
2024
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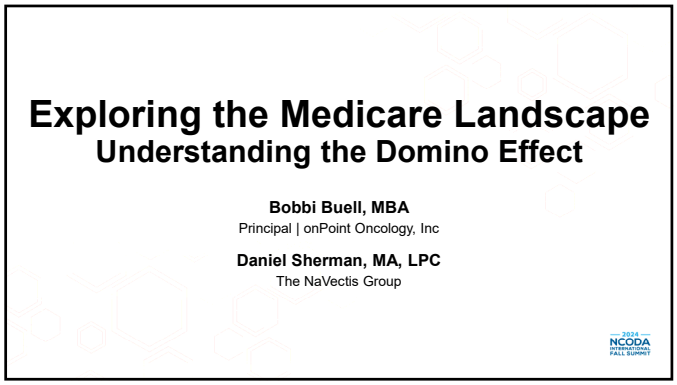
Exploring the Medicare Landscape
Understanding the Domino Effect
Bobbi Buell, MBA
Principal | onPoint Oncology, Inc
Daniel Sherman, MA, LPC
The NaVectis Group

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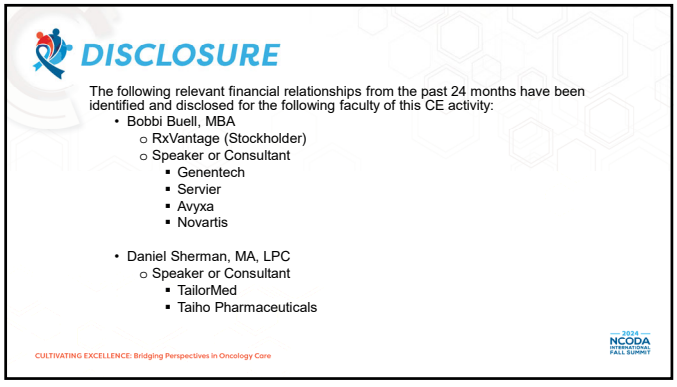
DISCLOSURE
The following relevant financial relationships from the past 24 months have been identified and disclosed for the following faculty of this CE activity:
Bobbi Buell, MBA
RxVantage (Stockholder)
Speaker or Consultant
Genentech
Servier
Avyxa
Novartis
Daniel Sherman, MA, LPC
Speaker or Consultant
TailorMed
Taiho Pharmaceuticals
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DISCLOSURE

No relevant financial relationships from the past 24 months have been identifie
for the following reviewers of this CE activity:

- Jacqueline Caban, MPA
- Taryn Newsome, CPhT
- Daisy Doan, PharmD

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OBJECTIVES

1. Review financial navigation interventions that help mitigate the experience of financial toxicity when high-dollar pharmaceuticals are used.
2. Discuss the advantages and disadvantages the Medicare Prescription Payment Program will have on Medicare Part D beneficiaries.
3. Recognize the impact of new IRA changes related to oral oncolytics, including possible price fluctuations, smoothing program implementation, and policy regulations.
4. Identify policy changes surrounding prior authorization, coding changes, and enhancements of step therapies (immunotherapies).

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Agenda

1. The Inflation Reduction Act 2025
2. The Drug Cap & The Prescription Payment Plan
3. Other Parts C and D Rules for 2025
4. Physician and Hospital Proposal Tidbits
5. Building a Proactive Financial Navigation Program

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The Inflation Reduction Act: Parts C and D 2025

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Inflation Reduction Act (IRA) will Support Reduced Drugs Costs through Part D Benefit Design and Drug Negotiations

	2024	2025	2026	2027	2028	2029
Part D Benefit Design	Eliminates 5% coinsurance for Part D catastrophic coverage	Adds $2,000 out-of-pocket cap in Part D and other drug benefit changes				
Drug Price Negotiations			Implements negotiated prices for certain high-cost drugs: 10 Medicare Part D drugs	15 Medicare Part D drugs	15 Medicare Part D and 15 Part B drugs	20 Medicare Part D and 20 Part B drugs

2024-2029: Limits Part D premium growth to no more than 6% per year

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Chart based on Kaiser Family Foundation slide Presentation, https://www.kff.org/slidedeck/what-are-the-prescription-drug-provisions-in-the-inflation-reduction-act/. Presented March 17, 2023. Accessed September 29,2024

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Provisions of the the Inflation Reduction Act of 2022 (IRA): Drug Summary

- ✓ Temporary Part B add-on for biosimilars that have a lower price than their reference product
- ✓ Inflation rebates paid by manufacturers for Part B and D drugs. Part B lowers patient out of pocket (OOP), now for 34 drugs (in 4th Quarter)
- ✓ Limits monthly cost sharing for insulin products to $35 for people with Medicare for Part B and D insulins
- ✓ For the first time, requires the federal government to negotiate prices for some top-selling drugs covered under Medicare
- ✓ Eliminates 5% coinsurance for catastrophic coverage in Medicare Part D in 2024, adds a $2,000 cap on Part D out-of-pocket spending in 2025, and limits annual increases in Part D premiums for 2024-2030
- ✓ Expands eligibility for Medicare Part D Low-Income Subsidy full benefits
- ✓ Eliminates cost sharing for adult vaccines covered under Medicare Part D and improves access to adult vaccines under Medicaid and CHIP
- ✓ Further delays implementation of the Trump Administration's drug rebate rule

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First Negotiated Drugs

Drug Name	Commonly Treated Conditions	Number of Medicare Enrollees Who Used the Drug in 2023	Drug List Price in 2023 for 30-day Supply	Negotiated Price for 2026 for 30-day Supply	Savings (%)
Eliquis	Prevention and treatment of blood clots	3,928,000	$521	$231	$290 (-56%)
Jardiance	Diabetes; Heart failure; Chronic kidney disease	1,883,000	$573	$197	$376 (-66%)
Xarelto	Prevention and treatment of blood clots; Reduction of risk for patients with coronary or peripheral artery disease	1,324,000	$517	$197	$320 (-62%)
Januvia	Diabetes	843,000	$527	$113	$414 (-79%)
Farxiga	Diabetes; Heart failure; Chronic kidney disease	994,000	$556	$178.50	$377.50 (-68%)
Entresto	Heart failure	664,000	$628	$295	$333 (-53%)
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	48,000	$7,106	$2,355	$4,751 (-67%)
Imbruvica	Blood cancers	17,000	$14,934	$9,319	$5,615 (-38%)
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis	23,000	$13,836	$4,695	$9,141 (-66%)
Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill	Diabetes	785,000	$495	$119	$376 (-76%)

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https://www.whitehouse.gov/briefing-room/statements-releases/2024/08/15/fact-sheet-biden-harris-administration-announces-new-lower-prices-for-first-ten-drugs-selected-for-medicare-price-negotiation-to-lower-costs-for-millions-of-americans/

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How Will Your Patients Benefit?

- These negotiated prices will become effective on **January 1, 2026**. A participating drug company with a selected drug is required to ensure the negotiated price is **made available to eligible individuals and to the pharmacies, mail-order services, and other entities that dispense the selected drug to such individuals.**
- As required by law, **Medicare prescription drug plans, including standalone Part D plans and Medicare Advantage-prescription drug plans, must include in their formularies the selected drugs** for which Centers for Medicare & Medicaid Services (CMS) and the participating drug company have agreed to a negotiated price.
- CMS will use its comprehensive formulary review process for Medicare prescription drug plans to assess **any practices that may undermine access to negotiated prices for selected drugs** for people with Medicare.

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CMS Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-drug-price-negotiation-program-negotiated-prices-initial-price-applicability-year-2026. Posted on August 14, 2024. Accessed September 19, 2024 [insert on the information]

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QUESTION 1

True or False: Are all Medicare patients only required to pay $2000 per year for Part D drugs?

a. True
b. False

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Drug Discounting

Change in List vs. Net Price, By Manufacturer, 2023

Company	[A] Average list price change	[B] Average net price change	[B] - [A] Gross-to-net difference	Average reduction from list price
Bristol Myers Squibb	+4.4%	-0.4%	-4.8%	-46.0%
Eli Lilly and Company	+5.0%	+2.3%*	-2.7%	-66.0%
Genentech	+4.6%	+1.3%	-3.3%	n.a.
GlaxoSmithKline	+3.2%	+0.4%	-2.8%	n.a.
Merck & Co	+4.5%	+4.4%	-0.1%	-37.0%
Novo Nordisk	+2.8%	-8.2%	-11.0%	-74.0%
Sanofi	+4.3%	-15.7%	-20.0%	-46.0%
Takeda	+4.4%	+3.5%	-0.9%	-44.0%
Teva	+3.5%	-0.2%	-3.7%	n.a.
UCB	+5.7%	+0.4%	-5.3%	-51.5%
Unweighted average	**+4.2%**	**-1.2%**	**-5.5%**	**-52.1%**

* Figure reflect Drug Channels Institute estimate.
Source: Drug Channels Institute analysis of company reports.

Published on Drug Channels (www.DrugChannels.net) on July 23, 2024.

DRUG CHANNELS INSTITUTE
An HMP Global Company

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DRUG CHANNELS INSTITUTE, 7/23/2024

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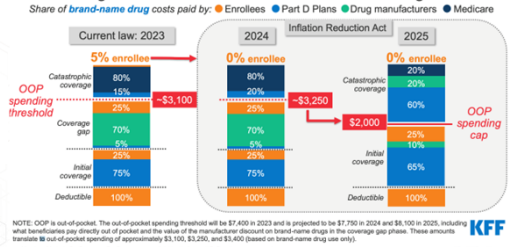
Negotiation Is Not The Only Change…

Changes to Medicare Part D for Brand-Name Drug Costs

*Share of **brand-name drug** costs paid by:* Enrollees, Part D Plans, Drug manufacturers, Medicare



NOTE: OOP is out-of-pocket. The out-of-pocket spending threshold will be $7,400 in 2023 and is projected to be $7,750 in 2024 and $8,100 in 2025, including what beneficiaries pay directly out of pocket and the value of the manufacturer discount on brand-name drugs in the coverage gap phase. These amounts translate to out-of-pocket spending of approximately $3,100, $3,250, and $3,400 (based on brand-name drug use only).

KFF

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KFF, https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/, Accessed 10/10/24.

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Replacement of Coverage Gap Discount Program

- Medicare Coverage Gap Discount Program will sunset for Medicare Part D drugs dispensed on or after January 1, 2025

- **New Manufacturer Discount Program**
  - Manufacturers must enter into new agreement with the Health and Human Services (HHS) Secretary to provide discounted prices for covered Part D drugs:
    - A 10% discount off the negotiated price where an applicable beneficiary has incurred costs equal to or above the deductible and below the out-of-pocket threshold ($2000)
    - A 20% discount off the negotiated price where an applicable beneficiary has incurred costs equal to or above the out-of-pocket threshold ($2000)

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The Drug Cap &
The Medicare Prescription Payment Plan (M3P)
"Smoothing Program"

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Drug Cap and "Smoothing"

Drug Cap:

$2000 Annual Out of Pocket costs for drug costs in 2025

Important: Opt-In Required

"Smoothing":

Option for all payments to be spread evenly throughout the year—this is why it is called smoothing

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The Prescription Payment Plan

- **Beginning in 2025**, anyone with a Medicare Part D prescription drug plan will have the option to enroll in the monthly payment plan, either before the beginning of the plan year or in any month during the plan year. The opportunity to enroll is not income-based.
- **The Medicare Prescription Payment Plan** only applies to out-of-pocket costs for prescription medications.

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PAN Foundation. https://www.panfoundation.org/everything-you-need-to-know-about-medicare-optional. Accessed 10/2/2024.

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The Medicare Prescription Payment Plan (M3P) (cont.)

- Program is voluntary
  - Part D beneficiaries will need to enroll in the program
- $2,000 Max out-of-pocket will be spread out throughout the year
  - Can enroll any time of the year
  - Can also disenroll at any time
- Enrollees will have a $0 co-pay at the point of sale
- Part D plan will bill the enrollee every month

Good information for patients:
https://www.medicare.gov/prescription-payment-plan/before-payment-option

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PAN Foundation. https://www.panfoundation.org/everything-you-need-to-know-about-medicare-reforms/. Accessed 10/10/24.

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Some Issues with Smoothing

What happens if a patient is newly diagnosed in the middle of the year with a condition that requires specialty drug treatment?

Will foundations decrease their grants?

What if a patient should require a mid-year switch from a less expensive, traditional chemotherapy under Part B to a more costly novel anticancer medication under Part D?

What if the enrollee does not pay the applicable plan?

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Some Issues with Smoothing (cont.)

- If the patient opts in for January 1, the $2000 owed is spread over 12 months, the cost is $166.67 per month. However, it can be more complicated, if the drug spend changes and/or the opt in is later in the year and the calculation is daunting..
- Here is the calculation for smoothing:

How are member payments calculated for M3P participants?

Payments are calculated using a CMS-defined formula.[3] The formula for the first month of participation is:

$$\frac{\text{Annual OOP Threshold}^{*} - \text{Incurred Costs of Beneficiary Prior to Program Enrollment}}{\text{\# of Months Remaining in Plan Year}^{**}}$$

The formula for subsequent months of participation is:

$$\frac{\text{Sum of Remaining OOP Costs Not Yet Billed + Additional OOP Costs Incurred}}{\text{\# of Months Remaining in Plan Year}^{***}}$$

*$2,000 for calendar year 2025

**Includes the month beneficiary opted in

***Includes the month for which the smoothing payment is calculated

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Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/medicare-prescription-payment-plan-final-part-one-guidance.pdf. Posted February 28, 2024. Accessed 9/28/24.

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Let's Take An Example

- Again, if you sign up in January and you have a monthly out of pocket of $600, your cost would be $2000/12 or $166.67. But it can be **more complicated**…
- Let's say a patient opts into the M3P in January 2025. They have no additional prescription drug coverage through another third party. They fill no prescriptions during January.
  - **Step 1:** Determine the previously incurred costs. The patient has had no prior pharmacy expenditures in January 2025; the TrOOP (True Out-of-pocket costs) Accumulator is at **$0**.
  - **Step 2:** Calculate the maximum monthly cap for the first month in which the program is effective for the participant. The annual OOP threshold for 2025 is $2,000. The month is January; months remaining in the plan year equals 12 (includes January). ($2,000 - $0)/12 = **$166.67**
- The plan will not bill them for January, since the patient has not incurred any OOP expenditures. **But what if they get a prescription later?**

Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/medicare-prescription-payment-plan-final-part-one-guidance.pdf. Posted February 28, 2024. Accessed 9/28/24

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Let's Take An Example (Cont'd)

- Our patient fills one high-cost prescription at the pharmacy in February. The OOP cost sharing for this prescription is **$1,030.37**.
  - **Step 1:** Determine the remaining costs owed by the patient. The patient incurred $0 in January and thus did not receive a bill.
  - **Step 2**: Determine the additional OOP costs incurred by the participant. The patient fills a single prescription with an OOP cost of $1,030.37. Additional OOP costs incurred = **$1,030.37**.
  - **Step 3:** Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February) = ($1,030.37 + $0)/11 = **$93.67** for the rest of the year IF no future costs are incurred.

Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/medicare-prescription-payment-plan-final-part-one-guidance.pdf. Posted February 28, 2024. Accessed 9/28/24

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QUESTION 2

What are some of the key features of the Prescription Payment Plan?

a. Enrollment is only available before the beginning of the plan year
b. The payment plan is income-based
c. The plan only applies to out-of-pocket costs for prescription medications, not premiums
d. Payments will include both out-of-pocket costs and premiums

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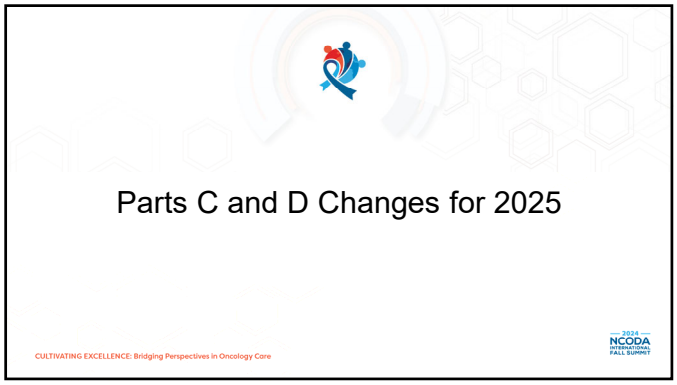
Parts C and D Changes for 2025
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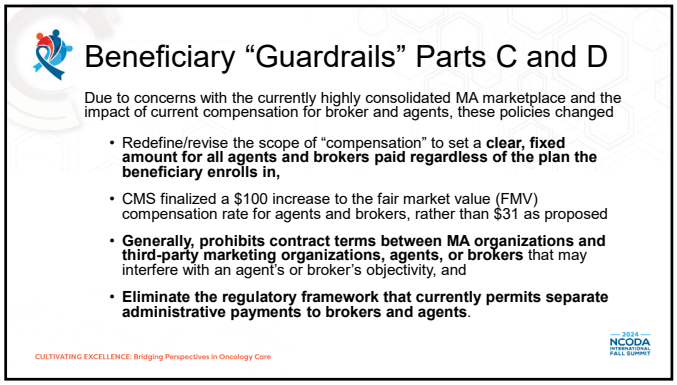
Beneficiary “Guardrails” Parts C and D
Due to concerns with the currently highly consolidated MA marketplace and the impact of current compensation for broker and agents, these policies changed
• Redefine/revise the scope of “compensation” to set a clear, fixed amount for all agents and brokers paid regardless of the plan the beneficiary enrolls in,
• CMS finalized a $100 increase to the fair market value (FMV) compensation rate for agents and brokers, rather than $31 as proposed
• Generally, prohibits contract terms between MA organizations and third-party marketing organizations, agents, or brokers that may interfere with an agent’s or broker’s objectivity, and
• Eliminate the regulatory framework that currently permits separate administrative payments to brokers and agents.
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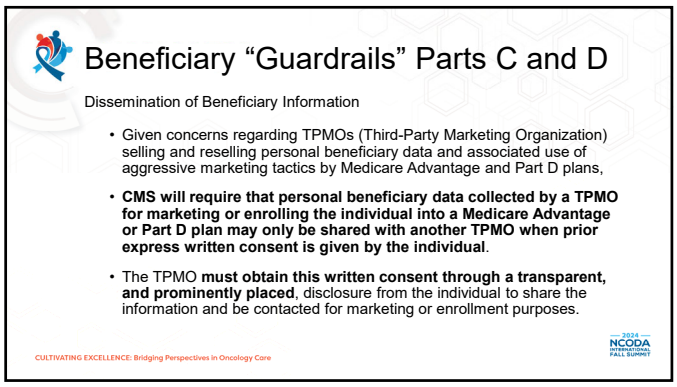
Beneficiary “Guardrails” Parts C and D
Dissemination of Beneficiary Information
• Given concerns regarding TPMOs (Third-Party Marketing Organization) selling and reselling personal beneficiary data and associated use of aggressive marketing tactics by Medicare Advantage and Part D plans,
• CMS will require that personal beneficiary data collected by a TPMO for marketing or enrolling the individual into a Medicare Advantage or Part D plan may only be shared with another TPMO when prior express written consent is given by the individual.
• The TPMO must obtain this written consent through a transparent, and prominently placed, disclosure from the individual to share the information and be contacted for marketing or enrollment purposes.
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Supplemental Benefits (Medicare Advantage or MA)

- **These benefits—transportation, dental, vision, club memberships, etc, are severely underutilized**
- **CMS finalizes its proposal to require plans to issue a "Mid-Year Enrollee Notification of Unused Supplemental Benefits"**
  - This notification will be issued annually no sooner than June 30 and not later than July 31 each year, personalized to each enrollee, and include a list of any supplemental benefits not accessed during the first half of the year
  - The notification will also provide information on the scope of the benefit, cost-sharing, directions for accessing the benefit, and any network application information
- "SSBCI"(Supplemental Benefits for the Chronically Ill**) items and services must meet the legal threshold of having a reasonable expectation of improving the health or overall function of chronically ill enrollees**

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Information Dissemination to Dual Eligibles (MAs)

To facilitate expanded care coordination, integration, and access for dually eligible beneficiaries, the final rule:

- Replaces the current quarterly special enrollment period (SEP) with a continuous, one-time-per month SEP for dually eligible individuals and others enrolled in the Part D LIS program to elect a standalone prescription drug plan (PDP);
- Creates a new integrated care SEP to allow dually eligible individuals to elect an integrated dual eligible special needs plan (D-SNP) monthly;
- Limits enrollment in certain D-SNPs to those individuals who are also enrolled in an affiliated Medicaid managed care organization (MCO); and
- Limits the number of D-SNP plan benefit packages a Medicare Advantage Organization (MAO), its parent organization, or an entity that shares a parent organization with the MAO; can offer in the same service area as an affiliated Medicaid MCO

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SheppardMullin. https://www.sheppardhealthlaw.com/2024/04/articles/centers-for-medicare-and-medicaid-services-cms/cms-issues-cy2025-medicare-advantage-and-part-d-final-rule/. Accessed 10/10/24

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Beneficiary Appeal Rights (MA)

Enhance Enrollees' Rights to Appeal a Medicare Advantage Plan's Decision to Terminate Coverage

Currently, enrollees in a Medicare Advantage plan do not have the same access to Quality Improvement Organization (QIO) review of a fast-track appeal as individuals in traditional Medicare. CMS is revising regulations to:

1. **Require the QIO, instead of the Medicare Advantage plan, to review untimely fast-track appeals of a Medicare Advantage plan's decision to terminate services in a skilled nursing facility, comprehensive outpatient rehabilitation facility, or by a home health agency.**
2. **Fully eliminate the provision requiring forfeiture of an enrollee's right to appeal a termination of services from these providers when they leave the facility.**
   - These changes will bring Medicare Advantage plan regulations in line with the parallel reviews available to individual's traditional Medicare and expand the rights of Medicare Advantage plan enrollees to access the fast-track appeals process

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Part D Plans Can Enhance Biosimilar Substitution

- In addition, as proposed in the Calendar Year 2024 Proposed Rule, CMS finalizes its proposal to permit Part D sponsors to immediately substitute:
  1. A new interchangeable biological product for its reference product
  2. A new unbranded biological product for its brand name biological product
  3. A new authorized generic for its brand name equivalent
- CMS asserts these changes will enhance beneficiary access to treatments that are equally effective yet potentially more affordable

CMS Newsroom. https://www.cms.gov/newsroom/fact-sheets/contract-year-2024-policy-and-technical-changes-medicare-advantage-and-medicare-prescription-drug. Accessed 10/10/24

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QUESTION 3

Which of the following substitutions does CMS allow Part D sponsors to immediately make as part of the Calendar Year 2024 Proposed Rule?

a. New interchangeable biological product for its reference product
b. A new unbranded biological product for its brand name biological product
c. A new authorized generic for its brand name equivalent
d. All the above

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Physician and Hospital Proposal Tidbits 2025

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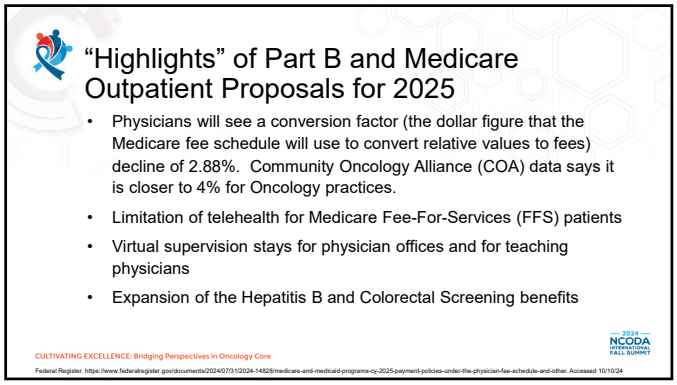
"Highlights" of Part B and Medicare Outpatient Proposals for 2025
• Physicians will see a conversion factor (the dollar figure that the Medicare fee schedule will use to convert relative values to fees) decline of 2.88%. Community Oncology Alliance (COA) data says it is closer to 4% for Oncology practices.
• Limitation of telehealth for Medicare Fee-For-Services (FFS) patients
• Virtual supervision stays for physician offices and for teaching physicians
• Expansion of the Hepatitis B and Colorectal Screening benefits
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Federal Register. https://www.federalregister.gov/documents/2024/07/31/2024-14828/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other. Accessed 10/10/24

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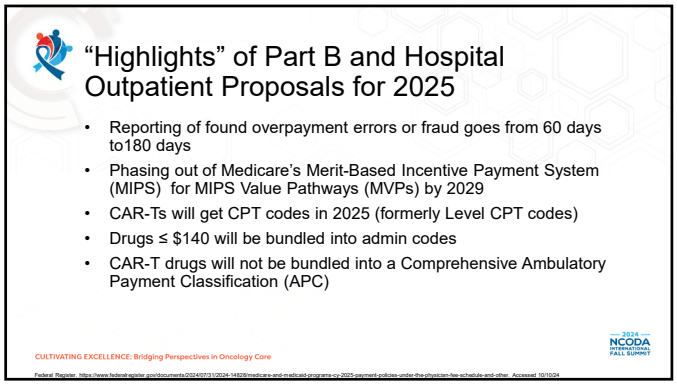
"Highlights" of Part B and Hospital Outpatient Proposals for 2025
• Reporting of found overpayment errors or fraud goes from 60 days to180 days
• Phasing out of Medicare's Merit-Based Incentive Payment System (MIPS) for MIPS Value Pathways (MVPs) by 2029
• CAR-Ts will get CPT codes in 2025 (formerly Level CPT codes)
• Drugs ≤ $140 will be bundled into admin codes
• CAR-T drugs will not be bundled into a Comprehensive Ambulatory Payment Classification (APC)
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Federal Register. https://www.federalregister.gov/documents/2024/07/31/2024-14828/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other. Accessed 10/10/24

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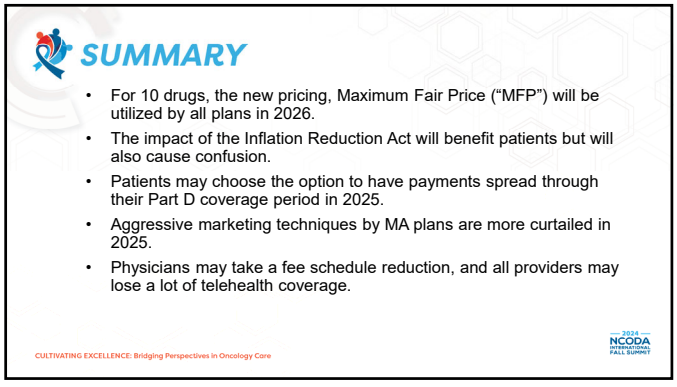
SUMMARY
• For 10 drugs, the new pricing, Maximum Fair Price ("MFP") will be utilized by all plans in 2026.
• The impact of the Inflation Reduction Act will benefit patients but will also cause confusion.
• Patients may choose the option to have payments spread through their Part D coverage period in 2025.
• Aggressive marketing techniques by MA plans are more curtailed in 2025.
• Physicians may take a fee schedule reduction, and all providers may lose a lot of telehealth coverage.
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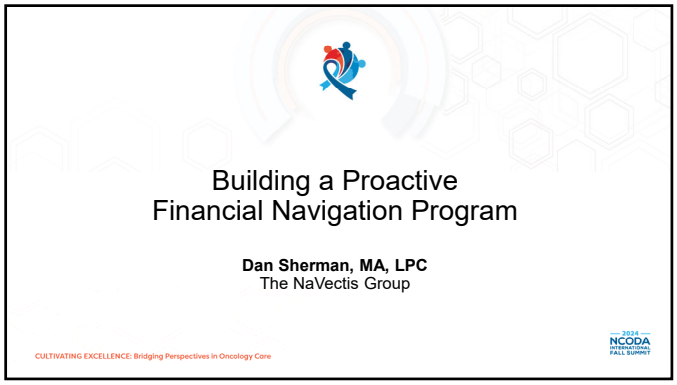
Building a Proactive
Financial Navigation Program
Dan Sherman, MA, LPC
The NaVectis Group
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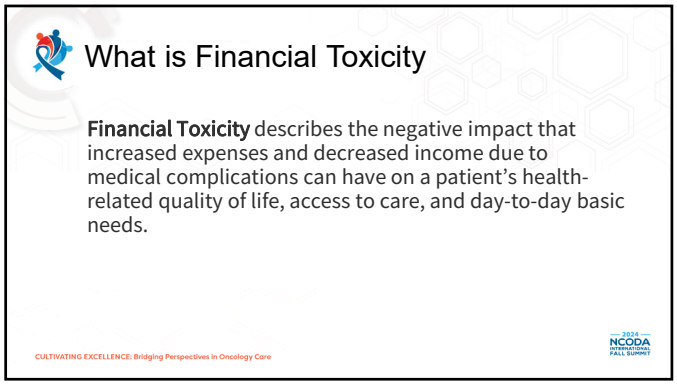
What is Financial Toxicity
Financial Toxicity describes the negative impact that increased expenses and decreased income due to medical complications can have on a patient's health-related quality of life, access to care, and day-to-day basic needs.
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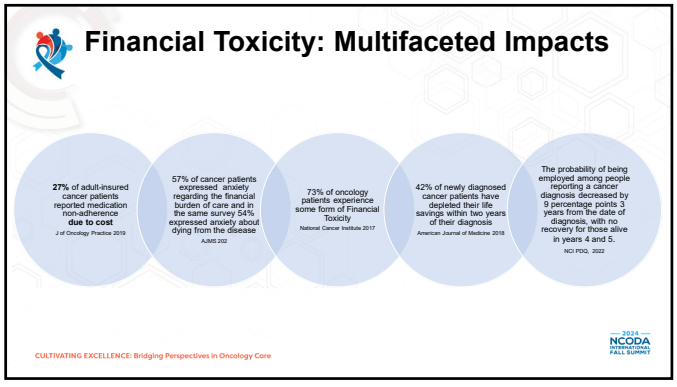
Financial Toxicity: Multifaceted Impacts
27% of adult-insured cancer patients reported medication non-adherence due to cost
J of Oncology Practice 2019
57% of cancer patients expressed anxiety regarding the financial burden of care and in the same survey 54% expressed anxiety about dying from the disease
AJMS 202
73% of oncology patients experience some form of Financial Toxicity
National Cancer Institute 2017
42% of newly diagnosed cancer patients have depleted their life savings within two years of their diagnosis
American Journal of Medicine 2018
The probability of being employed among people reporting a cancer diagnosis decreased by 9 percentage points 3 years from the date of diagnosis, with no recovery for those alive in years 4 and 5.
NCI PDQ, 2022
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Models of Financial Advocacy Services

Financial Counselors
- Medicaid Enrollment
- Charity Programs

Financial Advocates
- Co-Pay and Patient Assistance Programs (PAP)
- Basic Needs

Financial Navigation
- Focus is on treating the problem and not just the symptoms

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Financial Navigation

A proactive approach to treating financial toxicity by incorporating knowledge of the disease state and treatment plan with insurance optimization and utilization of external assistance programs.

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QUESTION 4

Which of the following components are essential in providing comprehensive financial support to patients facing cancer-related financial burdens?

a. Financial Counselors
b. Medicaid Enrollment
c. Co-Pay and Patient Assistance Programs
d. Financial Navigation
e. All the above

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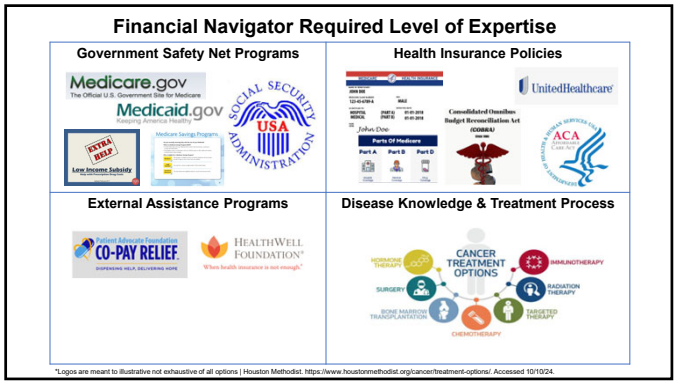

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Case Scenario

- A 65-year-old married female is diagnosed with endometrial cancer. Her monthly household gross income is $1,680 (FPL110), with $10,000 in assets. She is enrolled in a Medicare Advantage plan with a MOOP of **$6,750**. The MA plan includes Part D.
- The treatment regimen includes biologic therapies along with lenvatinib.
- Her co-pay for Part D oral medications will total no more than **$2,000** annually starting in 2025.

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MOOP – Max Out of Pocket; MA – Medicare Advantage

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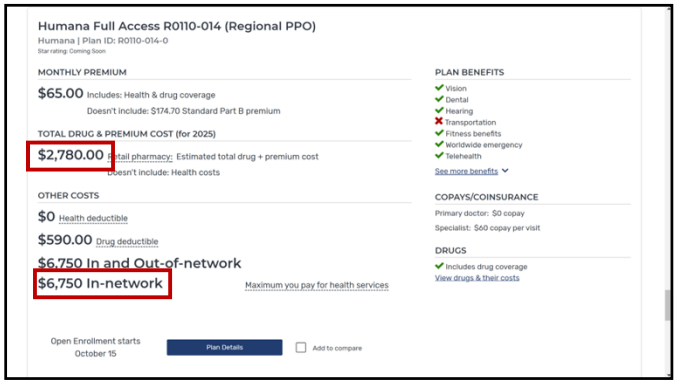

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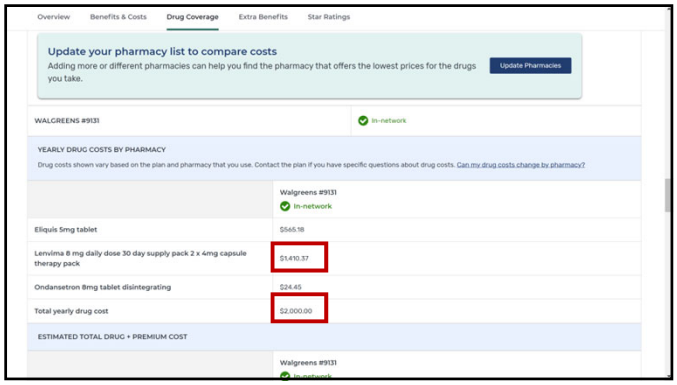

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Low-Income Subsidy (LIS)

The **Low-Income Subsidy Program**, also known as the **Extra Help program**, helps people with limited income and resources **lower or cut Part D costs**. Medicare Part D provides drug coverage, and the Extra Help program helps with the cost of prescription drugs, like deductibles and copays. You can apply for Extra Help **before or after** enrolling in Part D.

Low-Income Subsidy Enrollment

- At the Social Security Office
- At the Social Security Website (www.ssa.gov)

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Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare/enrollment-renewal/part-d-plans/low-income-subsidy/eligibility-low-income-subsidy. Accessed 10/10/24

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Low Income Subsidy

2024 Qualifiers

- Level 1
  - Dual Eligible and lives in a nursing home
- Level 2
  - Dual Eligible
- Level 3
  - Below 150% of FPL
  - Assets
    - $17,220 (Single)
    - $34,360 (Married)

2025 Benefits

- Level 1
  - $0 copay for part D covered drugs
- Level 2
  - Generics $1.60 Brand $4.80
- Level 3
  - Generics $4.90 Brand $12.15

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Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare/enrollment-renewal/part-d-plans/low-income-subsidy/eligibility-low-income-subsidy. Accessed 10/10/24

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What's New About LIS?

- The Inflation Reduction Act expands eligibility for full LIS benefits to individuals with incomes between 135-150% of FPL and resources at or below the limits for partial LIS benefits
- No partial subsidy

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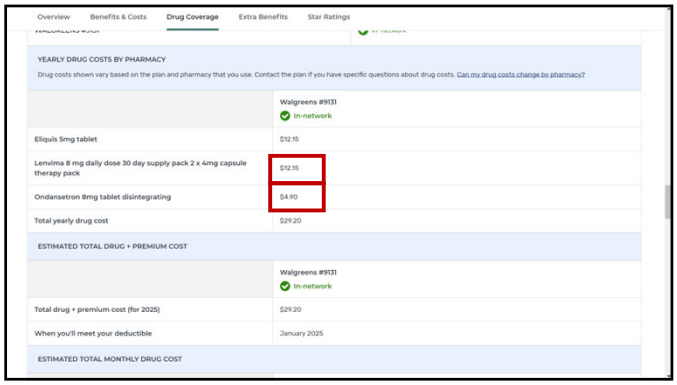
FPL – Federal Poverty Level; MOOP – Max Out of Pocket; MA – Medicare Advantage; Medicare Rights. https://www.medicarerights.org/medicare-watch/2023/08/15/new-tools-to-improve-access-to-medicare-part-d-

49



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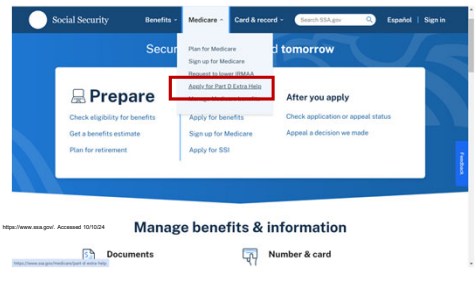
Applying for LIS



Social Security Administration. https://www.ssa.gov/. Accessed 10/10/24

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QUESTION 5

In the 2025 Medicare Part D benefits structure, what is the copay for a dual-eligible individual who is enrolled in LIS and is living in a nursing home (Level 1)?

a. $1.60 for generics, $4.80 for brand-name drugs
b. $0 copays for Part D covered drugs
c. $4.90 for generics, $12.15 for brand-name drugs
d. $3.50 for generics, $8.50 for brand-name drugs

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Case Scenario

- A 65-year-old married female is diagnosed with endometrial cancer. Her monthly household gross income is $1,680 (FPL110), with $10,000 in assets. She is enrolled in a Medicare Advantage plan with a MOOP of **$6,750**. The MA plan includes Part D.
- The treatment regimen includes biologic therapies along with lenvatinib.
- Her co-insurance responsibility for the biologic treatment will total **$6,750** for the year.

FPL – Federal Poverty Level; MOOP – Max Out of Pocket; MA – Medicare Advantage

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Medicare Choices

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Medicare Advantage Plans

- Privatization of Medicare
- HMO, POS, PPO, PFFS, SNP
- Yearly open enrollment (October 15 – December 7)
- No underwriting
- Provides “extra benefits”
- Co-Pay and Co-Insurance responsibilities
- MOOP as high as $9,350 (average is $4,835)

HMO – Health Management Organization
POS – Point of Service
PPO – Preferred Provider Organization
PFFS – Private Fee For Service
SNP – Special Needs Plan
MOOP – Max Out Of Pocket

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Medicare Advantage. https://www.medicareadvantage.com/plans-by-state. Accessed 10/10/24

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Medicare Supplemental Plans

- Secondary coverage to Medicare
- Guarantee issue open enrollment – within 6 months of being new to Medicare Part B
- Underwriting if enrolling past 6 months of being new to Part B
- Guarantee issue if within the first year of being in a Medicare Advantage plan
- No “extra benefits”
- All supplemental plans cover the Part B 20% co-insurance responsibility

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Medicare FAQ. https://www.medicarefaq.com/medicare-supplements/. Accessed 10/10/24

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Benefits	Medicare Supplement Insurance (Medigap) Plans									
	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood benefit (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	X	X	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	X	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	X	X	✓	X	✓		X	X	X	X
Part B excess charge	X	X	X	X	✓	✓	X	X	X	X
Foreign travel emergency (up to plan limits)	X	X	80%	80%	80%	80%	X	X	80%	80%
							Out-of-pocket limit in 2024**			
							$7,060	$3,530		

✓ = The plan covers 100% of this benefit
X = The plan doesn't cover this benefit
% = The plan covers that percentage of this benefit, and you're responsible for the rest.

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Centers for Medicare and Medicaid Services. https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf. Accessed 10/10/24.

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Medicare Supplement vs. Medicare Advantage

Medicare Supplement

- No Network
- No Prior Authorization needed
- Higher monthly premiums
- Does not include part D
- Does not include "extra benefits"
- Open Enrollment: No underwriting within 6 months of being new to Medicare
- Patient Financial Responsibility
  - **$240 (plan G)**

Medicare Advantage

- Network requirements
- Prior Authorization needed
- Lower monthly premiums
- Often includes part D
- Includes "extra benefits"
- Yearly Open Enrollment: with no underwriting
- Patient Financial Responsibility
  - **Up to $9,350**

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Medicare Advantage. https://www.medicareadvantage.com/plans-by-state. Accessed 10/10/24. Medicare FAQ. https://www.medicarefaq.com/medicare-supplements/. Accessed 10/10/24.

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Optimizing External Assistance Programs

- Manufacturer Patient Assistance Programs (PAP)
  - Are Free Drug programs harming our patients?
    - Self Pay
    - Off Label
    - High out-of-pocket

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Optimizing External Assistance Programs

- Manufacturer Patient Assistance Programs (PAP)
  - Are Free Drug programs harming our patients?
    - Self Pay
    - Off Label
    - ~~High out-of-pocket~~

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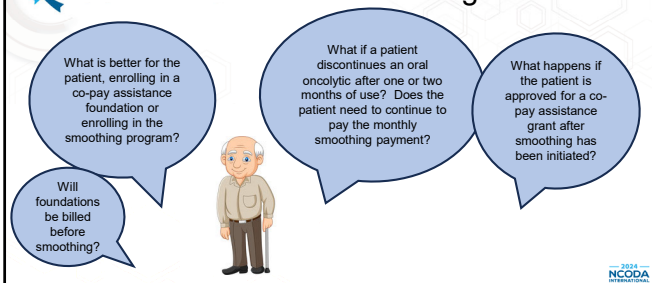
Some Issues with Smoothing



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QUESTION 6

Which services are included in a comprehensive financial navigation program?

a. Medicaid Enrollment, Charity Programs
b. Co-Pay and PAP Assistance, Basic Needs
c. Focus on treating the problem and not just the symptoms
d. All of the above

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Additional Resources
Financial Support Models
AJMC
ADVANCING QUALITY IN ONCOLOGY CARE
Orlando | Rosen Shingle Creek
April 5, 2018
REGISTER
Impact of Trained Oncology Financial Navigators on Patient Out-of-Pocket Spending
ABSTRACT

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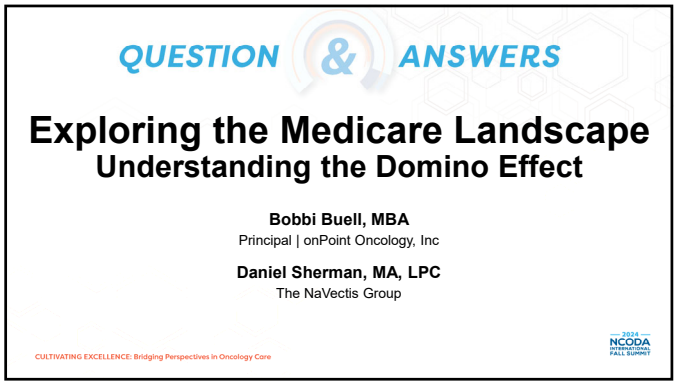
QUESTION & ANSWERS
Exploring the Medicare Landscape
Understanding the Domino Effect
Bobbi Buell, MBA
Principal | onPoint Oncology, Inc
Daniel Sherman, MA, LPC
The NaVectis Group
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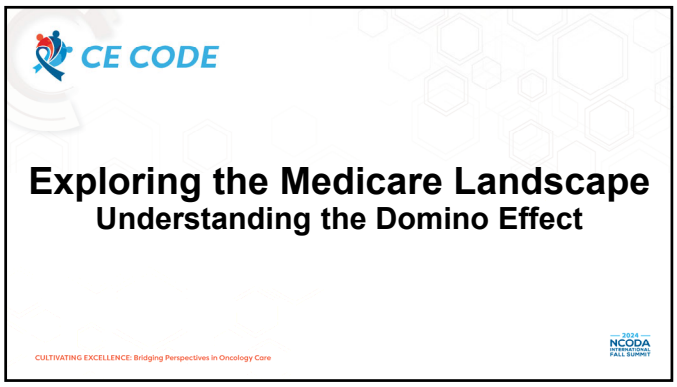
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Exploring the Medicare Landscape
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