2020 Changes to Medicare Parts B, C (Medicare Advantage), and D

The 2018 Balanced Budget Act (BBA), Centers for Medicare & Medicaid Services (CMS) 2019 Call Letter and Part C and D Final Rule, The SUPPORT Act, and revised CMS regulations made significant programmatic changes to Medicare for the coming year. This fact sheet provides an overview of the changes to Medicare Part B, Medicare Advantage (MA), and Part D programs that will impact Medicare beneficiaries effective January 1, 2020.

Be advised that the fact sheet is based on current CMS guidance which is subject to ongoing re-interpretation. NCOA will update the fact sheet in accordance with revised or reinterpreted CMS regulations. Please contact ann.kayrish@ncoa.org with any updates or questions.

Reminder to use the new Medicare Beneficiary Identifier

Starting January 1, 2020, all Medicare claims and inquiries must utilize the Medicare Beneficiary Identifier (MBI). Medicare will reject claims and eligibility transactions submitted with the social security- based health insurance claim numbers (HICN).

The transition period from HICN to MBI runs from April 2018 through December 31, 2019. During this period, providers are able to use either the HICN or MBI to exchange data with CMS.

Opioid Treatment Programs (OTP) for Opioid Use Disorder (OUD)

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act establishes a new Medicare Part B benefit for treatment of opioid use disorder (OUD). OTP services include toxicology (drug testing), dispensing and administration of medications including methadone, buprenorphine, or naltrexone, and individual and group therapy for individuals diagnosed with OUD and/or co-occurring mental health disorders.

Beneficiaries will have a zero-dollar copayment for all OUD treatment services provided by the OTP.

The SUPPORT Act allows counseling services to be provided via telehealth as clinically appropriate for individuals diagnosed with OUD and/or co-occurring mental health disorder regardless of geographic location. More on the SUPPORT Act’s impact on therapy services can be found in the next section entitled Advanced communication technology-based services – Telehealth.

CMS will begin accepting applications for opioid treatment programs beginning January 1, 2020. CMS has created new coding and bundled payments for management and counseling treatments for OUD.
Beneficiary concerns: OTP services may not be available to many beneficiaries on January 1, 2020, since all OTP providers must first be accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA) before offering services to Medicare beneficiaries. Any claim denials should be addressed through the Medicare Part B appeals process.

Historically Medicare did not recognize substance abuse treatment facilities as an independent provider type, nor provide bundled payment for services provided. Medicare coverage for outpatient substance abuse disorder was provided on service by service basis. Additionally, methadone was not covered in outpatient clinics when supplied orally.

OTPs and Medicare Advantage

Medicare Advantage plans must cover opioid use disorder treatment services furnished by OTPs as described above. As under Original Medicare, MA plans also have the option to provide counseling services to enrollees via telehealth, regardless of geographic location.

MA plans can limit OTP access to contracted network providers. Beneficiaries will have zero-dollar copayment for all OUD treatment services provided by the OTP.

CMS emphasized that in addition to the new OTP benefit, Medicare Advantage plans may also offer supplemental benefits that provide coverage for non-opioid pain management treatments like chiropractic or massage therapy. These pain management treatments, however, must be ordered by a physician or medical professional to address issues of pain and stiffness and not for the comfort or relaxation of the patient.

Beneficiary concerns: OTP services may not be available to many beneficiaries on January 1, 2020, since all OTP providers must first be accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA) before offering services to Medicare beneficiaries. Denials of OTP benefits can be appealed through the Medicare Advantage organizational determination process. MA supplemental benefits for treatment for non-opioid pain-management will be subject to plan copayments and are not included in the zero-dollar copayment services.

Historically Medicare did not recognize substance abuse treatment facilities as an independent provider type, nor provide bundled payment for services provided. Additionally, coverage for non-opioid pain management treatments have not been promoted by CMS as a supplemental benefit.

Advanced communication technology-based services - Telehealth

Medicare statute dictates that telehealth services may only be provided by approved originating sites, typically a healthcare facility for beneficiaries that reside in rural areas. To
facilitate telehealth expansion in both fee-for-service and Medicare Advantage plans, CMS has utilized its rule-making authority to re-classify some telehealth-like services into “communication technology-based services” thereby bypassing the statutory telehealth restrictions.

As a result, Original Medicare has begun paying for virtual check-ins across the country, meaning patients can now connect with their doctors from their home by phone or video chat. Usually, the check-ins are designed to determine if a patient’s condition warrants an in-person office visit.

Beginning July 1, 2019, the SUPPORT Act removed the originating site geographic conditions and adds an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

**Beneficiary concerns:** Beneficiaries pay 20% of the Medicare-approved amount for physician or other health care provider services, and the Part B deductible when applicable. Most telehealth services cost the same amount as the in-person service. Beneficiaries always have the option to be seen in the office and beneficiaries should contact 1-800-Medicare if they experience reduced in-person access to their providers. Any claim denials should be addressed using the Medicare Part B appeals process.

*Historically Medicare has only covered telehealth services delivered to Medicare beneficiaries when originated from authorized health care facilities in designated rural areas.*

**Basic telehealth benefits**

In 2020, MA plans may begin offering a new type of “basic” telehealth benefit in addition to current supplemental telehealth benefits offerings. These additional telehealth benefits allow MA plans to deliver Medicare Part B benefits through telehealth services when clinically appropriate. CMS stipulates that MA plans must continue to (1) offer enrollees the option to receive the covered benefit in person and (2) the telehealth benefits must be provided by contracted and credentialed providers.

**Beneficiary concerns:** Given the increased categories of telehealth services, MA enrollees should confirm plan limitations and copayment requirement prior to receiving services. Denial of telehealth benefits can be appealed through the Medicare Advantage organizational determination process.

*Previously, Medicare Advantage plans were only able to offer telehealth services as supplemental benefits.*
Special Supplemental Benefits for the Chronically Ill (SSBCI)

SSBCI is a new category of supplemental benefit that can be offered by Medicare Advantage plans to chronically ill enrollees. The new SSBCI benefits can include anything that CMS deems to have a reasonable expectation of improving or maintaining the health or overall function of enrollees with chronic diseases.

SSBCI include benefits that are not primarily health related and need only improve or maintain the health or overall function of an enrollee while the supplemental benefit is being utilized. The SSBCI is not required to be offered uniformly to all chronically ill eligible enrollees.

For 2020, CMS will consider any enrollee with a condition deemed chronic as described in section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual as meeting the statutory criteria. Medicare Advantage plans must document that enrollees meet chronic condition determinations before providing SSBCI.

Permissible examples of SSBCI include:

- Meals furnished to the enrollee beyond a limited basis
- Transportation for non-medical needs such as grocery shopping
- Pest control, indoor air quality equipment, or carpet shampooing to reduce irritants that may trigger asthma attacks
- Capital or structural improvements, e.g., permanent ramps, and widening hallways or doorways

Beneficiary concerns: MA plans are responsible for clearly identifying the cost and limitations of SSBCI in the plan’s Evidence of Coverage (EOC) and on Medicare Plan Finder. Enrollment into a plan does not guarantee eligibility for a supplemental benefit. Denials of supplemental benefits can be appealed through the Medicare Advantage organizational determination process.

In 2019, MA plans were able to begin offering expanded supplemental benefits to include services that could diagnose, prevent, treat, or improve an impact of an injury or health condition or reduce hospitalizations.

Update to step therapy for Part B drugs

Beneficiaries who are actively taking a drug covered under Part B are exempt from the step therapy requirement. CMS has implemented/codified a 365-day look back period to determine if the beneficiary is actively taking the drug in question or if the new start step therapy can be implemented. CMS also codified that plans have the flexibility to cross manage between Part B and Part D drugs.
**Beneficiary concerns:** MA plans participating in Part B step therapy must disclose that Part B drugs may be subject to step therapy requirements in the plan’s Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents. Medicare Advantage plans must respond/allow beneficiaries to expedite a coverage request or appeal a denial of such a request within 24-72 hours.

*In 2019, Medicare Advantage plans were first given the ability to apply step therapy for physician-administered and other Part B drugs.*

**Part D indication-based formulary design**

Indication-based formulary design is a formulary management tool that allows plans to include or exclude drugs on a formulary by indication/diagnosis.

In 2020, if a Medicare Part D plan decides to restrict on-formulary coverage of drugs to certain indications, it must ensure that another therapeutically similar drug is included on the formulary for the non-covered indication. When searching for plans, beneficiaries must not only determine that a drug is on the plan’s formulary but go a step further to ensure the drug is covered for their diagnosis or condition.

**Beneficiary concerns:** Utilization of indication-based formulary design must be disclosed in the plan Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents and on Medicare Plan Finder. Requests for coverage for excluded indications are considered exception requests for an off-formulary drug. Beneficiaries must contact the plan to initiate an exception request. Plans must provide written notice of its coverage decision within 24 hours for expedited requests or 72 hours for standard requests.

*Currently, CMS requires that Part D plans cover all indications approved by the U.S. Food & Drug Administration for its on-formulary drugs, except for those uses that are statutorily excluded from Part D coverage. Part D plan sponsors can and do use utilization management tools, such as step therapy and prior authorization requirements to promote cost-effective drug therapy by encouraging the use of preferred formulary agents.*

**Medicare Part D out-of-pocket cliff**

In 2020, Medicare Part D enrollees will be required to spend more before they are eligible to move into the catastrophic benefit period where beneficiary co-insurance is 5% of the cost of the drug or $3.60/$8.95 (generic/brand name) for Low Income Subsidy/Extra Help beneficiaries. The catastrophic coverage threshold will increase from $5,100 in 2019 to $6,350 in 2020.
Beneficiary concerns: The $1,250 increase in out-of-pocket expenses may come as an unwelcome and unbudgeted surprise in 2020.

Since 2014, a provision of the Affordable Care Act (ACA), which expired in 2019, limited the amount the catastrophic threshold amount could increase each year.

Modifications to Part D auto-ship policy

In 2020, Part D plans may offer members an auto-ship option for drug refills after the initial fill. Plans must send to the enrollee two shipping reminders prior to sending the first auto-ship refill, giving them an opportunity to opt out of the mail order delivery of the drug. Enrollees can choose to have their shipping reminders sent via phone, email, text, or direct mail.

Beneficiary concerns: To address beneficiary concerns, CMS has clarified that plan sponsors are required to refund any refills that the beneficiary reports as unneeded or unwanted. Plans may request that the enrollee return unwanted medications, but they cannot require a return as a condition of the refund.

CMS previously required that a beneficiary use a drug for four continuous months before it would be available for auto-shipment. Additionally, auto-ship consent policy varies by plan with some obtaining beneficiary approval before delivering each prescription while others obtain only an annual approval.

Limitation on Medigap Plan C and Plan F enrollment

As a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), individuals newly eligible for Medicare on or after January 1, 2020 will be unable to purchase Medigap plans that cover the Medicare Part B deductible. As both Plan C and Plan F cover the Part B deductible, newly eligible Medicare beneficiaries are prevented from buying these plans. The limitation also extends to the Plan F high deductible plans. This law also applies to the three waiver states Massachusetts, Minnesota, and Wisconsin.

If a beneficiary is eligible for Medicare before January 1, 2020, the beneficiary retains the right to purchase Plan C or Plan F after January 1, 2020, if they are within their Medigap open enrollment period or have a Medigap guaranteed issue right.

Beneficiary concerns: Plans C and F remain viable and active if the premium is paid. Beneficiaries are reminded that a federal guarantee issue right is not available if a plan becomes unaffordable.
Resources


CMS. *Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020*. July 29, 2019.

CMS. *CMS finalizes Medicare Advantage and Part D payment and policy updates to maximize competition and coverage*. April 1, 2019.


CMS. *CMS finalizes policies to bring innovative telehealth benefit to Medicare Advantage*. April 5, 2019.
