Medicare Coverage and Coronavirus

As the number of cases of COVID-19 (also known as coronavirus) increases, so does the importance of counselors in helping beneficiaries understand what services are covered.

Covered services include:

Coronavirus testing

Coronavirus testing is covered under Medicare Part B as a clinical laboratory test. A beneficiary's doctor can bill Medicare for this test beginning April 1, 2020 for testing provided after February 4, 2020. As of September 2, 2020, and for the rest of the COVID-19 public health emergency, Medicare covers one coronavirus test without the order of a physician or other health practitioner. However, Medicare requires a physician's or other health care practitioner's order for any additional coronavirus tests a beneficiary receives. A beneficiary will owe nothing for the laboratory test and associated provider visits (no deductible, coinsurance, or copayment). This applies to both Original Medicare and Medicare Advantage Plans.

Coronavirus vaccine

There is currently no vaccine for coronavirus. If a coronavirus vaccine is developed, it will be covered by Medicare Part B. Beneficiaries will owe no cost-sharing (deductible, coinsurance, or copayment).

COVID-19 antibody treatment

Medicare covers monoclonal antibodies to treat COVID-19. Beneficiaries will owe no cost-sharing (deducible, coinsurance, or copayment).

Inpatient hospital care

Inpatient hospital care is covered under Medicare Part A, and standard coverage rules and cost-sharing apply. Medicare typically covers a semi-private room, but it should cover a private room when it is medically necessary. For example, if a beneficiary needs a private room in order to be quarantined, they should not be asked to pay an additional cost for the private room. If a beneficiary has a Medicare Advantage Plan, they should contact their plan to learn about its costs and coverage rules.

Outpatient hospital care

Outpatient hospital care is covered under Part B, and standard coverage rules and cost-sharing apply. If a beneficiary receives observation services at a hospital, they are considered an outpatient—even if they have a room or stay overnight. Whether a beneficiary is an inpatient or outpatient is important because, depending on their situation, a beneficiary may need an inpatient stay before Medicare will cover skilled nursing facility (SNF) care, but this rule has been relaxed somewhat during the COVID-19 emergency (see next page).

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Covered services include (continued):

Skilled nursing facility care

Medicare Part A generally only covers Skilled nursing facility (SNF) care if someone was a hospital inpatient for three days in a row before entering the SNF. This is known as the three-day qualifying hospital stay. At this time, Medicare has removed the three-day qualifying hospital stay requirement for beneficiaries who experience dislocations or are otherwise affected by the coronavirus public health emergency.

This waiver includes but is not limited to beneficiaries who:

- Need to be transferred to a SNF, for example, due to nursing home evacuations or to make room at local hospitals
- Need SNF care as a result of the current public health emergency, regardless of whether they were previously in the hospital

Medicare is also changing other SNF coverage requirements. Typically, Medicare Part A covers up to 100 days of SNF care each benefit period. A benefit period begins when a beneficiary is admitted to a hospital as an inpatient, or to a SNF, and it ends when they have been out of a SNF or hospital for at least 60 days in a row. The 100 days of covered SNF care reset at the beginning of a new benefit period. Beneficiaries who are unable to start a new benefit period because of the public health emergency can get another 100 days of covered SNF care without having to begin a new benefit period.

These waivers apply to all SNFs, meaning a SNF does not have to apply in order to use them.

Home health care

During the public health emergency, some home health coverage requirements have been changed:

- The homebound requirement can be met in additional ways. Someone can be considered homebound if their physician certifies that they cannot leave their home because they are at risk of medical complications if they go outside, or if they have a suspected or confirmed case of COVID-19. If the beneficiary also needs skilled care at home, they could qualify for the home health care benefit.
- A doctor usually must prescribe home health care, but during the public health emergency other providers, including nurse practitioners and physician assistants, can prescribe the care, too. The face-to-face visit requirement can be met through telehealth.
- Home health care agencies can provide more services via telehealth, as long as the services are listed on the beneficiary's plan of care. The telehealth services cannot be used in place of in-person services listed on the plan of care.

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Covered services include (continued):

Physicians' services in the home

Part B covers services a beneficiary receives from a physician (or other provider, such as a registered nurse) who visits their home. Part B also covers some services that are not face-to-face with a doctor, such as check-in phone calls or assessment using an online patient portal. Virtual check-ins can be used to assess whether a beneficiary should go to their doctor's office for an in-person visit.

Telehealth services

A telehealth service is a full visit with a provider using telephone or video technology. Medicare generally only covers telehealth in limited situations for certain beneficiaries, but it has expanded coverage and access during the public health emergency.

Starting March 6, 2020, Medicare covers hospital and doctors' office visits, mental health counseling, preventive health screenings, and other visits via telehealth for all beneficiaries and in settings that include the beneficiary's home. Health care providers who can offer these telehealth services include doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers.

Standard cost-sharing may apply but note that a provider can choose to waive cost-sharing charges. If a beneficiary has a Medicare Advantage Plan, they should contact their plan to learn about its costs and coverage rules.

Prescription refills

If a beneficiary wants to refill their prescriptions early so that they have extra medication on hand, they should contact their Part D drug plan to learn what is covered. Their plan may require extra approval before it covers early refills, and not all prescriptions can be refilled in advance.

During the emergency, all Medicare Advantage and Part D plans must cover up to a 90-day supply of a drug when a beneficiary asks for it. However, plans cannot provide a 90-day supply of a drug if it has certain restrictions on the amount that can be safely provided. These restrictions are called safety edits. They commonly apply to opioids, for example.

Note: If a beneficiary takes medications that are covered by Part B, they should ask their doctor for advice.

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Helping beneficiaries access care during a public health emergency

During a public health emergency, beneficiaries may have difficulty accessing covered care as they normally would, such as seeing in-network providers or filling their prescriptions every month.

To help beneficiaries access covered care, plans must meet certain requirements after the declaration of a public health emergency, disaster, or emergency. Medicare Advantage and Part D plans must work to maintain access to health care services and prescription drugs for plan members living in affected areas.

Medicare Advantage Plans must:

- Allow beneficiaries to receive health care services at out-of-network doctor's offices, hospitals, and other facilities
- Charge in-network cost-sharing amounts for services received out-of-network
- Waive referral requirements
- Suspend rules requiring the beneficiary tell the plan before getting certain kinds of care or prescription drugs, if failing to contact the plan ahead of time could raise costs or limit access to care

Part D plans must:

- Cover formulary Part D drugs filled at out-of-network pharmacies
    - Part D plans must do this when you cannot be expected to get covered Part D drugs at an in-network pharmacy
- Cover the maximum supply of a beneficiary's refill at their request

Medicare has also given plans the flexibility to make **optional changes** to their cost-sharing and coverage. These optional changes include:

- Relaxing policies to permit mail and home delivery of prescriptions, when disaster or emergency makes it difficult for the beneficiary to go to a retail pharmacy
- Waiving prior authorization requirements that would otherwise apply to Part D drugs used to treat or prevent coronavirus, if or when such drugs are identified
- Removing prescription refill limits

If a beneficiary is having trouble getting care through their Medicare Advantage or Part D plan, you can help them file a grievance with the plan and a complaint with 1-800-MEDICARE (633-4227).

If a beneficiary thinks they are being discharged from the hospital or SNF too soon, you can help them appeal to their Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO). Depending on where the beneficiary lives, their BFCC-QIO is either:

- KEPRO (https://www.keproqio.com/aboutus/contacts) or
- Livanta (https://www.livantaqio.com/en)

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