

2022 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, 2022.

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.

Telehealth services

The passage of the Consolidated Appropriations Act (CAA) of 2021, coupled with the recent Centers for Medicare & Medicaid (CMS) regulation changes, have further expanded telehealth coverage in 2022. The key changes to Medicare's telehealth benefit and the impact on Medicare beneficiaries are outlined below.

CMS will retain all the temporary services currently on the Medicare telehealth services list until the end of the PHE or the end of calendar year 2023.

During the public health emergency (PHE), a new category of telehealth services was created—Category 3—which designates that a telehealth service is considered a temporary addition to the Medicare telehealth services list. CMS has decided that all current Category 3 telehealth services will be covered until December 31, 2023. CMS will use the extended coverage period to collect data to determine whether services should be permanently added to the telehealth list.

A second set of temporary telehealth services did not achieve Category 3 status and coverage is scheduled to expire when the PHE ends. CMS will continue to collect feedback to determine if these subsets of services should be considered for permanent addition to the telehealth list. See page 5 of the fact sheet for definitions of Category 1 and Category 2 telehealth services.

Beneficiary concerns: When the PHE ends, beneficiaries may be confused about which services will be permanently available via telehealth. Counselors should advise clients to check with their providers to ensure coverage for telehealth services received. A list of Medicare covered telehealth services is provided for reference:

[List of Medicare covered telehealth services](#)

Removing barriers to mental and behavioral health telehealth services

The CAA permanently removed long-standing telehealth geographic restrictions and now allows for coverage for mental and behavioral health services provided via telehealth in all areas. The CAA also established the patient's home as an allowable originating site to access telehealth services for diagnosis, evaluation, and treatment of mental health disorders.

To clarify, an originating site is the location of the beneficiary at the time the telehealth service is furnished, and a telehealth distant site is the location where the provider/specialist is seeing the patient (at a distance).

During the PHE access to telehealth services has been greatly expanded and the patient's home, regardless of geographic location, has temporarily been allowed as a originating site for telehealth services.

Permanent coverage for audio-only treatment for mental health

CMS will cover audio only (telephone) mental health counseling and services only when furnished by providers that have capability of offering two-way audio/video technology and only when the beneficiary does not have access to or consent to audio and video communication. To be eligible to receive audio-only mental health services, the beneficiary must be an established patient in that the individual has been seen in-person by the mental health professional at least once during the 6-month period prior to the first telehealth service. Beneficiaries utilizing the audio-only services will be required to meet face-to-face with their mental health provider on a regular basis. CMS is currently requiring a face-to-face visit once every 6 months, but the frequency requirement is subject to change. CMS is collecting comments and guidance on the appropriate frequency for the in-person visit requirement.

Permanent coverage for audio-only treatment for mental health by RHC, FQHC and OTP

In 2022, Medicare will permanently cover mental health visits furnished via telehealth by rural health clinics (RHCs) and federally qualified health centers (FQHCs). In this way, RHCs and FQHCs can act as distant site providers for mental health services in 2022 and after the end of the PHE. Additionally, RHCs and FQHCs will be able to provide audio-only mental health services after the end of the PHE. All the requirements described above (provider two-way audio capability, established patient, and periodic face to face visits) apply to RHCs and FQHCs.

Outpatient treatment programs (OTPs) will also be able to continue to provide audio-only mental health services after the end of the PHE. While the OTP must comply with the provider two-way audio capability and established patient requirements, OTPs are not subject to the new periodic face to face visit requirements.

Beneficiary concerns: During the PHE beneficiaries have come to rely on the availability of mental health counseling and services via telehealth and often through their phone. If the beneficiary chooses to receive audio-only services, they must be prepared to meet with their mental health professional, face -to-face, on a regular basis as defined by CMS.

Beneficiaries are reminded that standard cost-sharing applies for Original Medicare (20% coinsurance) and Medicare Advantage plans (copayments or coinsurance as described in plan information) whether services are delivered in-person or via telehealth.

Currently, Medicare covers audio-only telehealth services under temporary waivers which will expire when the PHE ends. Additionally, there are no face-to face meeting requirements for

beneficiaries currently receiving audio-only mental health services. Similarly, RHCs and FQHCs had only been authorized to be distant-site-providers for mental health services through the end of the PHE.

Expanded virtual check-in made permanent

Beginning in 2022, CMS permanently approved the use of an expanded virtual check-in services for established patients. The virtual check in must be initiated by the patient and can last up to 20 minutes. An expanded virtual check-in replaces or is in-lieu of an in-person visit. The virtual check-in can be audio-only or audio/video communications and is not limited to mental health services.

Beneficiary concerns: Given that the extended virtual check-ins are designed to replace in-person visits, beneficiaries should understand that opting for an extended virtual consult may delay their ability to be seen in-person for the same condition assessed during the extended virtual visit.

Additionally, beneficiaries are reminded that 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 should contact 1-800-MEDICARE if they experience reduced in-person access to their providers.

Medicare coverage for virtual check-ins has been expanding over the past few years as CMS has determined that virtual check-ins are “communication technology-based services,” and are not subject to statutory telehealth restrictions.

Therapy services

Beginning January 1, 2022, services provided in whole or in part by a physical therapy assistant (PTA) and/or an occupational therapy assistant (OTA) will be paid at a reduced rate (85% of 80%) of the applicable Part B fee schedule amount.

Beneficiary concerns: The delegation of a therapy maintenance services to a physical or occupational therapy assistant must be clinically appropriate and beneficiaries should contact their prescribing physician with questions on therapy received. It is unclear the impact the reduction in reimbursement will have on beneficiaries given that billing for therapy services has multiple components. Beneficiaries should contact their health plans for information on co-insurance and copayment for therapy services.

Currently, no distinction is made in reimbursement for service conducted by a physical therapist and physical therapist assistant and occupational therapists and occupational therapy assistance.

Physician assistant services

CMS is amending regulations to allow physician assistants to directly bill Medicare for professional services furnished under Medicare Part B.

Beneficiary concerns: Beneficiaries will want to ensure that the physician assistant that is providing care is a participating Medicare provider and will bill Medicare for services rendered.

Currently, Medicare's payment to Physician Assistants comes through an employing agency or independent contractor.

Changes to beneficiary coinsurance associated with colorectal cancer screening

CMS is establishing a special circumstances coinsurance rule that will gradually eliminate the coinsurance payment when a growth or polyp is found and removed as part of a screening colonoscopy or flexible sigmoidoscopy procedure. The coinsurance amount will be waived regardless of whether tissue is removed during the procedure. The coinsurance reduction will be phased in during an eight-year period as follows:

- 20% for 2022
- 15% for 2023-2026
- 10% for 2027-2029
- No copayment beginning in 2030

Currently, the addition of any procedure beyond the planned colorectal preventive screening (which carries no coinsurance) results in a patient having to pay coinsurance when a growth is found and removed.

Changes to Medicare Part D

Addition of a second specialty tier

Beginning in 2022, Medicare plans may offer a two-tier specialty formulary. The preferred or second tier must offer lower cost sharing than the plan's first or non-preferred specialty tier. Plans can choose which drugs belong on the preferred tier and must allow exceptions between the tiers. The current copayment range of 25% -33% for the non-preferred tier remains unchanged.

Beneficiary concerns: The addition of another tier to the existing six tier Part D drug benefit will likely cause additional confusion for beneficiaries. Some beneficiaries may experience savings if they are able to utilize specialty drugs that are in the preferred tiers.

Currently there is one Medicare prescription drug plan specialty tier with cost share ranging from 25% - 33%.

Changes to the Medicare Plan Finder for the 2022 Open Enrollment

As of September 2021, the following updates have been made to Medicare Plan Finder:

- My Medicare.gov dropped for single Medicare.gov website
- Logged in users can save pharmacy and drug lists
- Plan filters now appear horizontally across the page
- In-network pharmacy indicated
- More prominent filter to include Special Needs Plans (SNPs) in search results
- Removal of Insulin Savings/Senior Savings Program filters for both MA and PDP
 - Plans offering the insulin savings model are no longer identified
- Plan comparisons are easier to read on mobile screens
- Improved print function on plan comparison and detail pages
- Key costs are more prominent on plan detail page
- New pharmacy drug cost comparison table on plan detail page
- Anonymous users can email drug comparison results

Special Circumstances Special Election Periods (SEPs)

The special circumstances special enrollment period is not a new SEP and beneficiaries for many years have had the ability to contact 1-800-MEDICARE and explain the circumstances around their Medicare Advantage or Prescription Drug choice/enrollment and request for an exception to the current enrollment rules. CMS recently added a note on the Medicare.gov website on the special exceptions SEP that reads “if you believe you made the wrong plan choice because of inaccurate or misleading information, including using Plan Finder, call 1-800-Medicare and explain your situation.”

While the guidance for this SEP is no different than other years, the addition of the note on the Medicare.gov website provides an opportunity for more beneficiaries to know about and utilize this important SEP.

Beneficiary concerns: Since this is an exceptional circumstances SEP, beneficiaries must recognize that only CMS can approve the SEP. Additionally, there is no deadline for this SEP, beneficiaries may make the request throughout the year.

Resources

[2022 Medicare Physician Fees Schedule](#)

[CMS Fact Sheet on 2022 Medicare Physician Fee Schedule](#)

[CMS 2022 Medicare Part C and Part D final rule](#)

[CMS Fact Sheet on Medicare Advantage and Part D final rule](#)

Medicare Learning Network. [Telehealth Services](#). June 2021

[PDP enrollment and disenrollment guidance p.41](#)

Definitions

Category 1 telehealth service: A service that are like professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list.

Category 2 telehealth service: A services that are not like those on the current Medicare telehealth services list.

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