical term of TrOOP:

*What you pay when you fill or refill a prescription for a covered Part D drug. (This includes payments for your drugs, if any, that are made by family or friends.)*  

*Payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare’s Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs)*

*The pharmacy team should be able to explain what does count and what doesn’t count towards a patient’s TrOOP*

7,8 https://q1medicare.com/PartD-EOB3OutOfPocketAndTotalDrugCosts.php
OUT OF POCKET THRESHOLD

What can you tell a patient about their out of pocket costs or their TrOOP (True Out-Of-Pocket Costs)?

What **counts** towards the TrOOP?\(^9,10\)

- Payments made by the patient, patient’s proxy, family members and friends, State Pharmacy Assistance Programs, Extra Help Program, Indian Health Services, ADAPs, drug manufacturer discounts on brand/generic drugs under the coverage gap programs, Health Savings Accounts (HSA)

What **does not count** towards the TrOOP?\(^9\)

- Any amount paid by a Medicare drug plan, monthly premiums, monthly late fees, drugs not covered by plans, OTC medications, drugs excluded in Part D definition, government funded-programs and/or government funded reimbursement programs, other insurance coverages

\(^9\)https://q1medicare.com/PartD-EOB3OutOfPocketAndTotalDrugCosts.php. Accessed Feb 2 2018

WILL THE DONUT HOLE DIE?

- It was the goal of the ACA to completely close the process of the coverage gap
- What does it mean for your patients?
  - Advise that this simply could mean a **reduction in costs not an elimination of costs**

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The Four Phases of your 2018 Medicare Part D Plan
Based on the 2018 CMS defined standard Medicare Part D plan

- **$405 Initial Deductible (you pay 100% of retail)**
- **$3,750 Initial Coverage (you pay 25% of retail)**
- **You pay 44% of generic retail price**
- **You pay 35% of brand-name retail price**
- **Over $5,000 out-of-pocket Coverage (you pay approx. 5% of retail)**
- **2018 Donut Hole Discount: 65% of Brand-name cost and 56% of Generic drug cost**

Accessed February 1, 2018

[Link to the blog post](https://q1medicare.com/q1group/MedicareAdvantagePartD/Blog.php?blog=Understanding-the-2018-Medicare-Part-D-Coverage-Gap-or-Donut-Hole&blog_id=647&frompage=9)
DONUT HOLE 2020

What you will pay in 2020 and beyond when the Donut Hole is “closed”
Based on the CMS defined standard Medicare Part D plan

© Q1Group 2017

RATINGS AND MEASURES

WHAT DOES THIS MEAN FOR MY PHARMACY?
WHAT DOES THIS MEAN FOR THE PATIENT?
MEASURES

▪ What are measures?
  ▪ Measures are simply adaptations of what the minimum quality of care should be
  ▪ These measures are designed to help a patient choose plans in an “apples to apples” format

▪ Adapted from:
  1. Health of Seniors Survey (HOS)
  2. Healthcare Effectiveness Data and Information Set (HEDIS)
  3. Pharmacy Quality Alliance (PQA)

RATINGS

- Medicare PDP and MA-PD plans are rated on quality in an overall concept
- **FOUR Domain Scores**
  - Weights of scores may be adjusted as the years go by
- Weights vary upon category
  - Some weights are 3x and some can be 1x
- **Patient safety measures are always weighted higher**
  - PDP’S weigh these measures ~30-32% to overall ratings
  - MA-PDs weigh these measures ~20% to overall ratings
STAR RATINGS

- Measures how effectively Part D and Medicare Advantage plans perform
- Rated from 1 star to 5 stars
  - 5 stars rating is the highest
  - 1 star rating is the lowest
- Medicare reviews each plan over a year and assigns each plan an overall star rating
  - Releases this rating every Fall
  - Each plan also receives a star score in specific categories
STAR RATINGS

Medicare Part D drug plans are rated on performance based on the following four categories for prescription related services:

1. Customer Service
2. Experience with Drug Plan
3. Drug pricing and patient safety
4. Attendance and Complaints
   1. Member complaints
   2. Problem solving
   3. Patients that have left the plan

Centers for Medicare and Medicaid 2017 National Training Program Guide. June 2017
OVERALL STAR RATING SCORE

- Plans with higher ratings
  - More incentives
  - Exclusive and superior marketing options
  - Patients are able to choose these 5-Star plans year round

- Plans with lower ratings
  - Less than 3 Stars are penalized
    - CMS contract loss if rated less than 3 stars for 3 years or more
    - Online enrollment unavailable
    - Enrollments may have to be done over the phone

Centers for Medicare and Medicaid 2017 National Training Program Guide. June 2017
The goal of CMS implementing Star Ratings is to again, above all, put the patient first. Metrics, ratings, and scores are measured to enforce an “apples to apples” comparison between plans when patients choose their sponsors. The same concept then applies when a plan chooses which providers, medical centers, and pharmacies that their patients will use.

In December of 2018, CMS released the “Changes in Ratings” brief to the public. 44% of MA-PDs (170 contracts) that are offered and available in 2018 earned 4 stars or higher. 73% of MA-PD enrollees are in contracts that are 4 stars of higher. 2017 measured 69% of enrollees were in 4 star rated plans or higher.

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1 CMS First Plan Preview 2017. [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugs/PerformanceData.html](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugs/PerformanceData.html)
MEASURES AND RATINGS: DO THEY WORK FOR MY PHARMACY?

- Pharmacies factor into the individual plans’ Star Ratings **however** individual pharmacies **do not** receive a star rating as a sponsor would.

- Pharmacies **contribute** through **display measures**
  - Display measures are NOT included in the annual ratings report but are included in a review by CMS.
  - NOT included in overall rating.
  - Often develop into **Star Ratings** over time.

- Adapted from some measures from PQA.
  - Examples:
    - Adherence
    - Oral DM medications
    - CMR **completions** in Medication Therapy Management
    - Drug-Drug Interactions

CMS First Plan Preview 2017. [http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html)
MEDICATION THERAPY MANAGEMENT

- Designed to improve
  - Communication amongst providers, pharmacists, and patients
  - Patient care
  - Optimization of medication usage
  - Less medication-medication and medication-disease interactions
  - Adherence

- Intended to help Part D patients take an active role in their therapy
Targeted beneficiaries must meet all of the following criteria of the Part D plan to be enrolled in an MTM program:

1. **Have multiple chronic diseases**
   1. Sponsors cannot require a minimum of 3 chronic diseases to be enrolled.

2. **Taking multiple Part D drugs**
   1. Sponsors cannot require higher than 8 Part Drugs as their minimum requirement for enrollment.

3. **Are likely to incur drug coverage costs that will be equal to or greater than their MTM cost threshold**
   1. MTM cost threshold in 2018 increased to $3,967.
There are many moving wheels involving an MTM service

1. **TMR-Targeted Medication Review**
   - Performed to evaluate how the medication is used or if there are any drug related problems that have arisen or may occur in the future
   - Can be generated by the computer system put in place by the sponsor OR in a patient interaction
   - Specific to a singular medication related problem at one time

2. **CMR-Comprehensive Medication Review**
   - **Must** include an interactive, person-to-person OR telehealth medication review and counseling of **ALL medications** done by a pharmacist or provider
   - Summary documented and mailed to patient immediately
   - CMS awards a triple weighted score to sponsors that keep adherence rates high and score a weight of 1 to those with a 100% CMR completions
# PERSONAL MEDICATION LIST FOR <Insert Member’s name>, (Continued)

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<th>HOW TO USE IT</th>
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<tbody>
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<td>PURPOSE</td>
<td>STOP DATE:</td>
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### GOALS OF THERAPY:

<INSERT OTHER TITLE(s)>:

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MEDICATION THERAPY MANAGEMENT

MTM take home points for all pharmacy team members:

▪ Sponsors must by law enroll target patients that are eligible for the MTM service automatically

▪ TMRs must be done quarterly that are coupled with follow up interventions

▪ CMRs are to be completed annually. For newly enrolled patients, a CMR must be done no later than 60 days after initial enrollment

▪ Interventions are a necessity

▪ New targeted beneficiaries are expected to be searched for quarterly

▪ Document everything!
  ▪ Any returned MTM packages sent to the patient by mail or non-verification by phone are considered incomplete
  ▪ Date and sign any and every offer made for the benefit of the patient in regards to any MTM service
MEDICATION THERAPY MANAGEMENT

MTM take home points for pharmacy team members that service Part D and Medicare Advantage patients

- TMRs and CMRs are tools that are used as display measures that assess the following:
  1. Avoiding drug-drug interactions
     - Enhancing and using pharmacogenomics
  2. Avoiding excessive dosing with oral anti-diabetic medications
  3. Discontinuing the use of atypical antipsychotics with Part D elderly patients in nursing homes
  4. Administration of the pneumococcal vaccine
  5. Statin therapy for patients with CVD
  6. Medication reconciliation post discharge
     - *New 2018 Display Measure*
  7. Appropriate medication management with asthmatic Part D beneficiaries
  8. Drug treatment with COPD patients
     - Using bronchodilators or systemic corticosteroids

HOW CAN MTM HELP MY PHARMACY?

- Community pharmacist and technician
  - Gatekeeper and closest advocate to patient
  - Trust and knowledgeable
  - Arguably the binding thread between treatment strategies

- Teamwork with other providers
  - Educate other disciplines
  - Fill in the gaps of confusion
  - Enhance patient care

Increase ratings and display measures
In a pharmacy, your technician reminds a pharmacist that he or she needs to do an MTM for 6 patients by the end of the month. The pharmacist thanks the technician, however, corrects them and states that only a portion of the MTM is important for CMS measures. Which of the following statements are true?

Choose the correct answer from the following:

A. The MTM can be started by the pharmacist and completed by the technician only if they CMR is 90% complete or higher

B. The MTM is unnecessary if MAP is completed. The MAP is the only component that the third party pays the company to do

C. The MTM is weighted heavily and completion depends on 100% of the CMR

D. The MTM is weighted not as heavily as catching interventions and depends on 75% or better completion of the CMR
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WHAT DO I TELL MY PATIENT?
WHAT SHOULD THE PATIENT KNOW?

ENROLLMENT

▪ Your patient should be advised to search for an appropriate plan on Medicare Plan Finder (MPF)

▪ Special Enrollment Period
  ▪ Your patient should also know that they can enroll in a 5-Star plan at any point during this time

▪ Low performing plans are not listed on MPF

SPECIAL ENROLLMENT PERIOD (SEP) QUALIFICATIONS

▪ Changes in residence outside of zip code or country

▪ Anyone can qualify if you or anyone in your household lost health coverage in the past 60 days or expects to do so

▪ Seasonal work move

▪ Significant life event
  ▪ Death of someone on your plan
  ▪ Marriage
  ▪ Divorce
Pharmacists along with pharmacy technicians can always remind patients about:

- **Extra Help Program**¹
  - Commonly referred to as LIS or Low Income Subsidy
  - No premium payments or little to no co-payments for patients with limited income
  - No coverage gap or late enrollment penalties
  - Prolonged Special Enrollment Period

- Eligibility is based upon income limits per individual or married couple

- Advise eligible patients to apply by:
  1. Visit ssa.gov/medicare/prescriptionhelp/¹
  2. Call Social Security at 1-800-772-1213
<table>
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<th>Low-income Subsidy Category</th>
<th>Deductible</th>
<th>Copayment up to Out-of-Pocket Threshold*</th>
<th>Copayment above Out-of-Pocket Threshold*</th>
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<td>Institutionalized Full-Benefit Dual Eligible; or Beneficiaries Receiving Home and Community-Based Services</td>
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<td>$0</td>
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<td>Full-Benefit Dual Eligible ≤ 100% FPL</td>
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<td>$1.25 generic, $3.70 brand</td>
<td>$0</td>
</tr>
<tr>
<td>Full-Benefit Dual Eligible &gt; 100% FPL; or Medicare Saving Program Participant (QMB-only, SLMB-only, or QI); or Supplemental Security Income (but not Medicaid) Recipient; or Applicant &lt; 135% FPL with resources ≤ $9,060 ($14,340 if married)**</td>
<td>$0</td>
<td>$3.35 generic, $8.35 brand</td>
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<tr>
<td>Applicant &lt; 150% FPL with resources between $9,060 - $14,100 ($14,340 - $28,150 if married)**</td>
<td>$83</td>
<td>15%</td>
<td>$3.35 generic, $8.35 brand</td>
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</tbody>
</table>
COMMON MISTAKES FROM PATIENTS

- Patients trust pharmacists and pharmacy technicians to inform them about general third party knowledge that could make a difference in their coverage

- Common mistakes pharmacy personnel may warn patients about include:
  1. Enrolling after eligibility period
  2. Not enrolling during Open Enrollment
  3. Failing to recognizing a chosen plan that could affect your current plan or your spouse’s current plan
  4. Picking an insurance agent that is not attentive to your needs
  5. The best plan for you may not be the best for your spouse OR assuming your spouse’s coverage applies to you as well
  6. Adopting assumptions of a “one size fits all” healthcare plan
  7. Picking plans solely based on what’s the cheapest plan or what is the most expensive (seemingly the “best” plan)

8. NOT CHECKING PLAN CHANGES EVERY YEAR
COMMON MISTAKES FROM PHARMACY PERSONNEL

- Patients trust pharmacists and pharmacy technicians to inform them about general third party knowledge that could make a difference in their coverage.

- Common mistakes that occur from pharmacy personnel
  1. Recommending plans for patients
     - Recommending a specific plan for a patient is technically illegal
     - Instead, refer them to the plan finder on CMS.gov
  2. Assuming that the standards and practices of one plan applies to all PDP and MA-PD plans
  3. Failing to ask the patient if they have any other insurance that they are aware of
  4. Regarding MTM as a “burden”
  5. Advising a patient to pick a plan solely based upon cost
  6. NOT CHECKING PLAN CHANGES EVERY YEAR
PENALTIES

▪ Part D premiums are higher if the patient waits too long to enroll
  ▪ Exceptions
  ▪ Pay the penalty for as long as you have plan coverage
    ▪ 1% of base premium ($35.02)
  ▪ Penalty amount changes every year
EXAMPLE: PENALTY CASE

- Lori first became eligible for Part D April 17, 2013 but didn’t join a plan
- No drug coverage at all and is paying out of pocket for all medications
- Joined Medicare Part D during 2017 Open Enrollment
- Plan begins January 1, 2018

What is her monthly penalty fee?
PENALTY CASE: MATH TIME!

- How many months was Lori without coverage?
  - 56 months

- Penalty is 1% for each month
  - 56 months \times 1\
  - .56%

- National base beneficiary is $35.02
  - $35.02 \times .56 = 19.61 \text{ rounded to the nearest } $0.10

$19.60 \text{ monthly late fee in 2018}$
WHAT ‘S NEXT?

WHAT CAN A PHARMACY TEAM LOOK FORWARD TO IN THE FUTURE?
FUTURE POSSIBILITIES

GOOD CHANGES

The APhA supported the following changes that were made for 2018:

▪ Medication reconciliation post discharge for Medicare Part C Members as a new Star Rating measure
▪ High risk medications in the Medicare Part D elderly population being removed as a Star Rating measure to a display measure

The APhA recommended the following changes to be considered in the future:

▪ Pneumococcal vaccination status for older adults who are Medicare Part C participants to be moved from display measure to Star Rating
▪ Continue an aggressive approach to implement a team-based approach to lower the amount of elderly patients with dementia being treated with atypical antipsychotics

The APhA expressed that MTM services are valuable and yet still underutilized in practice. For every $1 spent on MTM services, anywhere from $4 up to $12 is saved. 

FINAL THOUGHTS

▪ Third party knowledge isn’t always fun
  ▪ Education and awareness from the pharmacy team can save time and money for the patient and the pharmacy

▪ Ask questions!
  ▪ Inquire about MTM quotas at your workplace
  ▪ Find out how well your pharmacy contributed to measures or scores and how you can improve

▪ Protect yourself!
  ▪ Remember, recommending a specific plan based on a patient’s health needs to the patient is considered illegal and a conflict of interest

▪ Stay tuned!
  ▪ A lot of national changes are coming in the years to come! Make sure you and your team stay aware of how it can affect you and your patients
QUESTIONS
Samantha.thompson@famu.edu
THANK YOU

SAMANTHA THOMPSON, PHARMD
ACADEMIC PHARMACY RESEARCH FELLOW 2016-2018
FAMU COLLEGE OF PHARMACY
REFERENCES


6. https://secure.ssa.gov/i1020/start


REFERENCES


17. https://q1medicare.com/PartD-EOB3OutOfPocketAndTotalDrugCosts.php