2021 Changes to Medicare Parts B, C (Medicare Advantage), and D

This fact sheet provides an overview of the changes to Medicare Part B, Medicare Advantage, and Part D programs that will impact Medicare beneficiaries beginning January 1, 2021.

Please be advised that this fact sheet is based on current CMS guidance, which is subject to additional rule revisions. NCOA will update this fact sheet in accordance with revised or new CMS regulations. Please contact ann.kayrish@ncoa.org with any updates or questions.

NOTE: This document's information describes only the permanent Medicare coverage changes, not temporary flexibilities related to the COVID-19 public health emergency. For details on changes specific to the public health emergency, please visit the Medicare Rights Center: https://www.medicareinteractive.org/get-answers/medicare-covered-services/medicare-coverage-overview/medicare-coverage-during-the-coronavirus-public-health-emergency

Initial Enrollment Period (IEP) Reminder Notice

Starting in late 2020, the Centers for Medicare & Medicaid Services (CMS) will send a separate reminder letter as part of the Initial Enrollment Period, which will provide information for individuals to learn more about Medicare, review benefits, and make their coverage choice. The reminder will follow the package sent to individuals auto-enrolled into Parts A and B and will be sent one month before Medicare coverage starts.

Beneficiary Concerns: Beneficiaries are reminded that this notice and the Welcome to Medicare packet, and automatic Medicare enrollment, are only provided to individuals already collecting Social Security retirement or disability benefits. Individuals not collecting Social Security must actively enroll in Medicare through the Social Security Administration. Medicare enrollments can be initiated by phone, online, or in-person at a local Social Security office.

Previously, Medicare auto-enrolled beneficiaries did not receive a follow-up reminder letter during their Initial Enrollment Period.

Online Premium Payment for Parts A, B, and D—New Option

CMS announced an additional new online payment system which is integrated into a beneficiary's account on MyMedicare.gov. The new online payment system can be used to pay Medicare Parts A or B premiums and Part D IRMAA (income-related monthly adjustment amount) with a credit/debit card or directly from a savings or checking account through the beneficiary's bank.

Beneficiary Concerns: It is important to note that the new online option will not allow beneficiaries to set up an automatic monthly payment to Medicare on a credit or debit card. Instead, beneficiaries must log in and make the payment every month. Additionally, Medicare

Advantage or Medicare Prescription Drug Plan premiums are not payable through the new online Medicare system.

Currently, Medicare beneficiaries can pay their Medicare premiums online through their bank's bill payment service or Medicare Easy Pay, as well as with a check, money order, or by credit or debit card.

End-Stage Renal Disease (ESRD) and Enrollment into Medicare Advantage

Beginning in 2021, and as required by the 21st Century Cures Act of 2016, Medicare beneficiaries with ESRD (end-stage renal disease/kidney failure) will have the opportunity to enroll in a Medicare Advantage plan. While dialysis coverage will be offered by Medicare Advantage plans, dialysis costs will be reimbursed by Parts A and B. In addition, Medicare Advantage plans will not be responsible for organ acquisition costs of kidney transplants.

Beneficiary Concerns: Beneficiaries enrolled in Medicare Advantage plans must obtain treatment from dialysis centers that are part of the plan's network. As a result, some ESRD beneficiaries may have access to fewer nearby dialysis centers. Beneficiaries should confirm the number and location of the plan's dialysis facilities prior to enrolling in the specific Medicare Advantage plan.

Currently, ESRD beneficiaries receive coverage largely through Original Medicare, unless they developed ESRD while enrolled in a Medicare Advantage plan.

Acupuncture for Back Pain

In 2020, Medicare Part B began covering up to 12 sessions of acupuncture treatment for those with chronic lower back pain (pain lasting 12 weeks or longer), that has no identifiable systemic cause (not associated with metastatic, inflammatory, or infectious disease), and is not associated with surgery or pregnancy. Beneficiaries must receive the 12 treatment sessions within a 90-day period. Medicare will cover an additional eight sessions if the beneficiary shows improvement. Absent improvement, no additional treatment will be covered. Under Original Medicare, beneficiaries will pay a 20% coinsurance for acupuncture services, and no more than 20 acupuncture treatments will be covered each year.

Medicare Advantage plans also cover acupuncture for chronic lower back pain. Additionally, plans may cover treatment for more conditions and/or session available under Original Medicare. Depending on the Medicare Advantage plan, enrollees may be required to obtain a referral from a primary care physician and/or obtain acupuncture services through providers within the plan network. Acupuncture services are subject to plan copayment or coinsurance amounts.

Beneficiary Concerns: Medicare beneficiaries are reminded that the acupuncture coverage is limited to chronic back pain only and does not extend to other areas of chronic pain or generals services such as dry needling. Beneficiaries should ensure that the acupuncture practitioner they use is a participating Medicare provider and will bill Medicare on their behalf. Individuals with Medicare Advantage plans should contact their plan to obtain a list of in-network healthcare professionals, clarification on the limits and level of acupuncture coverage, and an explanation of any referral requirements.

Previously, Medicare did not cover acupuncture to treat any condition. Acupuncture is recognized as an alternative to prescribing opioids to manage chronic pain, and this coverage decision is a strategy to reduce opioid usage among Medicare beneficiaries.

Opioid Treatment Program Benefit

Medicare now covers opioid use disorder treatment services provided by opioid treatment programs (OTPs) under Part B. The services available through OTP may include medication-assisted treatment, counseling, drug testing, and individual/group therapy. The counseling and therapy services are covered both in-person and by virtual delivery. The benefit includes Medicare's coverage of methadone. In 2020, the beneficiary was not responsible for any portion of the costs received from a Medicare-approved OTP.

Beneficiary Concerns: In 2021 beneficiaries enrolled in original Medicare, will not be responsible for any portion of the costs received from a Medicare-approved OTP. However, the Part B deductible does apply. Beneficiaries enrolled in a Medicare Advantage, can be charged copayments for opioid treatment program services. Medicare Advantage plan enrollees should contact their plan to learn more about plan copayment requirements and network limitations prior to receiving treatment.

Beneficiaries are also reminded that for the duration of the COVID-19 public health emergency, counseling/ therapy services and periodic assessments will be covered if delivered via telephone.

Outpatient treatment program services where a new benefit in 2020.

Prior Authorization for Certain Hospital Outpatient Procedures

Starting in July 1, 2020, some services when performed in the Hospital Outpatient Department (OPD) will require prior authorization, as CMS has determined that the procedures are commonly performed for cosmetic purposes. The services that require prior authorization include blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. Providers should allow at least ten days for a coverage decision. Additionally, coverage

for anesthesiology, physicians and, facility services related to the procedures may also be denied because of the prior authorization decision. The same procedures do not require prior authorization if performed in the setting of a doctor's office.

Beneficiary Concerns: Beneficiaries are reminded that Medicare coverage is based on medical necessity and cosmetic procedures are rarely, if ever, covered. Beneficiaries should talk with providers about any procedures planned for OPD and ensure all necessary prior authorizations are in place prior to the date of service. Beneficiaries should be wary of signing an Advanced Beneficiary Notice (ABN) for these services for Medicare may not pay the costs associated with the procedure. If the beneficiary receives a denial of coverage, the beneficiary may appeal or resubmit the request an unlimited number of times.

Prior authorization on blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation in the hospital outpatient department are new as of July 1, 2020.

Reminder on Step Therapy for Part B Drugs in Medicare Advantage

As of January 1, 2020, Medicare Advantage plans may use step therapy for Medicare Part B drugs. Other utilization management tools, such as prior authorization, continue to be allowed for Part B drugs as well.

Beneficiary Concerns: This change will only be applied to new prescriptions or administrations of Part B drugs. Beneficiaries currently receiving impacted drugs will not be required to change their medication. For new starts where step therapy applies, the beneficiary may ask the Medicare Advantage plan for an expedited exception. Depending on the health condition of the beneficiary, the exception request can be completed as quickly as possible but within 72-hours.

Further Changes to Medicare Advantage Special Supplemental Benefits for the Chronically Ill (SSBCI) Benefits

Beginning in January 2021, Medicare Advantage plans will have the flexibility to offer supplemental benefits that target any chronic health condition. Plans will no longer be limited to the chronic conditions listed in Chapter 16b of the Medicare Managed Care Manual. Plans must continue to ensure that the beneficiary meets the following criteria:

- Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
- Has a high risk of hospitalization or other adverse health outcomes; and
- Requires intensive care coordination.

Medicare Advantage plans must continue to document that enrollees meet chronic condition determinations before providing SSBCI.

Permissible examples of SSBCI may 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: Medicare Advantage plans are responsible for clearly identifying the cost and limitations of SSBCI in the plan's Evidence of Coverage and on the Medicare Plan Finder. Currently, the Medicare Plan Finder does not adequately reflect the many limitations on plan SSBCI benefits, and beneficiaries only learn after enrolling into a plan that they are ineligible for benefits listed on both the Medicare Plan Finder and plan websites. Beneficiaries seeking SSBCI benefits will only be able to confirm eligibility after enrolled in a plan; an agent or plan representative cannot confirm pre-enrollment. Denials of supplemental benefits can be appealed through the Medicare Advantage organizational determination process.

In 2020, CMS considered 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 chronic condition criteria.

Telehealth and Network Adequacy Standards

Beginning in 2021, CMS has modified the network adequacy standards for Medicare Advantage plans that serve non-urban areas in two interrelated ways. First, CMS has loosened (increased) the time and distance standards, resulting in a beneficiary having to travel further to see certain specialists. Second, Medicare Advantage plans will be allowed to use and count certain telehealth specialists to meet CMS's (lowered) network adequacy standards. The types of specialists available via telehealth and still count toward network adequacy requirements include dermatologists, psychiatrists, cardiologists, ophthalmologists, nephrologists, primary care physicians, gynecologists, endocrinologists, and infectious diseases specialists. CMS believes this flexibility will encourage plans to enhance access to telehealth benefits and increase plan choices for beneficiaries residing in rural areas.

Beneficiary Concerns: Previously, Medicare Advantage plans serving non-urban areas had higher network adequacy standards and telehealth providers counted less toward meeting the plan's network adequacy requirements. As a result, beneficiaries residing in rural areas may find that they have less access to in-person care or may have to travel further for in-person care, especially for certain specialties.

Previously, CMS had stricter time and distance standards for MA plan provider network requirements.

Part D Senior Savings Model – Capped Insulin Costs

Beginning January 1, 2021, CMS is testing a modification to the current Part D discount program that allow Part D sponsors, to offer a plan that caps beneficiary copayments to $35 for a 30-day supply of insulin in the deductible, initial coverage, and coverage gap phases of the Part D benefit. The model stipulates that the capped insulin costs be offered through enhanced benefit design plans only. The model is not open to individuals receiving Extra Help/Low-income subsidy benefits.

Beneficiary Concerns: To be eligible for the capped insulin costs, beneficiaries must be enrolled in one of the Part D plans participating in the Senior Savings Model. Participating plans are identified via a filter on the Medicare Plan Finder. Importantly, beneficiaries may have to switch plans and/or switch insulin products to experience savings on their insulin costs. Lastly, beneficiaries must consider and calculate costs for all prescription drugs taken over the course of the year and not sign up for a plan based strictly on insulin cost savings

This is the first year for the Senior Savings Model has been utilized to address rising insulin costs for Medicare beneficiaries

Medicare Part D Out-of-Pocket Cliff

In 2021, Medicare Part D enrollees will be required to spend more before they are eligible to move into the catastrophic benefit period where beneficiary coinsurance is 5% of the cost of the drug or $3.70/$9.20 (generic/brand name) The catastrophic coverage threshold will increase from $6,350 in 2020 to $6,550 in 2021.

Beneficiary Concerns: The increase from 2020 to 2021 is small at $200, but this on top of the $1,250 increase from 2019 to 2020 in out-of-pocket expenses may come as an unwelcome and unbudgeted surprise in 2021.

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

Changes to the Medicare Plan Finder for the 2021 Open Enrollment

CMS has been implementing updates to the Medicare Plan Finder periodically since the beginning of 2020. Listed are plan finder changes scheduled to be implemented by October 15, 2020.

- Default sort is lowest out-of-pocket cost + premium (May 2020)
- Launch redesigned Medigap tool (but does not include plan specific premiums)
- Improve pharmacy selection options to include:
    - Locating pharmacies by name and address
    - Select up to four pharmacies and the mail-order option
    - Add the ability to change pharmacies from the plan details page
- Add once or twice per year prescription fill options
- Adding drug data footnotes (i.e., frequency not covered, default pricing)
- Add plan type search filter (i.e., PPO, HMO, MSA)
- Display renal dialysis benefit information
- Display opioid treatment benefits information
- Add flag for plans participating in the Part D Senior Savings Model
- Updated My Medicare account features:
    - Allow beneficiaries to see future LIS pricing
    - Show beneficiary Medicare Medical Savings Accounts deposit information

Special Election Periods (SEPs) for Government Entity-Declared Disaster or Other Emergency

In 2020, CMS has renamed and expanded the scope of the Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster SEP. The expanded SEP now applies to FEMA-declared emergencies/disasters as well as disaster or other emergency declarations made by a federal, state, or a local government entity. (This SEP applied to COVID-19.)

The SEP allows individuals affected by a weather-related emergency or major disaster who were entitled to but unable to complete a valid election to enroll, disenroll, or switch PDPs or MA-PDPs. This SEP is also available to individuals who live in the geographic areas identified in the emergency/disaster declaration and those that do not live in the affected areas but rely on help making healthcare decisions from friends or family members who live in the affected areas. The SEP starts as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier. The SEP ends two full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later. The SEP end date on COVID-19 was 6/30/2020.

Beneficiary Concerns: It will be important to ensure that beneficiaries and the individuals who assist them are familiar with the SEP and know it is available to them.

Previously the SEP applied strictly to FEMA declared weather-related emergency or major disasters and not to state or locally declared disasters or emergencies.

Telehealth Benefits and COVID-19

Medicare has expanded coverage and access to telehealth benefits to Medicare beneficiaries enrolled in Original Medicare and Medicare Advantage plans. With the onset of the COVID-19 public health emergency, more Medicare beneficiaries are receiving benefits through telehealth. Currently, 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 that can offer telehealth services include doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers. Standard cost-sharing applies for Original Medicare (20% coinsurance) and Medicare Advantage plans (copayments or coinsurance as described in plan information). During the public health emergency, Medicare providers can choose to waive cost-sharing charges.

The Administration and CMS are actively working to ensure some of the telehealth flexibilities offered during the COVID-19 public health emergency are permanently adopted starting January 1, 2021. To date, these rules have not yet been finalized by CMS.

Beneficiary Concerns: A telehealth service is a full visit arranged in advance with a provider using telephone or video technology. Beneficiaries should be wary of unplanned calls from unfamiliar/unknown providers as fake telehealth appointments, which have been used to obtain Medicare or Social Security numbers. Beneficiaries can expect to be charged the same for telehealth services as for in-person care. Medicare Advantage enrollees should confirm plan limitations and copayment requirements prior to receiving telehealth services.

Beginning in 2018, CMS began reducing the provider and patient barriers to virtual and telehealth services.

Advanced Communication Technology-Based Services - Telehealth

In 2021, Medicare beneficiaries will continue to have the ability to connect with their doctors from home by phone (audio only) or video chat (audio and visual). Often, the check-ins are designed to determine if a patient's condition warrants an in-person office visit.

Beneficiary Concerns: Most telehealth services cost the same amount as the in-person service. Beneficiaries enrolled in a Medicare Advantage plan can expect to pay the usual copayment or coinsurance amount for the provided health care service; while beneficiaries enrolled in Original Medicare will pay 20% of the Medicare-approved amount for physician or other health care provider services, and the Part B deductible when applicable. Beneficiaries always have the option to be seen in the office and should contact 1-800-Medicare if they experience reduced in-person access to their providers.

Over the past few years, Medicare has reduced barriers and increased access to telehealth benefits for more and more Medicare beneficiaries. 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.

Resources

CMS. *Implementing Supplemental Benefits for Chronically Ill Enrollees*. April 24, 2019.

CMS. Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. July 2, 2020.

CMS. Announcement of Calendar Year (CY) 2021 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. April 6, 2020.

Medicare Learning Network. *Telehealth Services*. March 2020.

CMS. Decision Memo for Acupuncture for Chronic Low Back Pain (CAG-00452N). January 21, 2020.

CMS. Prior Authorization for Certain OPD Services FAQ, June 2020.

CMS. Part D Senior Savings Model Landing Page. Live Updates.

HHS. SEP for FEMA declared or other major disasters. August 2020

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