Technician Tutorial:
The ABCs of Medicare

Medicare is the nation's largest health insurance program. It provides coverage for over 60 million people in the U.S. and continues to grow year after year. Medicare consists of multiple parts, which can be confusing to keep straight. Pharmacy technicians should understand the different parts of Medicare to help with billing and answering questions patients may have.

What's the difference between Medicare and Medicaid?

Medicare is administered by the federal government. **Medicaid** is a joint federal and state program that helps people with low income and limited resources pay for medical and prescription costs. Some people are referred to as "dual eligible." This means they're eligible for both Medicaid and Medicare and will get government aid for their part of Medicare costs.

Who's eligible for Medicare?

Medicare provides health insurance coverage for:

- people 65 years or older.
- some people under 65 with a disability.
- people of any age with kidney failure being treated with dialysis or who have a kidney transplant.
- people of any age with amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

What's the difference between Medicare Parts A, B, C, and D?

Medicare Part A is **hospital insurance**. It helps pay for hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare. Medicare Part A does not have a monthly premium and does not cover prescription drugs for outpatients.

Medicare Part B is **medical insurance**. It helps pay for doctors' services, outpatient hospital care, physical therapy, home healthcare, a limited number of Rx drugs for outpatients, certain vaccines (e.g., flu), and medical supplies and equipment. Most people who have Medicare Part B must pay a monthly premium.

Medicare Part A plus Medicare Part B is considered "original Medicare." Patients with original Medicare will have a "red, white, and blue" insurance card. Cards indicate if the patient is eligible for Medicare Part A, Part B, or both, and the effective dates of each. The card also contains the patient's ID number, which in the past has been the patient's Social Security number with an additional letter. However, in 2018, Medicare started replacing the Social Security numbers with a Medicare Beneficiary Identifier (MBI), a unique, randomly assigned 11-character ID made up of a combination of numbers and uppercase letters. This change is to help protect against fraud and identity theft. Medicare only accepts claims using the MBI, so be sure you're using this number when billing Part B. Watch for patients who present an older card with a Social Security number. If patients have lost or misplaced their newer card, they can call 1-800-Medicare or they can sign into MyMedicare.gov to print a copy of their Medicare card once they create an account.

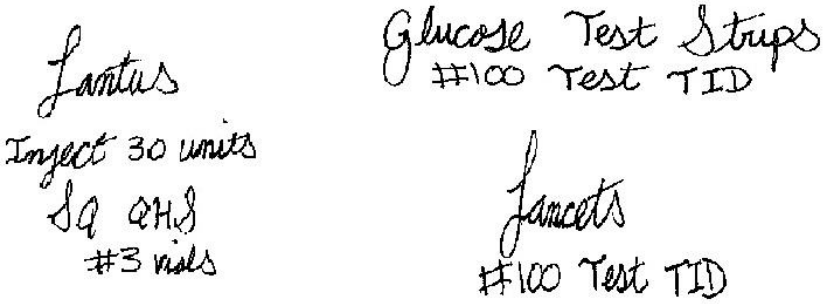
Some people with original Medicare might get a **Medigap policy**, or supplemental coverage that helps pay for certain deductibles, coinsurance, and other costs that are not covered by Medicare. Medigap policies are offered by private insurance companies, not by the federal government.

Medicare Part D is a **prescription drug plan**. There are a lot of different choices, since these plans are administered by private insurance companies and approved by Medicare. Part D coverage is optional and can be added on to "original Medicare." Most people who have Medicare Part D plans will pay a monthly premium. Prescriptions for patients with Part D plans are processed just like those for any other insurance

company. Patients will have a separate insurance card, in addition to their "red, white, and blue" card, indicating which insurance company you will use to process their Rxs.

Medicare Part C, also referred to as a Medicare Advantage Plan or Medicare Health Plan, is an alternative to original Medicare (Medicare Part A and Medicare Part B) and possibly Medicare Part D. Medicare Advantage Plans are run by private companies, such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs), but they're approved by Medicare. Medicare Advantage Plans may include prescription drug plans, but not all do. If a Medicare Advantage Plan includes prescription drug coverage, you may hear it referred to as an MA-PD (Medicare Advantage-Prescription Drug) plan. Patients with Medicare Part C will not present the "red, white, and blue" card. They will instead present a card that is from a private insurance company. Use this card to bill Medicare Part B-covered vaccines, meds, and supplies. Patients with a Medicare Part C plan that does NOT include prescription drug coverage may present another insurance card if they have added a separate Part D plan. Patients with an MA-PD plan will likely just have one card that contains information for billing the health plan and the prescription drug plan.

Mr. Gomes is a 68-year-old patient at your pharmacy. He has diabetes and high blood pressure, and today he needs to get his Lantus *insulin, diabetes test strips, and lancets filled. You ask Mr. Gomes if he has his insurance card, and he hands his "red, white, and blue" card to you, along with some new scripts. He is also enrolled in a Part D plan and has his insurance card for the Part D plan.*



When should I expect to bill Medicare Part B versus Part D?

Part D prescription drug plans pay for most prescription drugs in the outpatient setting. This includes biological products (*Humira*, etc); insulin; some vaccines (shingles, etc); and medical supplies associated with the injection of insulin like syringes, pen needles, alcohol swabs, and gauze. Part D plans are **not required** to pay for the following in most cases:

- drugs used for weight loss (e.g., phentermine [*Adipex-P*], orlistat [*Xenical*]) or for anorexia or weight gain (e.g., megestrol [*Megace*])
- drugs used to promote fertility (e.g., clomiphene citrate, chorionic gonadotropin [*Pregnyl*])
- drugs used for cosmetic purposes or hair growth (e.g., finasteride [*Propecia*])
- drugs used for the symptomatic relief of cough and colds (e.g., benzonatate [*Tessalon*])
- drugs used for erectile dysfunction (e.g., sildenafil [*Viagra*], tadalafil [*Cialis*])
- prescription vitamins and minerals, except prenatal vitamins, niacin, and fluoride preparations
- nonprescription drugs

Part D also covers Medication Therapy Management, known as MTM. These are patient-centered services provided by a pharmacist or another healthcare professional. MTM is a medication review that is used to help ensure patients are taking their medications properly and avoiding any medication problems. Most of

the billing for MTM is done through an electronic MTM platform that your pharmacy may use. One example of an MTM platform is *OutcomesMTM*.

Medicare Part B pays for a limited set of drugs. Many of these drugs are injectables that aren't usually self-administered. Examples of drugs covered by Medicare Part B include:

- injectable drugs for osteoporosis for women (e.g., zoledronic acid [*Reclast*])
- epoetin alfa (e.g., *Epogen*, *Procrit*) to treat anemia in patients with end-stage kidney disease
- clotting factors for self-administration by patients with hemophilia
- immunosuppressive drug therapy (e.g., cyclosporine [*Neoral*, *Sandimmune*, etc]) for Medicare-covered organ transplants
- oral cancer drugs prescribed for the treatment of cancer if the same drug is available in injectable form, or if it's a prodrug of the injectable drug (e.g., capecitabine [*Xeloda*] is a prodrug of the injectable cancer drug, 5-fluorouracil)
- oral anti-nausea drugs (e.g., granisetron, ondansetron) for patients receiving cancer drugs, for use within 48 hours of chemotherapy
- flu, COVID-19, and pneumococcal vaccines; hepatitis B vaccine for intermediate to high-risk individuals; and vaccines like tetanus toxoid given for treatment of an injury or direct exposure to a disease
- parenteral nutrition for patients with permanent dysfunction of the digestive tract
- insulin pumps and insulin used with the pump (insulin not used with a pump is covered by Part D)
- drugs that will be used with durable medical equipment (DME). For example, solutions to be administered in a nebulizer (e.g., albuterol) or infused drugs.
- DME, such as blood glucose (sugar) testing supplies, nebulizers, wheelchairs, enteral nutrition (*Jevity*, etc), undergarments, prosthetics, and orthotics

Retail pharmacies often bill Medicare Part B for blood glucose testing supplies, including:

- blood glucose meters
- blood glucose test strips
- continuous glucose monitoring (CGM) system supplies and accessories
- lancing devices and lancets
- glucose control solutions for checking the accuracy of testing equipment and test strips

Note that the number of blood glucose test strips and lancets Medicare will cover depends on whether the patient uses insulin or not. For beneficiaries that use insulin, Medicare will cover up to 100 test strips and lancets **every month**. For beneficiaries that do NOT use insulin, Medicare will cover up to 100 test strips and lancets **every three months**.

In order for the pharmacy to be paid by Medicare for these supplies, there must be a signed prescription (written, faxed, or electronic), with the following information:

- confirmation that the patient has diabetes (diagnosis code for type 1 or type 2 diabetes)
- whether or not the patient requires insulin
- the kind of blood glucose monitor that is needed
- how often the patient is to test blood glucose. This cannot be "as needed" or "use as directed." If the prescriber writes either of those, the pharmacist will need to contact the prescriber for clarification.
- date the prescriber signs the prescription
- prescriber's signature

Not all pharmacies are set up to bill Medicare Part B electronically for blood glucose testing supplies. Check with your pharmacist if you are unsure about procedures for billing blood glucose testing supplies. Policies and procedures vary in different practice settings.

Most pharmacies are required to be accredited to bill Medicare Part B for DME and blood glucose testing supplies. In order to be accredited, pharmacies must apply to an accrediting organization, pay their required fees, and meet all their requirements (training, etc). For more information on billing DME, review our CE, *Supplying Durable Medical Equipment (DME) to Medicare Patients*. And for general information on billing prescription drugs, use our technician tutorial, *Billing for Rx Drugs*.

You will need to bill Medicare Part B for Mr. Gomes' test strips and lancets. You notice Mr. Gomes' prescriber did not include the diagnosis code on the Rx, which can be a problem when billing Part B. Remember, Medicare needs to know that the patient has diabetes, and whether they use insulin or not, since this determines how many test strips and lancets are covered. Since the diagnosis code documentation is missing, the pharmacist will have to contact the prescriber for clarification.

While waiting for the pharmacist to get the diagnosis code from the prescriber, you process Mr. Gomes' Lantus *Rx through his Part D plan. After entering this Rx, you ask Mr. Gomes if he has a minute for you to update his vaccine history. He agrees, and thanks you for bringing this up since his prescriber recommended he get a shingles vaccine and he also needs to get a flu shot. You check your pharmacy stock to make sure you have both and then let Mr. Gomes know he can get vaccinated today. You bill his shingles vaccine to Medicare Part D and his flu vaccine to Medicare Part B.*

What are some Medicare terms I should be familiar with?

Star Ratings: The Medicare Star Rating program was developed to hold Medicare Advantage health plans and Medicare Part D prescription drug plans accountable for low-cost, quality care. Medicare plans with high ratings get marketing advantages, such as year-round open enrollment, and possible bonus payments. Ratings are based on quality measures. Quality measures related to medication use account for about half of a Medicare Part D plan's rating. Some of the key quality measures that pharmacies can impact include medication adherence and providing MTM services (specifically, the completion of comprehensive medication reviews [CMRs]). Patients may ask you about what Star Ratings mean because this information is displayed on the Medicare Plan Finder tool. Plans are rated anywhere from one to five stars, with five being the highest possible rating. Tell patients to look at Star Ratings to help narrow choices. Higher ratings can mean the plan does a better job with patient satisfaction and ensuring safe and appropriate medication use.

Coverage gap: The coverage gap begins after the initial coverage phase, the phase that starts once the patient meets their deductible. After the patient has paid a certain amount in prescription drug costs, referred to as the initial coverage limit ($4,430 in 2022), they will enter the coverage gap. During the coverage gap, patients pay no more than 25% of the prescription drug cost for either brand or generic drugs, which is a smaller percent than what they may have had to pay in the past. But don't be surprised to continue to see some Part D co-pays increase, in some cases by a lot, when the patient reaches the coverage gap. This is due to the specifics of the Part D plan and the retail price of the medication. For example, let's say a patient has a $20 co-pay for insulin during the initial coverage phase, and that the product's full cost is $500. Once entering the coverage gap, the patient could pay up to 25% of the full cost, or $125, which is significantly higher than $20.

Patients will continue to pay up to 25% of drug costs until they have spent enough to reach catastrophic coverage.

Catastrophic coverage: After a certain amount of money has been spent on Part D-covered drugs, patients will enter catastrophic coverage where they pay no more than 5% of their prescription drug costs. Be aware that the specific amount of money that must be spent before entering catastrophic coverage changes from year to year. In 2022, catastrophic coverage is reached when total out-of-pocket drug expenses reach $7,050.

Extra Help or **low-income subsidy**: For certain individuals who meet qualifications based on income, the government subsidizes the cost of prescription drug plans. Premiums, deductibles, and co-pays can either be less expensive, or completely paid for by the government subsidy. For more about Extra Help, patients can call 800-772-1213 or go to https://secure.ssa.gov/i1020/start.

Patients who don't qualify for Extra Help may still need assistance reducing prescription drug costs. If a patient expresses concern about being able to afford their meds, let the pharmacist know. The pharmacist may be able to work with the prescriber to find generic or less expensive brand name drugs for the patient. Drug manufacturers and national, state, or community-based programs offer assistance programs for these patients (see www.medicare.gov/pharmaceutical-assistance-program). Some counties contract with private companies to match patients with patient assistance programs that offer medications for free or at reduced cost.

What are the important dates for patients to know when enrolling in Medicare?
Individuals first become eligible for Medicare in the three months before turning age 65, the month they turn 65, and through the three months after turning 65. They can sign up for a Medicare Part D plan during this seven-month period. If patients sign up after this period, they will be penalized financially, and have to pay higher monthly premiums for as long as they have Medicare drug coverage. However, people eligible for Medicare who have "creditable prescription drug coverage," such as from an employer or union, can usually keep that coverage without paying a penalty if they decide to enroll in Part D later. Those who are younger and eligible for Medicare because of a disability can join a Part D plan during the three months before or the three months after the 25th month of their cash disability payments. Individuals who qualify for Extra Help can enroll in a Part D plan at any time.

Each year, **open enrollment for Part D plans begins on October 15th and ends on December 7th**. This is the period of time when people can change plans or enroll if they had not enrolled before. People who do not sign up for Medicare Part D or other prescription insurance coverage within the required timeframe are likely to end up paying more if they enroll later. A monthly penalty premium will be added to their monthly Part D premium.

Changes made during open enrollment take effect on January 1st of the following year. Patients can also switch from their current plan to a 5-star plan once each year during the timeframe of December 8th through the following November 30th. This is only possible if there's a 5-star plan available in their area.

Warn patients that open enrollment is a time when scams will be in full swing. Tell them that Medicare will never "cold call" a patient and ask for them to share personal information so they can keep their coverage. Medicare also won't visit a patient's home to help them sign up for Part D or try to sell them anything. Suspicious activity should be reported to 800-MEDICARE immediately. More information about Medicare, such as how to enroll is available at www.medicare.gov.

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—Continue for a "Cheat Sheet" for The ABCs of Medicare—

"Cheat Sheet" for The ABCs of Medicare

Who is eligible for Medicare?

- people 65 years and older; individuals can enroll in Medicare during a 7-month period: 3 months before and 3 months after the month they turn 65
- some people under 65 with a disability
- people of all ages with kidney failure on dialysis or with a kidney transplant
- people of any age with amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease

What do the different parts of Medicare cover?

- Part A – hospital insurance
  - Typically covers hospital visits, skilled nursing facility care, hospice care, some home healthcare.
- Part B – medical insurance
  - Typically covers doctors' services, outpatient hospital care, physical therapy, home healthcare, limited set of drugs, medical equipment.
  - Pharmacies may bill Part B for certain drugs (injectable drugs for osteoporosis, epoetin alfa to treat anemia in patients with end-stage kidney disease, oral cancer drugs, etc), certain vaccines (influenza, pneumococcal, COVID 19, etc), drugs to be used in durable medical equipment (DME) (nebulizer solution, insulin for insulin pumps, etc), and for DME (blood glucose testing supplies such as glucose meters, test strips, lancets, etc)
- Part C – health insurance; also referred to as Medicare Advantage Plan or Medicare Health Plan
  - Typically includes everything covered in Parts A and B, but administered by a private company instead of Medicare; however, Medicare approves these plans.
  - May or may not include Rx drugs; plans with Rx drug coverage are called MA-PD plans
- Part D – prescription insurance
  - Typically covers most prescription drugs, medical supplies associated with insulin injections (alcohol swabs, syringes, etc), MTM services, vaccines not covered by Part B (shingles, etc).

What are some Medicare terms to be familiar with?

- Star Ratings – a rating system based on quality measures. Plans are rated from one to five stars, with five being the highest rating possible. Higher ratings can mean the plan does a better job with patient satisfaction and ensuring safe and appropriate medication use.
- Coverage gap – once patients have met the initial coverage limit, they enter the coverage gap in which they pay no more than 25% of brand or generic prescription drug costs.
- Catastrophic coverage – once patients who are in the coverage gap have spent a specified amount out-of-pocket, they enter catastrophic coverage, a phase in which they pay no more than 5% of prescription drug costs.
- Extra Help or low-income subsidy – government subsidized prescription drug plans for certain individuals who meet qualifications based on income. Premiums, deductibles, and co-pays can either be less expensive or completely paid for.

When can patients change their Medicare prescription drug plan?

- During open enrollment: October 15th through December 7th
  - Changes made during open enrollment take effect on January 1st of the following year.
- From December 8th to the following November 30th, patients can switch from their current plan to a Medicare plan with a 5-star rating (can only be done once during this timeframe).

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