Changes to Medicare and Benefits Eligibility under COVID-19
May 28, 2020 Webinar

This handout provides the answers to questions typed into the chat by participants during the Changes to Medicare and Benefits Eligibility under COVID-19 Webinar on 5/28/20. The answers are accurate as of 6/4/20.

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Skilled nursing facility (SNF) waivers

**Question:** Does the three-day SNF waiver apply to all medical conditions or just care related to COVID?  
**Answer:** The waiver of the 3-day stay is not dependent on someone needing care related to COVID-19. It would apply to anyone who has a condition that requires care in a SNF. As described in this [CMS memo](#) from March:

- SNF care without a 3-day inpatient hospital stay will be covered for beneficiaries who experience dislocations or are otherwise affected by the emergency, such as those who are:
  1. evacuated from a nursing home in the emergency area
  2. discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients, or
  3. need SNF care as a result of the emergency, regardless of whether that individual was in a hospital or nursing home prior to the emergency.

**Question:** For the additional 100 days, what is the cost sharing? Does it start over with days 1-20 being $0 or will they have to pay a copay for the additional 100 days?  
**Answer:** Cost-sharing starts over, so $0 coinsurance for days 1-20 and $176 coinsurance or days 21-100 (under Original Medicare).
**Question:** How do the rules apply regarding SNFs if a beneficiary is in LTC SNF care self-pay, goes to the hospital for care, and returns to the SNF? Does a new benefit period start, and do they pay for their own care if they are self-pay or does Medicare kick in when they return to the SNF?

**Answer:** Assuming the beneficiary has exhausted Medicare Part A’s 100 covered days of SNF care in a current benefit period, and assuming also that s/he needs and receives skilled nursing and/or rehabilitation services on a daily basis when s/he returns to the SNF after being hospitalized, it is possible that Medicare would cover additional days (beyond the 100 already covered) if the reason for the SNF stay is related to the Covid-19 pandemic. To date, CMS' guidance on what "related to" the pandemic means is not entirely clear. Note that CMS' waiver of the 100 day limit for SNF coverage does not mean that one benefit period has ended and a new one is starting. Section 10.4.2 in Chapter 3 of the Medicare Benefit Policy Manual still applies: *The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF.* This rule applies even though the beneficiary pays privately for hospital or SNF care outside of Medicare’s covered days. [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf)

**Question:** What about if a client was sent home from the hospital with a prescription to have IV antibiotics through a home infusion agency? The client was told that it was covered under Part D instead of Part B, but then it was not covered by Part D either. The whole reason they didn’t do the treatment in the hospital was because of COVID-19. Could the waiver be used for that?

**Answer:** The waiver could not be used to get coverage for the home infusion drugs. It could have been used to possibly get the client into a SNF without a prior hospital stay in the moment. Part B covers infusion drugs as a supply when used by durable medical equipment. Part D covers infusions when administered without DME. [See more information in the Prescription Drug Manual Chapter 6, Appendix A, 2.](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf) Without knowing the denial reason it’s hard to say why it’s not being covered, but our advice is to appeal.

**Troubleshooting issues with SNFs not using waiver:** The NJ SHIP has found that QIO does not get involved in the waiver. Instead, they tell the SNF to contact the Medicare contractor who processes SNF claims.

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**Telehealth**

**Question:** Do all of these communications channels, e.g. phone, telehealth methods, etc. have to be HIPAA compliant?

**Answer:** They do not have to be HIPAA compliant and HHS will not be enforcing HIPAA standards. Providers are to act in good faith. Language below and [link here](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf):

> During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.
OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

Durable medical equipment

**Question:** Can telehealth services be used to eliminate the need to have the face-to-face for Durable Medical Equipment? If so, what are the limitations, if any?

**Answer:** Yes, telehealth can be used for the face-to-face visit. One of the webinar participants included this background experience:

> My wife just suffered a broken tibia and is having a knee replacement - needs a w/c. We called 1-800 Medicare and have also spoken with our primary care provider and with the therapist who is supervising care. She had not seen her PCP in about five months (outside the 3 month window). 1-800 Medicare and the PCP and therapist all agree: a video call can suffice for the face-to-face evaluation requirement.

**Question:** Is Medicare still requiring 3 step Oxygen check for Oxygen with DME Companies?

**Answer:** Here is information about DME changes during coronavirus. It does not mention changes to oxygen equipment documentation. For more information, the prescribing doctor should contact the DME Medicare Administrative Contractor with questions about documentation requirements.

Testing and other coverage

**Question:** If in preparation for a family vacation I want to take a COVID-19 diagnostic test to ensure I am not COVID-19 positive. Is such a test covered without a doctor's prescription?

**Answer:** Yes, the test is covered without a doctor’s prescription or order.

**Question:** Have you heard anything about PPE being provided or paid for Medicare Beneficiaries?

**Answer:** Not at this time.

**Question:** Will Medicare pay for more than one COVID test if being tested more than once is medically necessary?

**Answer:** There is no limit on the number of COVID tests that Medicare will cover.

**Question:** If a person receives out-of-network services for something not related to COVID-19, can the provider still bill in-network charges?

**Answer:** Yes. During public health emergencies, MA Plans must charge in-network cost-sharing for services received out-of-network. The services do not have to be related to COVID-19.
Question: What about someone who is enrolled in a dual ICO and is stuck in another state due to PHE? Do the Medicare advantage plans in regards to covering out of network apply to those?
Answer: If a dual ICO is a Medicare Advantage Plan, then the requirements for covering out-of-network services and charging in-network cost-sharing should apply.

General Medicare questions

Question: If there is primary insurance and Medicare is secondary. Primary insurance is not providing home health care like how Medicare will allow this now. How would the coordination of benefits work? If primary does not mimic Medicare allowances, can Medicare still pay for this based on the circumstances? I have a consumer on ALS whose primary insurance has no providers, but there are Medicare providers around. Can they receive home health services through the secondary Medicare plan?
Answer: Coordination of benefits rules have not changed. If primary insurance does not cover something, secondary insurance may cover some or all of the service. Medicare makes a decision about whether to cover a service independently from what the primary insurance decided. The claims should be submitted first to the primary insurance. Primary insurance has to deny the claim and then Medicare pays secondary.

Question: If a beneficiary has been on Medicare for a period of time due to disability, what does he need to do when he becomes 65?
Answer: The beneficiary does not have to do anything, unless he wants to change his coverage. When someone had Medicare due to disability and then turns 65, they get a second Initial Enrollment Period (IEP) surrounding their 65th birthday month. They can use this IEP to make coverage changes, if they wish. If not, they do not have to do anything. Medicare continues as it had before they turned 65.

Enrollment

Question: If someone just turned 65 this month, typically they have 3 months to sign up for Medicare. Is that period of time changed due to COVID?
Answer: No. The Initial Enrollment Period (IEP) has not changed.

Question: Can equitable relief be applied for over the phone with SSA?
Answer: It is best for there to be a paper trail when someone is requesting equitable relief, so requesting it by certified mail is recommended. For example, someone requesting equitable relief because they could not enroll on time due to coronavirus should fill out CMS form 40B and write in the remarks section that they are requesting equitable relief due to coronavirus. If someone cannot request equitable relief through the mail, they should contact their local Social Security office (https://secure.ssa.gov/ICON/main.jsp) to see what options they have for submitting paperwork and requesting equitable relief.
**Question:** Can anyone with a Medicare Advantage Plan can change plans using the Special Enrollment Period (SEP)?

**Answer:** The way the SEP works is not as a blanket SEP for anyone with a Medicare Advantage Plan. However, the SEP can be used if someone missed a previous enrollment period because of the public health emergency, and everyone with a Medicare Advantage Plan has missed the Medicare Advantage Open Enrollment Period (MA OEP, 1/1-3/31) at this point. If someone in that situation wants to use this FEMA-declared emergency SEP, they could do so, because they missed the MA OEP.

**Question:** During the Initial Enrollment Period (IEP), will the assumption be the person would have signed up in his birthday month? Or at the end of the IEP?

**Answer:** At this time, we have not seen any clarification from Social Security on this topic. The information from Social Security is unclear about when someone’s Medicare starts if they use equitable relief to enroll in Medicare after their IEP has ended. We are also unsure if someone can use equitable relief to enroll in Medicare while still in the later months of their IEP and get a more favorable effective date. The argument could be made in favor of earlier effective dates, but we have not seen enough cases at this time to say for sure what the effective date might be.

**Question:** Client is citizen who has been overseas, enrolled in their National Health System, so has only had Part A. Wants to now enroll in Part B SEP (understand without penalty). How to proceed, and what proof do they need to prove they have had National Health in host country. Will they be able to access a Medigap & Part D (also without penalty) Or Medicare Advantage Plan, or only Advantage?

**Answer:** To use the Part B SEP, your client will need to prove that they were covered by National Health System and currently working. They can get an employer to fill out CMS form L564 and provide some sort of proof of coverage through the National Health System like if there’s a notice or something confirming their coverage. They could also sign an affidavit that says they had coverage. Medigap open enrollment period is when someone is 65+ and enrolled in Part B. Client would have open enrollment period to purchase Medigap once they meet both criteria. [Here’s more information about Medigap enrollment rights.](#) Once enrolled in Medicare Part A and B, client can decide whether to go with a Medigap or an MA Plan.

**Question:** Is the SEP only for Part B enrollment, or would it apply to changing plans as well?

**Answer:** The SEP is not for Part B enrollment. It is only for changing coverage once someone is already enrolled in Medicare. For example, the SEP can be used to change a Part D plan or changing a Medicare Advantage Plan if the beneficiary missed their previous opportunity to do so because of the public health emergency. [Here is a link to the CMS memo about the SEP.](#)

**Question:** During COVID-19, if a client has a Part D plan, is there help for medications for donut hole or paying deductible?

**Answer:** Beyond Extra Help, there is no federal cost assistance. A beneficiary may want to contact their plan to learn if the plan has made any cost-sharing changes that could benefit them.
**Question:** Will any of the changes that take place because of the present virus go back to the original version, once, let’s say a vaccine is produced?

**Answer:** Many of the changes will no longer be valid once the public health emergency has been declared to be over, but some may extend past the “end date” of the emergency. Right now it is a question of waiting to see what happens, as there is no set end date that applies to all of the changes.

**Question:** Can people on SSDI with credible coverage from a private insurance delay enrollment to Medicare if they are going to be automatically enrolled on their 25th month of disability payment?

**Answer:** Someone can delay their Medicare enrollment when nearing their 25th month of SSDI. They will likely be automatically enrolled and will have to decline Part B. If the insurance they have is from an employer with more than 100 employees, then they will already have primary insurance. If the employer has fewer than 100 employees, the job-based insurance will be secondary and the person should not decline Medicare because then they will not have primary insurance. In either scenario, however, they can use the Part B SEP to enroll in Medicare when they lose the job-based insurance (unless the job-based insurance was from a family member’s work at a company with fewer than 100 employees). [Here is more information about job-based insurance and Medicare for people with disabilities.](#)

**Question:** If a person has been on disability for two years and then becomes Medicare eligible in full, can they apply for MSP at the same time or is there a waiting period to do so?

**Answer:** Someone can generally apply for the MSP the month before their Medicare would begin. Contact local department of Social Services for more information about MSP applications.

**Question:** If a Medicare beneficiary missed the GEP not because of Covid-19, can the person obtain the relief to get enroll through June 17?

**Answer:** Yes.

**Question:** Does anyone know when SSA offices might reopen?

**Answer:** We haven’t heard anything yet.

**Question:** When the federal government announces the emergency is over, some states may still have emergency periods in place. Which date will be used?

**Answer:** The national public health emergency declaration will be the one that applies to the Medicare changes.