

Medicare Changes in 2020

Numerous changes are occurring within the Medicare program in 2020 as a result of legislation like the [Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients And Communities Act \(the SUPPORT Act\)](#), and the [Bipartisan Budget Act of 2018 \(BBA\)](#), and several administrative rules such as the [2020 Medicare Physician Fee Schedule](#). These changes affect Medicare in several ways, for instance by expanding Medicare coverage of substance use disorder treatment, further increasing Medicare Advantage (MA) flexibility, and more.

The following primer provides a detailed explanation of important changes to Medicare relevant to Medicare beneficiaries and the professionals who serve them.

Table of Contents

- A. Medicare Part B
 - A. Coverage for opioid treatment programs
 - B. Expansion of telehealth benefits in Original Medicare for substance use disorders
- B. Medicare Advantage
 - A. Expansion of telehealth benefit flexibility
 - B. Expansion of supplemental benefits for individuals with chronic conditions
 - C. Dual Eligible Special Needs Plan (D-SNP) integration requirements
- C. Medicare Part D
 - A. Closure of donut hole
 - B. Indication-based formularies
- D. Medigap policies
 - A. Elimination of Medigap Plan C and Plan F for those newly eligible for Medicare
- E. Income-related monthly adjustment amounts (IRMAA)
 - A. IRMAA brackets adjusted for inflation

1. Medicare Part B

A. Coverage for opioid treatment programs

Effective January 1, 2020, Medicare Part B covers opioid use disorder (OUD) treatment received at opioid treatment programs (OTPs). This is a result of the passage of the [SUPPORT Act](#) and changes to the [2020 Physician Fee Schedule](#). The expanded Medicare coverage is intended to help address the opioid epidemic by providing beneficiaries with access to more services.

OTPs, which are also known as methadone clinics, are certified by the Substance Abuse and Mental Health Services Administrations (SAMHSA) to provide methadone as part of medication-

assisted treatment (MAT). OTPs are the only places where an individual can receive methadone to treat opioid use disorder (methadone prescribed for pain relief does not have to be provided by an OTP). Before 2020, Medicare did not cover OTPs, which meant that beneficiaries could not get Medicare coverage for any care they received at an OTP, including methadone treatment.

Types of services provided by an OTP that Medicare now covers include:

- FDA-approved opioid agonist and antagonist treatment medications
 - There are currently three FDA-approved medications: methadone, buprenorphine, and naltrexone
- Dispensing and administering of such medication (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

In order for OTPs to bill Medicare for MAT provided to Medicare beneficiaries, they must be certified by SAMHSA and must enroll in the Medicare program. If an individual has both Medicare and Medicaid and was previously receiving Medicaid-covered OTP services, Medicaid will continue to pay primary for treatment until the OTP is enrolled in Medicare.

At this time, once they meet their deductible, a beneficiary will not owe any cost-sharing (coinsurance or copayment) for OTP. This is intended to minimize any barriers to accessing care.

Relevant citation: 84 Fed. Reg. 62568, 62630.

B. Expansion of telehealth benefits in Original Medicare for substance use disorders

The [SUPPORT Act](#) and the [Physician Fee Schedule](#) also made changes to telehealth benefits in Original Medicare. Telehealth benefits use technology, like real-time video and audio, to facilitate communication with a provider who is not at an individual's physical location.

Original Medicare covers certain telehealth benefits such as professional consultations, office visits, including psychiatry services, and a limited number of other services. These telehealth benefits are generally only available under limited conditions to beneficiaries who live in rural areas and get the telehealth benefits in certain health care settings, rather than at home. This is known as the originating site requirement. Beginning in 2020, there is no originating site requirement for telehealth services provided to treat individuals with behavioral health conditions, including substance use disorders. This means that an individual can access these telehealth benefits from home in addition to health care settings, and they do not have to live in a rural area. Services to diagnose, evaluate, or treat symptoms of acute stroke are the only other telehealth benefits that Original Medicare covers without an originating site requirement.

Relevant citations: 84 Fed. Reg. 62568, 62628

2. Medicare Advantage

A. Expansion of telehealth benefit flexibility

MA Plans must cover all of the telehealth benefits included in Original Medicare, and they have always been able to cover more telehealth services, too. In 2020, the way that MA Plans can bill Medicare for these additional telehealth benefits (ATBs) is changing, due to the [BBA](#) as implemented in the [2020-2021 Part C and D Final Rule](#). This makes it more likely that MA Plans will offer ATBs to their enrollees. ATBs are available regardless of whether the beneficiary lives in a rural or urban area, and a beneficiary does not have to receive ATBs in certain health care settings; they can receive ATBs at home.

MA Plans may cover ATBs that they deem clinically appropriate. An MA Plan must provide in-person access to any services offered as ATBs, and a plan enrollee must have the option to choose between receiving an ATB at an in-person visit. MA Plans may charge different cost-sharing for services when provided through telehealth or an in-person visit.

MA Plans can cover supplemental benefits (those not covered by Original Medicare) as telehealth benefits, too. These are known as MA supplemental telehealth benefits.

Relevant citations: 84 Fed. Reg. 15680, 15683.

B. Expansion of supplemental benefits for individuals with chronic illnesses

Supplemental benefits are items or services covered by Medicare Advantage Plans that are not covered by Original Medicare. Historically, supplemental benefits had to be primarily health-related. Beginning in 2020, due to the [BBA](#) as implemented in the [2020 Call Letter](#), MA Plans can offer supplemental benefits to individuals with chronic conditions. These are known as Special Supplemental Benefits for the Chronically Ill (SSBCIs). SSBCIs aim to improve health outcomes for those with chronic conditions, and they **do not** have to be primarily health-related. An MA Plan may provide a benefit to an enrollee with a chronic illness if the benefit has a reasonable expectation of improving or maintaining health or function.

For an individual to be eligible for these supplemental benefits, they must be chronically ill. This means that the individual:

- Has at least one medically complex chronic condition that is life-threatening or significantly limits their health or function
 - Medically complex chronic conditions include cardiovascular disorders, diabetes, chronic lung disorders, neurologic disorders, chronic heart failure, chronic and disabling mental health conditions, cancer, dementia, chronic alcohol or drug dependence, autoimmune disorders, stroke, end-stage renal disease (ESRD), severe hematologic (blood) disorders, end-stage liver disease, and HIV/AIDS.

- Has a high risk of hospitalization or other negative health outcomes
- Requires intensive care coordination

Types of benefits that MA Plans can offer for enrollees with chronic illnesses include:

- Reduced cost-sharing for Medicare-covered benefits
- Reduced cost-sharing for primarily health-related supplemental benefits
- Additional primarily health-related supplemental benefits
- Non-primarily health-related supplemental benefits

Examples of SSBCIs include:

- Meal delivery, food, and produce
- Transportation for non-medical needs
- Pest control
- Equipment to improve indoor air quality, such as air conditioner, dehumidifiers, and carpet cleaning
- Social needs benefits, such as park passes and family counseling
- Complementary therapies, which are offered in addition to traditional medical treatment
- Home modifications, such as wider doorways or easy-to-use doorknobs
- Services to support health care management, such as financial literacy classes and assistance establishing power of attorney
- General support, such as subsidies to pay for housing on a limited or extended basis

MA Plans can tailor SSBCIs to plan enrollees with only certain chronic conditions, which means that a benefit may not be available for all enrollees with chronic conditions. For example, a plan may cover pest control only for plan enrollees with severe asthma. If a plan enrollee does not have severe asthma, even if they have mild asthma, then they may not be able to get the plan to cover pest control.

Relevant citation: Centers for Medicare & Medicaid Services, “Final 2020 Call Letter” (April 1, 2019).

C. Integration requirements for D-SNPs

Dual-Eligible Special Needs Plans (D-SNPs) are types of Medicare Advantage Plans for individuals enrolled in both Medicare and Medicaid. The [BBA](#), as implemented in the [2020-2021 Part C and D Final Rule](#), has updated requirements for D-SNPs, including Medicare and Medicaid integration criteria and a unified grievance and appeals process. Previously, D-SNPs did not necessarily deliver an enrollee’s Medicaid benefits or coordinate Medicare and Medicaid coverage, but this will change by 2021.

By 2021, the BBA requires D-SNPs to:

- Meet new minimum criteria for Medicare and Medicaid integration
- Create unified grievance and appeals processes at the plan level

Although plans do not have to meet these requirements until 2021, they may begin implementing changes in 2020.

Minimum criteria for Medicare and Medicaid integration

To comply with integration requirements, a D-SNP must meet at least one of the following criteria:

- Cover Medicaid long-term services and supports (LTSS) and/or behavioral health care services
- Notify the state Medicaid agency of hospital and skilled nursing facility admissions for at least one group of high-risk dually eligible beneficiaries, as determined by the state agency

The BBA also proposed that D-SNPs perform additional Medicaid care coordination activities. Such activities could include verifying an enrollee's eligibility for LTSS or behavioral health services under Medicaid or determining how an enrollee receives such services (such as through Medicaid managed care or fee-for-service Medicaid).

Unified grievance and appeals processes

By 2021, some D-SNPs are required to have a unified process at the plan level for grievances and appeals. A grievance is a formal complaint that a beneficiary files with their plan if they are dissatisfied with the plan. An appeal is a formal request for review of a decision made by the beneficiary's MA Plan. If a beneficiary is denied coverage for a health care service or item, they may appeal the decision.

Medicare and Medicaid have separate processes for handling appeals and grievances, with different reviewers and deadlines for filing and at subsequent levels. This makes it harder for D-SNP enrollees to understand how and where to file a grievance or appeal, resulting in delayed or denied access to needed services.

A unified process for grievances and appeals means that beneficiaries will use a single process to receive plan coverage determinations and grievance responses for Medicare and Medicaid. Plans must also have one timeline for filing, responding to, and resolving the appeal or grievance, rather than different timelines depending on whether Medicare or Medicaid is handling the grievance or appeal. Beneficiaries should also receive a unified notice when appealing or filing a grievance, rather than multiple notices from the Medicare Advantage Plan and the state Medicaid agency.

The unified appeal and grievance processes apply to services covered by both Medicare Part A or Part B and Medicaid. Grievances and appeals will only be unified at the plan level, however. This means that if a beneficiary escalates their appeal to levels that involve outside entities, they will have to file their appeal with either Medicare, Medicaid, or both, depending on the service being denied.

Relevant citations: 84 Fed. Reg. 15680, 15696.

3. Medicare Part D

A. Closure of the Part D donut hole for generic prescription drugs

The Part D donut hole, also known as the coverage gap, is a phase of Part D coverage during which a beneficiary pays more for the cost of their prescription drugs. Before entering the donut hole, a beneficiary is in the initial coverage period and pays their plan's copays and coinsurance for prescription drugs (after they meet the plan's deductible, if there is one). A beneficiary leaves the initial coverage period and enters the donut hole once their total drug costs (including what they and their plan have paid for their drugs) reach a certain limit.

The donut hole closes completely in 2020, which means that beneficiaries pay, on average, 25% of the cost of their generic **and** brand-name drugs. The donut hole closed for brand-name drugs in 2019 as a result of the [BBA](#). In 2020, as a result of the [Patient Protection and Affordable Care Act](#) of 2010, the donut hole closes for generic drugs.

Plans are required to set their copays and coinsurance so that, across all enrollees and all prescriptions, beneficiaries pay for about 25% of the costs, and the plan pays for 75 percent. However, for any particular beneficiary, or any particular drug, the percentage may be quite different, and a beneficiary may still see a difference in cost between the initial coverage period and the donut hole. For example, if a drug's total cost is \$100 and the beneficiary pays their plan's \$20 copay during the initial coverage period, they will be responsible for paying \$25 (25% of \$100) during the coverage gap.

Relevant citations: Bipartisan Budget Act of 2018, Pub. L. 115-123, § 53116 (2018); Patient Protection and Affordable Care Act, Pub. L. 111-148, §3301 (2010).

B. Indication-based formularies

The Food and Drug Administration (FDA) approves drugs for certain indications, which are the uses of a drug to treat particular diseases. In 2018, the Centers for Medicare & Medicaid Services (CMS) gave Medicare Part D plans the option [to create indication-based formularies](#), beginning in 2020. This means that Part D plans can choose to cover a drug for only certain uses, rather than for all of the FDA-approved uses.

If plans choose to tailor drug coverage to specific indications, they are required to ensure that there is another similar drug on formulary for the non-covered indication. Plans are also required to update beneficiary materials so that the limitations are clear to prospective enrollees. These changes must be detailed in the plan's Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). The Medicare Plan Finder should also reflect when indication-based management of a drug is applied.

If a beneficiary needs a drug for an indication the plan does not cover, the beneficiary can request a formulary exception. If the plan denies the formulary exception, the beneficiary can appeal that decision as they would any other unfavorable exception request.

Relevant citations: Centers for Medicare & Medicaid Services, “Indication-Based Formulary Design Beginning in Contract Year (CY) 2020” (August 29, 2018).

4. Medigap policies

A. Elimination of Medigap Plan C and Plan F for those newly eligible for Medicare

Individuals who are newly eligible for Medicare on or after January 1, 2020 will not be able to purchase Medigap Plan C or Plan F (including the Plan F high deductible option). This is due to federal legislation, [Medicare Access and CHIP Reauthorization Act of 2015](#) (MACRA), that prevents individuals new to Medicare from purchasing Medigaps that pay for the Part B deductible. Both Plan C and Plan F cover the Part B deductible.

This law also applies to the three states (Massachusetts, Minnesota, and Wisconsin) that operate their own Medigap systems. People new to Medicare in those states will also not be allowed to purchase Medigaps that pay for the Part B deductible.

These Medigap changes only affect individuals who are newly eligible for Medicare in 2020 or after. If an individual is eligible for Medicare before January 1, 2020, they will still be able to purchase Plan C or Plan F. If an individual was eligible for Medicare before this time but did not enroll, they will be able to purchase Plan C or Plan F as long as they are within their Medigap open enrollment period or have a guaranteed issue right once they enroll in Original Medicare.

If an individual is newly eligible for Medicare on or after January 1, 2020, they will not be able to purchase Plan C or Plan F. However, Plan D and Plan G currently provide coverage for all the same out-of-pocket costs, except for the Part B deductible coverage.

Case example: Rhonda turns 65 on May 11, 2020. She has not received Social Security Disability Insurance (SSDI), and does not have End-Stage Renal Disease (ESRD). She cannot purchase a Plan C or Plan F because she is newly eligible for Medicare after January 1, 2020. Instead, she can purchase Plan D or Plan G for coverage of almost all of the same out-of-pocket costs.

Note that under federal law, individuals only have the right to buy a Medigap if they are 65 or older. However, some states require companies to sell Medigap policies without medical underwriting (refusing to sell a policy, or charging more, because of a person’s health condition) to Medicare beneficiaries under 65. This includes people eligible because they receive SSDI or have ESRD.

Case example: Hector and his friend Wynn live in a state that provides Medigap enrollment rights for all individuals eligible for Medicare. Hector received SSDI for 24 months and became eligible for Medicare in the 25th month, on October 1, 2019. He can buy a Plan C or Plan F. Wynn also

receives SSDI, but his 25th month of SSDI is November 2020. He will not be able to purchase a Plan C or Plan F.

Hector will also be able to buy a Plan C or Plan F later, including when he turns 65 in 2022 and has his federal Medigap open enrollment period. Wynn will not be able to buy a Plan C or Plan F once he is 65, as he was newly eligible for Medicare after January 2020.

Relevant citation: Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, § 401 (2015).

5. Income-related monthly adjustment amounts

A. IRMAA brackets adjusted for inflation

IRMAA is an amount beneficiaries may pay in addition to their Part B and Part D premium if their income is above a certain level. The Social Security Administration (SSA) sets income brackets that determine a beneficiary's, or their spouse's, IRMAA. SSA determines if a beneficiary owes an IRMAA based on the income the beneficiary reported on their IRS tax return two years prior, meaning two years before the year that they start paying IRMAA. The income that counts is the adjusted gross income the beneficiary reported plus other forms of tax-exempt income.

To account for inflation, some of the IRMAA income brackets for Part B and Part D were increased for 2020.

Annual income (2018 tax year)	
Individuals	Couples
Equal to or below \$87,000	Equal to or below \$174,000
\$87,001 - \$109,000	\$174,001 - \$218,000
\$109,001 - \$136,000	\$218,001 - \$272,000
\$136,001 - \$163,000	\$272,001 - \$326,000
\$163,001 - \$500,000	\$326,001 - \$750,000
\$500,000 and above	\$750,000 and above

Relevant citation: 84 Fed. Reg. 61625, 61627