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PRESIDENT'S MESSAGE

Dear Members of MPhA,

Greetings! As I write this letter, we are closing in on the end of the school year, the halfway point of 2021, and the annual convention. Another milestone that approaches is the end of my term as President of MPhA.

I cannot express to you all enough how excited I am to be having a live convention on the Mississippi Gulf Coast. It sure feels good to be able to see many of you face-to-face and to be bringing the convention back home to Mississippi.

Many things have transpired with my time serving on the Executive Committee and, as President, most of which have been very enjoyable and great for the advancement of the association and the profession. Many have worked to make MPhA and our profession a little better each day, and it has been a privilege to work alongside you. I am looking forward to seeing what the next year holds as we will be under the leadership of a new Executive Committee and President, Peyton Herrington, and the continued leadership of Executive Director, Beau Cox. I would also like to take this opportunity to thank our Executive Director, Executive Committee, Office Manager (Corrie Sigler), committee leaders and members, and volunteers that have made this past year the success it has been.

It has truly been an honor to serve you as President of MPhA. If we can be of help to you, please to not hesitate to contact us.

Sincerely,

Wes Pitts, Pharm.D., BCPS, FASHP, FMSHP
President, Mississippi Pharmacists Association

EXECUTIVE DIRECTOR'S MESSAGE

WHAT AN AWESOME CONVENTION! Thank you so much to all of you who were able to attend the 150th annual MPhA Annual Convention. A post COVID live meeting is hard enough to put together, not to mention our original venue canceling on us within 60 days of having the event. I want to thank our office manager, Corrie Sigler, for all the time and energy she put into making the event successful as well as our Executive Committee (Wes Pitts, President), Education Committee (Olivia Strain, Chair), and Awards Committee (Wilma Wilbanks, Chair). And most importantly, I want to thank those who were able to attend this year. We had 83 members join us at convention along with 40 students and 22 exhibitors. I was especially impressed with the caliber of students this year.

Convention is time of year that we have a changing of the guard on our Executive Committee and I am very excited to be working with the new line up. Peyton Herrington-President, Tripp Dixon- President Elect, Buddy Ogletree-Vice President, Emily Bond-Treasurer, Olivia Strain-Member at Large, Cliff Kelly-Member at Large, and Wes Pitts-Past President. Please take a moment to visit our website, www.mspharm.org, and look under the "about us" tab to learn a little more about each of our Executive Committee Members.

Peyton, the Executive Committee, and I have already hit the ground running and have big plans for the upcoming year. We will be sending out information soon on the details of our upcoming Consultant Pharmacist Seminar in September making sure that our CE will be engaging and specific for the needs of our consultant pharmacists. We are also looking at redrawing our district map to reduce the number of districts from 9 to 4 and working closely with our district chairs to have more events throughout the state this fall.

We need your help. As with any association, civic club, church, etc, our greatest asset is our membership and we want you to be involved and get others involved to get the most out of your membership. MPhA is focused and dedicated to offering our members opportunities for networking, education, and legislative action.

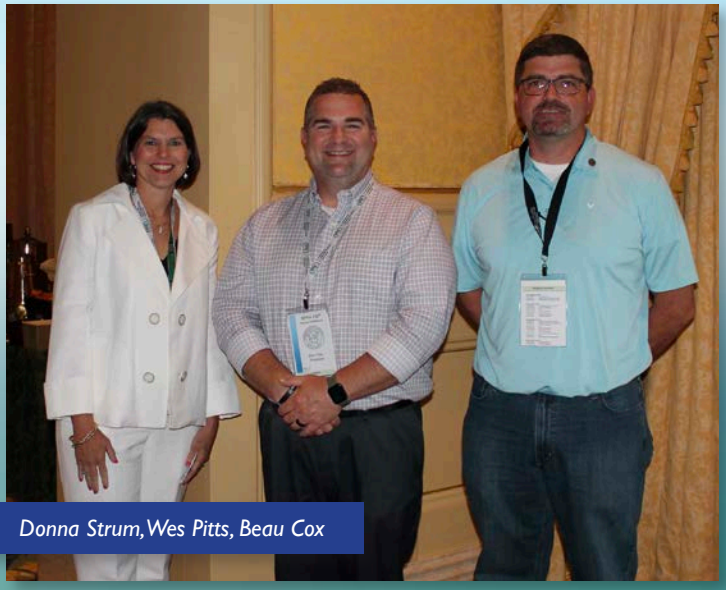
A lot of pharmacists don't understand how important the legislative piece of our association is and how much time we spend working on issues that affect pharmacy. As I write this letter, we have been working with MIPA, NCPA, CMS and other groups to try and stop the implementation of the new Medicaid Technical Amendments bill that will freeze NADAC as of July 1, 2021 and can not be changed without approval from the legislature. Please take a minute to reach out to your legislators to let them know how detrimental this is going to be for not only pharmacists, but more importantly, patients we serve throughout Mississippi. This leads me into the need for a robust PAC fund to help fight issues affecting pharmacy in MS. Please consider donating online to help us continue to fight for pharmacy in the state.

As always, I am grateful to be able to serve as the Executive Director and look forward to working for our great profession in the coming year.

Thank you,

Beau Cox

150TH ANNUAL CONVENTION



Donna Strum, Wes Pitts, Beau Cox

Jay Barnhart, Manisha Dadlani, Kim Allen, Anna Kathryn Ward

Gerimed: John Schutte, Beau Cox, Denny Sherrill, Randa Raymer

Matt Mangold, Kim Allen

Olivia Strain, Peyton Herrington

Tripp Dixon, Kelly Dixon, Olivia Strain, Tyler Hendrix

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2021 MPhA AWARDS

BOWL OF HYGEIA
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JORDAN BALLOU

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LARONDA MANUEL

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MISSISSIPPI DEPARTMENT OF HEALTH

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VERONICA GUASTELLA

DISTINGUISHED YOUNG PHARMACIST:
KIMBERLY ALLEN

EXCELLENCE IN INNOVATION:
ANNA KATHRYN WARD

MEDICARE PART D AND OPPORTUNITIES FOR PHARMACISTS WITHIN PART D

Matthew Wittman, PharmD Candidate 2022, University of Mississippi School of Pharmacy
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Topic: Medication Therapy Management and Health Outcomes

GOAL:

This continuing education article is intended to provide Mississippi pharmacists and pharmacy technicians with baseline knowledge regarding Medicare structure, recent Medicare changes, and billable Medicare pharmacy services.

OBJECTIVES:

By the completion of this activity, the participant will be able to…

- Identify patients eligible for services provided in Medicare Parts A, B, C, and D
- Define and describe recent changes related to the Medicare coverage gap
- Recognize pharmacy-related services covered under Medicare Part D
- Differentiate billing and reimbursement methods for pharmacy clinical services provided under Medicare Part D

INTRODUCTION

A study published in 2012 entitled, "Use of Pharmacists or Pharmacies as Medicare Part D Information Sources" utilizing a sample of 4,724 Medicare beneficiaries, showed only 13% utilized pharmacists for their Medicare Part D information. In addition, only 15% of sampled patients with three or more prescriptions utilized a pharmacist for Medicare Part D information.[1] While this study was performed over 10 years ago, it still shows a potential area of growth for pharmacists as a source of information regarding Medicare. In 2019, the Center for Medicaid and Medicare Services (CMS) produced an 88-page document titled "Your Guide to Medicare Prescription Drug Coverage."[2] This document is extremely dense and contains information for patients regarding Medicare coverage. Patients can be directed to this document if they have Medicare questions, but they could be overwhelmed by it. Rather, there is a need for the pharmacy staff to be able to answer patient questions about Medicare Part D. This article will explain the basic structure of Medicare and billing related to different Medicare parts, and Medicare Part D will be discussed more in-depth including the coverage gap and pharmacy related services.

MEDICARE HISTORY

Medicare was founded in 1965 when President Lyndon B. Johnson signed into law the Social Security Act Amendments. Upon initial signing, there were only 2 parts to Medicare, Part A and Part B. The third part to Medicare, Part C, was added with the Balanced Budget Act of 1997. In 2003, the Medicare Prescription Drug Improvement and Modernization Act was signed, effectively creating Part D. Medicare Part D, the prescription drug plan, went into effect in 2006, 3 years after the Medicare Modernization Act was signed.[3] There are four different populations that qualify for Medicare eligibility. The first three are individuals with End Stage Renal Disease (ESRD), individuals younger than 65 years of age collecting disability for at least 2 years, and individual's living with Lou Gehrig's Disease (ALS). The fourth population group contains the most beneficiaries and includes Americans over the age of 65.[4] In total, Medicare covers approximately 61.2 million beneficiaries in the United States, which is around 15% of the national population.[5]

UNDERSTANDING MEDICARE PARTS

As previously mentioned, Medicare has 4 parts that may be utilized for healthcare coverage. Medicare parts include A, B, C, and D, and each part covers a different aspect of healthcare. Part A covers most inpatient services. Commonly seen services that are covered in Part A can be found in Table 1.[6] Most of these costs are handled by facilities billing offices and are not directly handled by pharmacists. Part A is funded and paid for by the Hospital Insurance (HI) Trust Fund. The HI Trust Fund is primarily funded by Medicare taxes, interest earned on the HI Trust Fund, and Part A premiums from those who are not eligible for premium-free Part A. Any individual receiving Social Security payments is eligible for premium-free Part A. This incorporates a majority of Medicare Part A beneficiaries. In addition to paying Part A expenses, the HI Trust Fund also funds all general Medicare program administration costs.

Medicare Part B covers most outpatient services. Common services that are covered in Part B can be found in Table 1 as well.[6] All screenings for infections and disease states are billed under Part B in addition to the other mentioned services. Pharmacists currently do not have provider status to bill for services through Part B. The third part of Medicare, Part C, has been called Medicare Advantage due to changes from the Medicare Modernization Act of 2003. Medicare Advantage is a private health care plan providing Medicare Part A and Part B coverage under Medicare approval.[7] Medicare Advantage is not a supplemental insurance plan, rather it is a managed care healthcare plan. The final part of Medicare is Part D and is the part with which pharmacists and technicians are often most familiar. Medicare Part D is a voluntary program utilizing private prescription drug plans to provide prescription coverage. Part D does not cover physician services or inpatient costs since it is strictly prescription coverage. Many immunizations and other clinical services are also covered under Medicare Part D, and this will be discussed later in the article.

Enrollment varies between each of the Medicare parts in addition to the types of services covered. An individual is automatically enrolled in Medicare Part A upon reaching the age of 65. Beneficiaries then have the opportunity to participate in voluntary enrollment, which occurs in Part B, C, and D. Part B enrollment is not automatic but recommended at the same time as Part A. and premiums are standard following initial enrollment.[7] If a patient chooses to not enroll in Part B initially, and instead sign up later, they could face an additional 10% penalty added to their premiums for each 12 month period they delayed coverage. Patients who wait to enroll in Part B for 36 months, for example, would be required to pay a 30% penalty on all premiums for the rest of their Medicare coverage.[8]

BASIC STRUCTURE OF MEDICARE PART D

Medicare Part D is funded through the Supplementary Medical Insurance (SMI) Trust Fund, which also funds Part B. The SMI Trust Fund is funded by the federal government and by premiums that some Medicare beneficiaries pay. In 2018, the federal government funded about 71.5% of the SMI Trust Fund.[9] Part D prescription drug plans are required to have CMS-approved formularies that are reviewed regularly. Each plan must have a Pharmacy and Therapeutics (P&T) Committee composed of pharmacists, physicians, and other relevant clinicians that assess and amend the formulary, as necessary. This is to ensure that beneficiaries are receiving an acceptable level of quality care. CMS's Medicare Modernization Act Formulary Guidelines stated that the goal of their guidelines on P&T formulary management is, "for plans to provide high-quality, cost-effective drug benefits by negotiating the best possible prices and using effective drug utilization management techniques."[10] Plans have the freedom to perform and encourage step therapy, prior authorizations, and other cost utilization therapy decisions. Plans may also have tiered medications and offer lower copayments for patients taking medications from the preferred tiers. Tiers are commonly broken up based on the price and benefit of the medication. These tiers may vary between prescription drug plans but often all involve separating generic, brand, and specialty medications into separate tiers.

Beneficiaries enrolled in Medicare Part D still have to pay premiums for Part D in addition to premiums paid for Part A, B, and C. However, unlike Part A and B, beneficiaries of Medicare D have a choice in the coverage they receive and select a Part D plan from the list Medicare provides. Part D enrollment opens in mid-October and runs through early December. Plans have yearly coverage that begins on January 1st, assuming enrollment is completed by early December. Although many Medicare Part D plans exist, each plan has differences that benefit eligible members. Commonly seen and recognized Part D plans include Aetna, Humana, WellCare, United Healthcare, and Express

Scripts. The two important factors eligible beneficiaries need to consider when selecting their plans are whether their current medications are covered and whether they will need to use a specific pharmacy after selecting that plan. These factors are of immense importance for patients to consider when selecting a plan.

The three financial questions that each eligible beneficiary needs to consider when selecting their plans are: What is my deductible? What is my premium? and What is my coinsurance percentage? Both pharmacists and pharmacy technicians also need to be knowledgeable about Medicare premiums, deductibles, and coinsurances in order to best assist patients. Premium refers to the monthly payment required for a Medicare plan. A premium can be compared to any other consistent, monthly bill and spoken about to Medicare beneficiaries as such. Premiums are required monthly for Medicare coverage and do not directly affect the price of medications in the pharmacy. A deductible is a set out-of-pocket dollar amount that must be paid by beneficiaries prior to full benefits taking effect. These payments are not paid in the form of a bill to the plan but rather often occur as out-of-pocket expenses for medications, usually at the pharmacy. Deductibles and premiums can vary from plan to plan, but Medicare has added an income element to monthly premiums: depending on the yearly income from the previous year, beneficiaries might fall into certain brackets that require slightly higher premiums. These usually require increases in monthly premium payments based on the income bracket to which the individual is assigned. The deductible is usually relevant at the beginning of the new year as most Medicare plans run from January 1 to January 1. In the year 2021, no Medicare plan may have a deductible higher than $445.[11]

A final important factor for beneficiaries to consider when selecting their plan is the coinsurance payment they will have to make for each prescription drug. Coinsurance is defined by Medicare as the percentage beneficiaries may be required to pay as their share of costs after the deductible is met.[11] Coinsurance payments are similar to copayments but vary in that coinsurances are set percentages, whereas copayments are set payment amounts. Coinsurance percentages are usually, though not always, the reason why beneficiaries are required to pay out-of-pocket costs for prescription medications. Deductibles and coinsurances factor into the daunting Medicare coverage gap, but premiums do not.

THE COVERAGE GAP

While beneficiaries are allowed to freely select their plan in Medicare Part D, most plans will have a coverage gap, sometimes referred to as the "donut hole". The coverage gap exists in these plans as a temporary period where patients have to spend more on medications. The coverage gap is not defined by a time period, rather it is defined by spending amounts. There are four major phases in Part D plans: the deductible phase, the coverage phase, the coverage gap phase, and the catastrophic coverage phase. These 4 phases make up the working coverage provided to Medicare beneficiaries. The timeline through Part D coverage progresses in the previously listed order. Most beneficiaries start in the deductible phase at the beginning of the calendar year in January. Some plans don't have a deductible, and patients enrolled in these plans immediately, instead, enter the coverage phase.

The coverage phase is the period in which a patient's Part D plan is providing full benefits. In the coverage phase, patients will have certain copayments for medications based on their plan specifications. Medicare and its beneficiaries pay a set amount based on the agreement signed when the plan is selected during this time. The coverage phase continues until a fixed amount of spending is reached. This amount is the sum of Medicare spending and beneficiary spending for medications.[12] The set amount for 2021 is $4,130 in combined spending. According to Medicare.gov, the items contributing to the coverage gap spending amount include deductibles, coinsurances, and copayments.[12] Items that do not contribute to the coverage gap spending amount include the premium paid to the plan, the dispensing fee, and medications that are bought over the counter or without Medicare coverage. Once the combined spending reaches $4,130 for the calendar year, the patient enters the coverage gap phase. It is important for some beneficiaries who are uneasy about Medicare to know that not every person enters the coverage gap. Beneficiaries of Medicare Part D should receive a monthly Explanation of Benefits (EOB) notice stating how much they have spent on covered medications, as well as, how close they are to the coverage gap.[2] This information can be quite useful to beneficiaries as they track how much medication spending has occurred. Drug plans send these EOBs in the mail to the beneficiaries monthly and are recommended to be kept and read thoroughly each month.

When inside the coverage gap, or donut hole, beneficiaries are required to pay more than they would be required to in the coverage phase. Before the Affordable Care Act, patients in the donut hole were required to pay for 100% of their medicines until they got out of the coverage gap. Since the Affordable Care Act, the coverage gap coinsurance has been steadily dropping. Over the last 10 years, under the Affordable Care Act, the goal for the coverage gap was to lower the coinsurance from 100% to 25%. In 2021 the coinsurance required of beneficiaries in the coverage gap is 25%.[13] The coverage gap phase has an upper limit of out-of-pocket spending, similar to the coverage phase. Once a beneficiary spends $6,550 out of pocket in the calendar year, they progress to the next phase of coverage, the catastrophic phase. The tricky part about calculating these numbers for patients is that generic medications and brand name medications do not work the same in getting the beneficiary to $6,550. Both types of medications have 25% coinsurances, but the amount applied to the out-of-pocket spending sum varies. For generics, the beneficiary will pay 25% of the plan's cost of the medication and 25% of the dispensing fee. Both of these numbers contribute to the out-of-pocket spending amount that the beneficiary has spent, but the 75% that Medicare spent does not count towards out-of-pocket costs. For brand name medications, the beneficiaries still pay 25% of the medication and dispensing fee. The difference is that instead of Medicare paying the remaining 75%, the manufacturers discount the medication price by 70%. This leaves Medicare to pay only 5% of all brand name drug costs and 75% of the drug dispensing fee.[12] While Medicare spends less on brand name medications, this breakdown of payments helps beneficiaries get out of the coverage gap sooner. For brand name medications, 25% of the medication price and dispensing fee, in addition to the the 70% manufacturer discount are all applied to out-of-pocket spending. With brand name medications, Medicare pays less, but beneficiaries are quicker to get out of the coverage gap. Regardless of medication type, however, the beneficiary is expected to pay 25% of the medication fee and dispensing fee.[12]

Once a patient has met the $6550 amount in the coverage gap phase, the next phase is the catastrophic phase. This phase is where Medicare assumes a large portion of the costs and leaves the patient with a very small coinsurance to pay. Once a patient reaches the catastrophic phase, their out-of-pocket spending lowers dramatically. While this phase is helpful for beneficiaries, there were considerable healthcare costs already paid by the beneficiary to get to this point. There is no phase after the catastrophic phase, so once a patient reaches this phase, it can be expected for the remainder of the calendar year. When the calendar year resets, these patients will start back in the deductible phase of their plan. A study by the Commonwealth Fund in 2017 found that only 5% of Part D beneficiaries reached the catastrophic phase, while approximately 35% of those taking one or more specialty drugs reached the catastrophic phase.[14] So while this phase is relatively uncommon to reach in the usual retail setting, it still can occur. Patients taking high-cost medications or specialty drugs in the retail setting could reach their catastrophic phase. In addition to the retail setting, specialty pharmacists frequently encounter beneficiaries in the coverage gap.

Communication with patients is a key part of the patient-pharmacy relationship. Pharmacists and pharmacy technicians need to be able to articulate to patients how and why their medication prices have increased. For Medicare Part D beneficiaries, the likely reason for increased prices is that they have entered the coverage gap. Beneficiaries may not even know that the coverage gap exists, so having a pharmacist or technician explain it to them could be very helpful and worthwhile.

CHANGES TO MEDICARE PART D

While varying medication prices may be stressful, the Center for Medicaid and Medicare Services is attempting to make significant changes. One of the major campaigns CMS is promoting is increased drug pricing transparency. To initiate this campaign, CMS has announced that starting January 1, 2023, all Part D plans will be required to have a real-time benefit comparison tool.[14] This will assist patients in having a better idea of the true out-of-pocket cost of their medications at any time before picking up from the pharmacy. It can also be utilized by prescribers to help patients minimize out-of-pocket costs. This real-time utilization tool was mandated in 2021, with full implementation required by January 1, 2023. Another change that is occurring is that the specialty tier on formularies will now have a preferred specialty tier and non-preferred specialty tier.[14] This will allow for lower costs to patients since plans will be able to negotiate lower prices from the manufacturers and place medications on the preferred specialty tier. This

change will allow for beneficiaries on specialty drugs to have lower out-of-pocket costs and potentially lower the chance that they enter the coverage gap phase.

Another change that is going to occur in Medicare Part D will impact pharmacies more than beneficiaries. Prior to this 2022 Final Rule change, plans did not have to disclose to CMS methods for measuring quality of care in pharmacies for reimbursement. Pharmacies would be reimbursed based on their quality of care, but the measures themselves were unknown to CMS. The 2022 Final Rule change now says that plans must disclose these measures to CMS which allows for CMS to see how the measures are being applied. CMS then has the opportunity to publicly relay information regarding these measures and performance for transparency reasons. This should help highlight specific metrics used in measuring quality of care.

Since Medicare is a federally funded program, it is subject to potential legislative changes. The aforementioned Affordable Care Act worked to close the coverage gap from 100% coinsurance to 25% by 2020. According to the American Journal of Managed Care's article on Part D Coverage Gap Reform, "After the Affordable Care Act's coverage gap reform, beneficiary out-of-pocket costs for prescription drugs significantly decreased despite an increase in drug utilization."[13] There were hopes of the coverage gap phase closing entirely, however that has yet to be put through the legislative process. Other legislative proposals have included removing the manufacturer's discount from the amount that gets applied to out-of-pocket expenses when beneficiaries are in the coverage gap.[15] This would result in increased beneficiary costs when in the coverage gap if the 70% manufacture discount no longer applies. This proposal did not pass, and currently discussions in legislation regarding Medicare Part D center around pharmaceutical industry companies reducing their required discounts. This is in response to the Bipartisan Budget Act of 2018, which pushed Medicare and beneficiary spending down, and required manufacturers to discount their medications even more when in the coverage gap.[15] Manufacturers previously had to discount their prices by 50% but the Bipartisan Budget Act of 2018 pushed those numbers up to 70%. This led to some pushback by manufacturers in the industry.

PART D RESOURCES

Studies have found that "the coverage gap in Part D plans has unfavorably affected beneficiaries' out-of-pocket costs, drug use, and medication adherence."[13] Medication adherence is often adversely affected due to the coverage gap and can lead to poorer health outcomes. Pharmacists and pharmacy technicians, through proper resources and training, can assist patients in better understanding the coverage gap to lower additional negative outcomes. Proper understanding of the Part D process, and in particular the coverage gap, can lead to better patient adherence and less out-of-pocket spending by patients. The coverage gap can be tricky for patients to understand and both pharmacists and technicians need to be able to explain the gap to patients. Sometimes pharmacy staff may also need to find additional resources to give to the patients to aid in explanations of coverage.

Medicare sends out resources to their beneficiaries but often times can be long, dense, and confusing. When patients have questions, it is important for pharmacists to not only have the knowledge to answer such questions but know additional resources to provide to patients. Medicare.gov contains basic Medicare information, how it is funded, and what services are covered by the different parts. Medicare.gov is also very informative regarding the coverage gap- and could be a great resource for patients who need additional information. "Your Medicare Guide" is available on the Medicare website and is extremely informative, but the 87-page document can be overwhelming.[2] Thus, it is a good resource but could be too much for some patients. AARP has a good link to Medicare Made Clear that can help educate patients about what Medicare is and how they can improve their healthcare and limit expenditures.[16] Ehealthinsurance.com has a very good example of calculating coverage gap costs that could be useful to pharmacists in practice.[17] This example walks through step by step how patients transition into to the coverage gap and how they can get out of the coverage gap. This resource would be beneficial for pharmacists to utilize at a moment's notice if needed. Pharmacists can be valuable resources of information and should be adequately equipped to answer Part D questions and explain the coverage gap. While explaining the cost of their medications to patients may be uncomfortable, these resources could give pharmacists and technicians additional techniques for communication with patients about increasing medication expenditures.

Pharmacists and technicians will encounter Part D drug plans for the foreseeable future, so familiarity with Medicare Part D can alleviate headaches and make patient interactions more comfortable. The coverage gap is a tricky situation to encounter and can be confusing for everyone involved. Keeping up with Medicare changes can help pharmacists stay on top of Part D and provide better care for their patients concerning their prescription drug plan. The remainder of this article will focus on pharmacy-related services covered under Medicare Part D, qualifications for medication therapy management eligibility, and methods for billing clinical services under Medicare Part D.

PHARMACY-RELATED SERVICES COVERED UNDER MEDICARE PART D

Coverage for pharmacists' advanced clinical services is a topic of ongoing discussion, and reimbursement for these services differs from plan to plan. Current coverage for direct Part D billing includes immunization administration, point-of-care testing, and Medication Therapy Management (MTM). [18, 19, 20] While it is important to recognize that expanded clinical services for pharmacists are covered under Part B as 'incident to the physician' billing, that will not be a focus of this discussion.

Providing immunization services in the pharmacy has become increasingly common over the last decade, with the vast majority of pharmacies offering this clinical service. Any commercially available vaccination may be covered under Part D, but reimbursement for each differs between specific Medicare plans. [21]

Point-of-care testing is a newer avenue for billing under Medicare Part D to which pharmacists have become accustomed after stepping up to combat the COVID-19 pandemic. To perform point-of-care testing, a pharmacy must submit the form CMS-116 to the Mississippi State Department of Health. After approval, a pharmacy may perform point-of-care testing for Influenza, Streptococcus A, HIV, Hepatitis C, Lipids, A1C, INR, and COVID-19; however, reimbursements for each differ among specific Medicare plans. [19, 22, 23] It is also important to note that more or fewer point-of-care testing options may be available depending upon the specific Medicare plan and state.

Medication Therapy Management (MTM) is a distinct service or group of services that optimizes therapeutic outcomes for individual patients. [18, 24, 25, 26] This broad definition makes it applicable to many different pharmacotherapy interventions, including comprehensive medication review, safety and efficacy monitoring, disease state control assessment, medication therapy optimization, adherence monitoring, patient education, analysis of medication cost-effectiveness, transitions-of-care, and creation of action plans for treatment. [18, 27] These clinical services apply to any disease state, which provides pharmacists the opportunity to use professional knowledge and clinical skills to ensure that the patient's medication therapy is ideal for both disease state control and quality of life. The primary means that Medication Therapy Management is administered by pharmacists is through Comprehensive Medication Reviews (CMR) and targeted medication interventions. Although CMRs and targeted medication interventions are distinct services, both revolve around patient education, monitoring of medication use, and assessment of disease state control.

The most robust clinical service covered under Medicare Part D is the comprehensive medication review (CMR). CMRs allow the pharmacist to apply high-level clinical knowledge to assess medication therapy in terms of efficacy, safety, adherence, and disease state control. [18] CMRs involve the pharmacist, not only to conduct an expert review of medication use but also to make suggestions for interventions or changes to treatment. Pharmacists have the potential for an immense impact on the quality of patient care through providing MTM services because of their accessibility, patient contact frequency, and established patient relationships. One study showed the benefits of pharmacist-led MTM programs by highlighting 886 drug-related issues in just 150 patients, 313 of which led to medication changes. [28] Although pharmacists have the potential to provide valuable services because of their patient education skills, accessibility, knowledge, and clinical expertise, starting a new service is always challenging. CMS requires pharmacists completing a CMR to document it in the specific format of Form CMS-10396, which can be found on the CMS website. [1] Figure 1 outlines the essential components of a CMR mandated by CMS to help highlight the roles pharmacists can play. [18, 24, 26]

As mentioned previously, CMS does not restrict the type of clinical services that the pharmacist may provide or for which disease states, but the common reasons for pharmacists to perform targeted medication interventions that are known to be billable by Part D plans are listed in Figure 2. With that being said, interventions should be patient-specific, and

services may be provided that fall outside of these areas as long as it is allowed under the Mississippi Pharmacist's scope of practice. The scope of practice as defined by the Mississippi Pharmacy Practice Regulations is as follows.[29]

> The "Practice of pharmacy" shall mean a health care service that includes, but is not limited to, the compounding, dispensing, and labeling of drugs or devices; interpreting and evaluating prescriptions; administering and distributing drugs and devices; maintaining prescription drug records; advising and consulting concerning therapeutic values, content, hazards, and uses of drugs and devices; initiating or modifying of drug therapy following written guidelines or protocols previously established and approved by the Board; selecting drugs; participating in drug utilization reviews; storing prescription drugs and devices; ordering lab work in accordance with written guidelines or protocols as defined by Section 73-21-73, paragraph (jj), Mississippi Code of 1972

Figure 2 provides an overview of targeted medication interventions. Whether performing A CMR or targeted medication intervention, proper documentation of each encounter is essential for continuity of patient care. Documentation also provides proof, in the event of an audit, that the service was performed to the standards of CMS by a competent pharmacist.

Figure 1.

Essential Component	Necessary Inclusions	Comments
Systematic Review of Current Medication Therapy	Name, dose, strength, route of administration, and instructions for use of every medication, including prescriptions, OTC medications, herbal products, vitamins, and foods with the possibility of interactions Disease symptoms Adverse drug reactions Adherence to medications Medication affordability	Adequate collection of data is essential to quality MTM services. It is key to assess in each component the patient's knowledge, barriers to care, and current medication use. Use open-ended questions when possible.
Professional evaluation of each medication	Assessment of treatment efficacy based on symptom or disease state markers Adverse reactions to listed medications Drug-Drug interactions Drug-Disease interactions Drug-Food interactions Need for additional medication use Need for medication de-escalation or discontinuation	This portion involves taking the information gathered to determine in what areas treatment could be optimized. It is important to use clinical resources for reference and consider all aspects of the patient's health. Any identified patient gaps in knowledge, barriers to care, or nonadherence may be addressed here as well.
Personalized Medication Action Plan	Suggestions for immunizations Suggestions for diet and exercise Suggestions for current medication use, including time of day, relation to meals, relation to concurrent medication administration, etc. Suggestions for providers	The personalized action plan should be ranked from the most important to the least important interventions. It may be appropriate to contact the provider immediately if rapid or serious intervention is needed.
Mailed copy for the patient's reference	A mailed copy of the Personal Medication List and Medication Action Plan should be sent with a cover letter. This mailed copy will detail the medication list with instructions for use, recommendations for care, and an action plan personalized to the patient's needs.	This gives the patient a reference for medication use, lifestyle improvements, and topics to discuss with their medical provider.

CMS ELIGIBILITY REQUIREMENTS FOR MTM SERVICES

CMS requires that every Medicare Part D plan must cover, at minimum, any enrolled beneficiary who meets all of the following criteria: have multiple chronic diseases, are taking multiple Part D drugs, and are likely to incur annual Part D drug costs that meet or exceed a certain threshold. The annual drug cost threshold is updated yearly based on the previous year's spending data, and $4,376 represents the 2021 requirement.[18] Individual plan beneficiary requirements may be less strict than the requirements outlined by CMS but cannot be more restrictive.[30] Humana's MTM requirements are listed below for reference.[31]

Humana Requirements for MTM Services:

- Have at least 3 of the following chronic diseases:
  - o Diabetes
  - o Chronic Heart Failure
  - o Dyslipidemia
  - o Asthma
  - o Rheumatoid Arthritis

AND

- Take a minimum of 8 chronic maintenance (Part D) drugs

AND

- Have anticipated Part D drug costs of at least $4,376 in 2021

As you can see from this specific plan, the ambiguity of CMS requirements allows an insurance company to limit which chronic diseases that it chooses to include. While many Medicare patients will have three chronic diseases, to qualify for receiving clinical pharmacy services, the patient must fit into this restricted set of criteria. Likewise, the insurance provider is allowed to interpret 'multiple part D drugs' as 8 or

more chronic medications. Being adherent to one medication daily can be extremely challenging for patients, so this large medication threshold withholds MTM services from many patients who would benefit. Although CMS left the first two requirements up to interpretation, the last requirement is a dollar value that will not change until CMS reevaluates said value for the following year. When the patient meets all three criteria, they are eligible for MTM services in the form of both CMRs and targeted medication intervention. If billing directly to a particular insurance company, it is important to know that your patient meets the exact requirements for that specific plan, or the claim may be rejected.

METHODS FOR BILLING CLINICAL SERVICES UNDER MEDICARE PART D

The ability to bill for clinical services has historically been a significant barrier for pharmacists to hurdle, because a lack of reimbursement makes diverting working hours to perform these valuable assessments difficult. Before the rise of MTM-specific codes and platforms, the only way to receive compensation for advanced clinical services was through incident-to the physician billing. Since pharmacists still are not recognized as a provider of clinical services, a pharmacist must bill under the physician for the services provided. This requires protocols, contracts, and restrictions that make it infeasible for pharmacists in the community to undertake. This section seeks to give an overview of how to bill for the Medication Therapy Management services outlined previously.

Figure 2. Targeted Medication Intervention

Target Intervention Type	When is it Performed?	What does that look like?
Provider Consultation	Medication conflicts arise, duplicate therapy exists, or a more cost-effective therapy is available	After speaking to the patient to confirm the medication issue, reach out to the prescriber to present the issue and provide a suggestion for alterations in therapy.
Adherence Monitoring	Medication filling is over or under-utilized.	Speak to the patient about their current medication use patterns, address barriers to adherence to proper medication use or administration, counsel and educate the patient on proper medication use, and provide solutions to improve adherence.
Education	Point of sale (or closely thereafter) of a new prescription or over-the-counter (OTC) medication	Perform normal medication-specific education with all relevant drug information. This includes, but is not limited to drug name, strength, dosage form, route of administration, instructions for use, disease state education, the potential for side effects, medication storage, the potential for drug interactions, the potential for food interactions, instructions for a missed dose, and any other information that the pharmacist deems necessary for safety and efficacy.
Medication Monitoring	Routinely throughout the course of chronic disease management with the purpose to identify drug therapy problems, of which may be future billable MTM opportunities	Discuss with the patient satisfaction with therapy, adverse effects, disease symptoms, adherence, and addressing any patient questions.

The most basic form of billing is submitting a direct claim to the patient's Medicare plan through MTM-specific billing codes.[32] These codes, outlined in Figure 3, are the means by which pharmacists may be reimbursed for their clinical services. The aforementioned MTM services, point-of-care testing, and immunizations are covered and billed by submitting these codes with an insurance claim after completion and documentation of services, so long as the services comply with the pharmacist's scope of practice.

MTM billing could present a unique challenge as there are different codes for new versus established patients. If the patient is new, the pharmacist provides an initial assessment in addition to the normal services and bills using

Figure 3. Billing Codes for MTM [4, 13]

Billing Code	Parameter For Billing
99605	Initial 15 minutes with assessment and intervention with a new patient
99606	Initial 15 minutes with an established patient
99607	Additional 15 minutes with a new or established patient

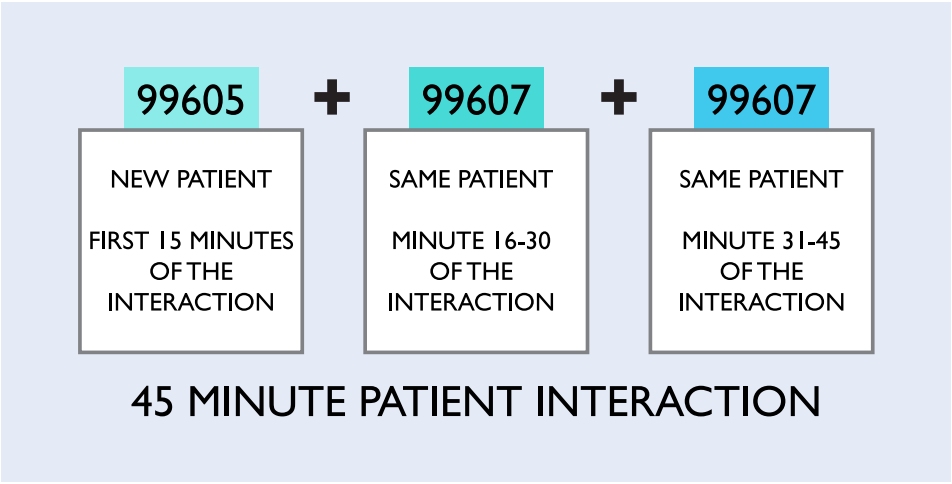
the code 99605.[33] If the patient is established, the pharmacist will bill for the initial 15 minutes with code 99606.[33] These two codes cover the initial 15 minutes of the patient interaction. Every additional 15 minutes spent afterward may be billed with code 99607.[33] To be compensated for the additional time, the pharmacist must submit codes for both the initial 15 minutes and each additional 15 minutes.[33] See figure 4 for an example using a 45 minute conversation with a new patient.

Requirements and reimbursement for MTM services differ among Part D plans. Each plan may require different documentation, training requirements, and means for super-billing (ie. electronic or paper form). A superbill is essentially an itemized list of services provided for a patient.[34] It is important to understand these requirements before beginning to

offer MTM services to ensure that the pharmacist meets the Part D provider's requirements and knows which items to document. After ensuring an adequate understanding of the Part D requirements and performing the MTM services, completing the superbill is as easy as completing the online or paper superbill with plan-specific documentation and including the appropriate billing codes. Determining plan-specific requirements is extremely time-consuming and difficult. Additionally, many insurance plans have in-house pharmacists providing the service or are already contracted with another pharmacy. In either situation, the superbill would be rejected. There are two alternative methods for ensuring payment that require less preparation and risk. The first method involves receiving payment from the patient at the time of service. After completion of the service, the pharmacist gives the patient a copy of the superbill with a receipt and instructions to submit the claim to their insurance for reimbursement.[35] The second method involves the pharmacist submitting the superbill; and, if the claim is rejected, the patient is responsible for paying for the MTM services.[35] Point-of-care testing codes are submitted in a similar way using the codes outlined in figure 5. It is incredibly important to fully inform the patient that the service may not be covered and exactly how much cost will be transferred to them.

The billing codes in figures 3 and 5 are a huge leap towards allowing pharmacists to be compensated for many of the duties they already performed, but submitting individual codes for each patient can be impractical for many

Figure 4.



pharmacies.[36] Identifying the patient eligibility for these services can also be challenging due to limits in immediately accessible information necessary to determine eligibility. This leads to the pharmacist spending time and resources to gather this information or to proceed with performing the service while having no guarantee of reimbursement. Neither of the alternative billing options is ideal considering many plans already have contracts with pharmacies or third-party platforms, and reimbursement may often depend on the patient's willingness to pay for the services. Individual pharmacies may seek out contracts with Medicare plans to provide MTM services, but this often involves far more time and effort than the average pharmacy can manage. Due to these shortcomings, many pharmacies find a more feasible means of completing and billing for medication therapy management is to use a third-party billing platform.

Third-party billing platforms either have contracts with specific Medicare insurance providers or view claim data to find patients that qualify for MTM services. These platforms then offer specific targeted interventions for these patients to the pharmacies where the patients fill their medicine. Although these platforms give specific interventions based on the patient's medication use, the majority of them allow the pharmacist to add new billable interventions as they arise. The identification of eligible patients and provided interventions from the platform streamline the time required of the pharmacist by both identifying patients and handling the billing for services. The platforms also filter eligible patients by the pharmacy in which they fill medications. This retains the advantage of established patient relationships that retail pharmacists have over insurance companies or third-party pharmacies. The primary drawback for the increase

Figure 5.
Billing Codes For Point-of-Care Testing These are common billing codes, but the specific code used depends upon the brand and type of test performed. See references for a full list of codes provided by CMS [20,23].

Billing Code	Test Performed
87635	SARS-CoV-2 Nucleic Acid Test
87426	SARS-CoV-2 Antigen Test
86408, 86409	SARS-CoV-2 Antibody Screen and Titer
87449QW, 87502QW, 87631QW, and 87804QW	Influenza
86703QW and 86701QW.	HIV
86803QW	Hep C
80061QW.	Lipids
83036QW and 83037QW.	A1c
85610QW	INR

in convenience is that the third-party platform takes a portion of the reimbursement.

A myriad of online MTM platforms are available, including OutcomesMTM, Clinical Support Services (CSS) Health, Neumentum, Integrated Prescription Management, SinfoniaRx, and Benzer Pharmacy, to name a few. This list is not exhaustive, and more platforms continue to appear as the number of pharmacies participating in MTM increases. After acquiring Mirixa, OutcomesMTM became the largest online administration portal for medication therapy management. It is widely used because it is a longstanding service, has an interface that is easy to use, and provides a large number of opportunities for MTM in the form of comprehensive medication review and targeted intervention. The targeted interventions OutcomesMTM provides are specific to a patient's disease and medications, but the platform also allows pharmacists to create new targeted interventions that are not already available on the MTM portal. This allows a method to bill for any additional interventions that the pharmacist provides during patient counseling or other MTM service.

Several MTM platforms, like CSS Health, Integrated Prescription Management, and SinfoniaRx provide very similar services to OutcomesMTM, while others offer more specialized MTM services. Neumentum is a neurology-focused MTM platform, Benzer Pharmacy is a chain of independent and specialty pharmacies, and ReviewGx is an MTM software focusing on pharmacogenomics. While these specialized MTM programs are interesting, the majority of pharmacies might not have use for them because of their niche patient populations.

When selecting which option for billing MTM services is best for a particular pharmacy, it is important to weigh the balance between opportunities available and the possibility for reimbursement. Billing for pharmacy services under Medicare Part D has greatly changed over the last decade and will likely continue to change in the future. As the practice of pharmacy progresses, the billing for clinical services lags further and further behind. The goals to increase billable opportunities for pharmacists to perform clinical services should be to engage local lawmakers to allow qualified pharmacists to practice at the highest end of their scope of practice and to encourage CMS to include pharmacists as providers for advanced clinical services involving medication therapy.

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CONTINUING EDUCATION

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MEDICATION THERAPY MANAGEMENT IN BARIATRIC SURGERY PATIENTS

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1. Which of the following accurately depicts the 4 basic parts of Medicare?
   a. I, II, III, IIII, b. 1,2,3,4
   c. A,B,C,D d. i, ii, iii, iiii

2. Which one of these populations is eligible for Medicare coverage based on their condition?
   a. Patients living with HIV
   b. Patients with End Stage Renal Disease
   c. Patients with Diabetes
   d. Patients with Hypertension

3. When patients are in the Medicare Coverage Gap, what percent of their medication costs do they need to pay for out of pocket?
   a. 15% b. 20%
   c. 25% d. 30%

4. The term for the amount paid, by a patient, for coverage each month to a Medicare Part D plan is called what?
   a. Coinsurance b. Deductible
   c. Copayment d. Premium

5. The Coverage gap is sometimes referred to as the _____ by patients and other healthcare professionals?
   a. Premium Hole b. Donut Hole
   c. Medicare Hole d. Payment Hole

6. When purchasing a brand name medication in the coverage gap, which answer choice accurately lists those responsible for paying for the medication?
   a. Pharmacy, Manufacturer, Patient
   b. Medicare, Pharmacy, Patient
   c. Manufacturer, Pharmacy, Medicare
   d. Manufacturer, Medicare, Patient

7. When a patient leaves the Coverage Gap, they enter what phase of Medicare Part D?
   a. Deductible Phase b. Coverage Phase
   c. Coverage Gap Phase d. Catastrophic Phase

8. What is being required of Part D drug plans starting January 1, 2023?
   a. Real-time benefit tool b. Free medications
   c. Lowered Premiums d. No coverage gap

9. What website has resources that can be given to the patient to better explain Part D?
   a. Medicaid.gov b. Medicare.gov
   c. FDA.gov d. CDC.gov

10. What is the highest amount a deductible is allowed to be in 2021?
    a. $4,130 b. $4,450
    c. $445 d. $45

11. A tool that beneficiaries can use to understand their Medicare spending, called the Explanation of Benefits, is received how often?
    a. Weekly b. Monthly
    c. Quarterly d. Annually

12. Which of the following is a covered service under Medicare Part D?
    a. Immunization services
    b. Point-of-Care testing
    c. Comprehensive Medication Reviews
    d. Targeted Medical Intervention
    e. All of the above are covered

13. Which of the following is required to be submitted to the Mississippi State Department of Health before initiating point-of-care testing?
    a. Form CMS-4 b. Form CMS-116
    c. Form POC-116 d. Form POC-4

14. Which of the following is not an essential component of a Comprehensive Medication Review (CMR)?
    a. Systematic review of current medication therapy
    b. Professional evaluation of select medications
    c. Personalized action plan
    d. Mailed copy of medication list and action plan for the patient's reference

15. Which of the following is true regarding the personalized action plan?
    a. The pharmacist should provide nonpharmacological recommendations
    b. The action plan should be listed from least important to most important interventions
    c. The patient's provider must be contacted immediately if lack of intervention may result in serious injury
    d. Both a and c
    e. All of the above

16. Which of the following is not billable under Medicare Part D because it falls outside of the Mississippi pharmacist's scope of practice?
    a. Instructing a heart failure patient complaining of diuretic-induced nocturia to take their diuretic in the morning rather than the evening
    b. Changing a patient's prescription for Metoprolol tartrate twice daily to an equivalent dose of metoprolol succinate once daily to help with medication adherence.
    c. Recommending the use of Coenzyme Q10 to help with statin-induced myopathy
    d. Providing medication recommendations to the prescribing physician for alterations to maintenance asthma therapy based on rescue inhaler use

17. Which of the following patients would meet the minimum requirements for MTM services regardless of the Part D plan?
    a. A 70-year-old male with heart failure taking 8 medications, totaling $6,000 per year in drug costs
    b. A 65-year-old female with heart failure, asthma, and rheumatoid arthritis that takes one medication for each disease, totaling $10,000 in yearly medication spending.
    c. A 65-year-old male with heart failure, dyslipidemia, and diabetes taking 8 medications, totaling $4,400 in yearly medication spending.
    d. A 75-year-old male with heart failure, dyslipidemia, diabetes, and asthma taking 10 chronic medications, totaling $4,000 in yearly medication spending

18. Which of the following is a reimbursement method for MTM services?
    a. Contracting your pharmacy with the insurance company
    b. Billing the insurance directly using claim codes for each service performed
    c. Charging the patient for services up-front with instructions for the patient to bill the insurance directly for reimbursement
    d. Third-party billing platforms like Outcomes MTM, Sinfonia Rx, and Integrated Prescription Management
    e. All of the above

19. Which of the following is proper coding for a 45-minute consultation with a new patient?
    a. Code 99605 once and code 99607 once
    b. Code 99606 once and code 99607 once
    c. Code 99605 once and code 99607 twice
    d. Code 99606 once and code 99607 twice

20. Which of the following is true regarding point-of-care testing?
    a. The billing code used for a specific test differs depending upon which brand of that test is used
    b. Reimbursement rates for a point-of-care test is mandated by Medicare and uniform across Part D plans
    c. Medicare Part D mandates that every plan under Part D must include the same point-of-care tests
    d. None of the above

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