THE NEW NORMAL FOR MEDICARE ADVANTAGE

Presented by RAM Technologies, Inc.

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REGULATORY CHANGES DUE TO AND DURING COVID-19

Amid and in light of the COVID-19 pandemic, CMS has published a variety of regulations — some temporary and some permanent — for Medicare Advantage (MA) plans. These changes make it easier for seniors to access diagnostic and treatment services for COVID-19, and also continue the government's push toward improved efficiency and quality of healthcare. Some of these changes could very well be made permanent.

It's essential for MA plans to keep abreast of ongoing regulatory changes and adapt their back-end technology and processes to support these needs. Although uncertainty abounds, one thing is clear: Healthcare will never be the same.

TESTING AND VACCINE COVERAGE[1-4]

Among recent temporary changes, CMS is requiring MA plans to cover testing and associated services, such as an e-visit or in-person appointment, necessary to diagnose COVID-19. Plans may not impose cost-sharing, such as deductibles, copayments and coinsurance, for these testing services and they cannot subject them to prior authorization or utilization review requirements.

CMS created similar rules for MA plans to follow once a vaccine becomes available, stipulating that plans must cover a vaccine and the professional services necessary to administer it without cost-sharing, utilization review or prior authorization requirements.

In keeping with the federal government's gradual loosening of restrictions on telehealth, and in light of the need to reduce in-person interactions, CMS has issued both temporary and permanent changes for the provision of these services to MA beneficiaries.

To increase the types of testing venues available to seniors, CMS no longer requires enrollees to obtain a written order from a healthcare provider to receive a test. The agency further said it will allow pharmacists to work with physicians and other practitioners to collect specimens. If a pharmacy is enrolled in Medicare as a lab, it can perform testing.

Given concerns about rapid spread of COVID-19 in nursing homes, CMS unveiled new rules in June that apply specifically to these settings. The agency said MA plans must pay for testing of nursing home residents and patients as outlined in guidelines from the CDC. Residents and patients with symptoms consistent with COVID-19 should be tested, along with those who are asymptomatic but have been exposed to COVID-19 during a facility outbreak. MA plans are additionally required to pay for testing at nursing homes to determine if an outbreak has been resolved or to support public health surveillance.

TELEHEALTH[5-13]

In keeping with the federal government's gradual loosening of restrictions on telehealth, and in light of the need to reduce in-person interactions, CMS has issued both temporary and permanent changes for the provision of these services to MA beneficiaries.

In May, CMS issued a final rule for MA plans that includes an expansion of telehealth services, beginning with the 2021 contract year. For rural areas, the agency reduced the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90% to 85%. It is giving a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers in certain specialties.

CMS also made temporary changes in its rules governing telehealth for all beneficiaries in either traditional Medicare or MA plans. Until the end of the COVID-19 public health emergency, CMS is allowing:

- Physical therapists, occupational therapists and speech language pathologists to deliver services via telehealth.
- Audio-only equipment to furnish medical evaluation and management, behavioral health and educational services.
- Telehealth visits between a provider and patient, even if the provider has not seen the patient in person within three years.
- Physicians to deliver telehealth services in states in which they do not have a license, although CMS said providers still need to meet applicable state licensing requirements.

These moves come amid a growing interest in telehealth among MA members. Before the pandemic, 5% of MA members had used telehealth services. Since the start of the pandemic, 20% of members now say they are interested in learning more about telehealth, according to J.D. Power research.

These figures highlight the importance of offering telehealth in MA plans, as well as the potential to boost member satisfaction.

A recent survey of more than 1,000 MA members found high favorability for telehealth, at 91%, and determined that 78% are willing to use it again.

Apart from the member satisfaction benefits, plans may ultimately be required to continue providing these services post-pandemic, as health industry experts and members of Congress have urged CMS to make these changes to telehealth permanent. A May 2020 White House executive order urged all agencies to consider continuing temporary regulatory relief on a permanent basis and in August, the CMS proposed changes to permanently expand telehealth in conformance with the order. These would include home visits for patient evaluation and management and certain visits for patients with cognitive impairments.

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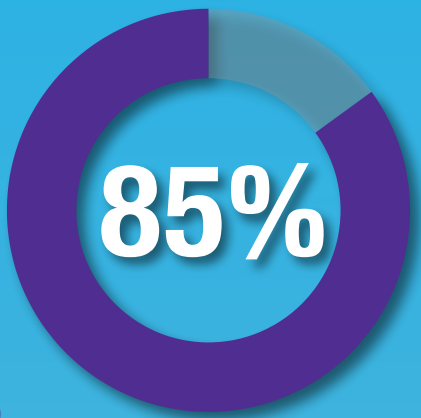

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OTHER HEALTHCARE SERVICES[1,5,14-16]

In addition to coverage of testing and telehealth services, temporary rules require expanded coverage of other healthcare services. MA plans must pay for hospital and nursing home stays for patients with COVID-19, including hospital stays to quarantine infected patients. CMS waived a requirement that skilled nursing facility stays be preceded by a hospital stay of at least three days, making it easier for infected seniors to receive care at a nursing home.

To further ease access to care, CMS blocked new network restrictions and said plans must cover Part A and B and supplemental Part C plan benefits at non-contracted providers and facilities with the same cost-sharing requirements as for contracted facilities. They must also waive gatekeeper requirements and the 30-day notification requirement.

In addition, CMS temporarily relaxed rules governing the types of benefits and cost-sharing arrangements that plans may implement, by allowing midyear enhancements to their benefits packages. Such changes can include:

- Adding supplemental services to address beneficiaries' needs, such as meal delivery or medical transportation.
- Extending the deadline for mandatory disenrollment for members who are away from their permanent residence beyond the usual six-month time limit.

Plans are taking a variety of steps to respond to these changes and to the pandemic, and some are going beyond what is required to streamline access to care and support members.

END-STAGE RENAL DISEASE

Plans are also facing some permanent changes unrelated to the pandemic. Next year, the 21st Century Cures Act will allow people with end-stage renal disease to enroll in MA during open enrollment regardless of previous coverage. Previously, people with ESRD enrolled in MA plans only under limited circumstances. This will allow about 600,000 previously ineligible patients to enroll and could increase the proportion of ESRD member claims from 5% to 20%. Plans will need to prepare to meet the needs of this challenging population.

SPECIAL NEEDS PLANS

Another permanent change involves phasing out what CMS refers to as "Look-Alike" Dual Eligible Special Needs Plans, which the agency defines as plans that have similar levels of beneficiaries who are eligible for both Medicare and Medicaid D-SNP plans, but are not officially D-SNP plans. D-SNP plans must meet regulatory requirements, such as providing health risk assessments and coordinated care, that go beyond the standard regulatory requirements for MA plans.

CMS further granted MA plans temporary flexibility to extend the deadline for re-certifying members' eligibility to continue their enrollment in special-needs plans.

BOTTOM LINE FOR PLANS[17,18]

Plans are taking a variety of steps to respond to these changes and to the pandemic, and some are going beyond what is required to streamline access to care and support members. This includes:

- Waiving out-of-pocket costs for in-network primary care and specialist telehealth visits.
- Providing expanded telehealth coverage.
- Waiving cost sharing for in-network telehealth visits for medical and mental health or substance abuse disorders.
- Waiving cost-sharing for all services provided during in-person primary care visits, for in-person behavioral health services and for telemedicine.

Many of these changes will be beneficial for plans and their members. The changes for the 2021 plan year and during the pandemic continue a pattern of recent years in which CMS has given MA plans more flexibility to improve the health of their beneficiaries — particularly the most vulnerable, such as the chronically ill or those with challenging socioeconomic circumstances — with access to non-traditional benefits, such as telehealth visits, care coordination, risk assessments and services to address the social determinants of health, such as in-home caregiver support, pest control services and access to healthy food.

This year has clarified how rapidly the world — and the world of healthcare — can change. MA plans will remain committed to helping beneficiaries access the healthcare services they need, but they must also remain committed to compliance with evolving regulations and agile for adapting to further changes in the regulatory landscape, and the entire healthcare space.

In the meantime, the changes of 2020 will have a permanent impact on healthcare and MA plans must be ready to adapt to, and even lead, that evolution. Those that have a flexible, complete, end-to-end approach to operations will be best positioned to thrive in this environment. The fastest path to operational effectiveness is partnership with an organization that is able to track and respond to new developments quickly, so plans can focus on what they do best.

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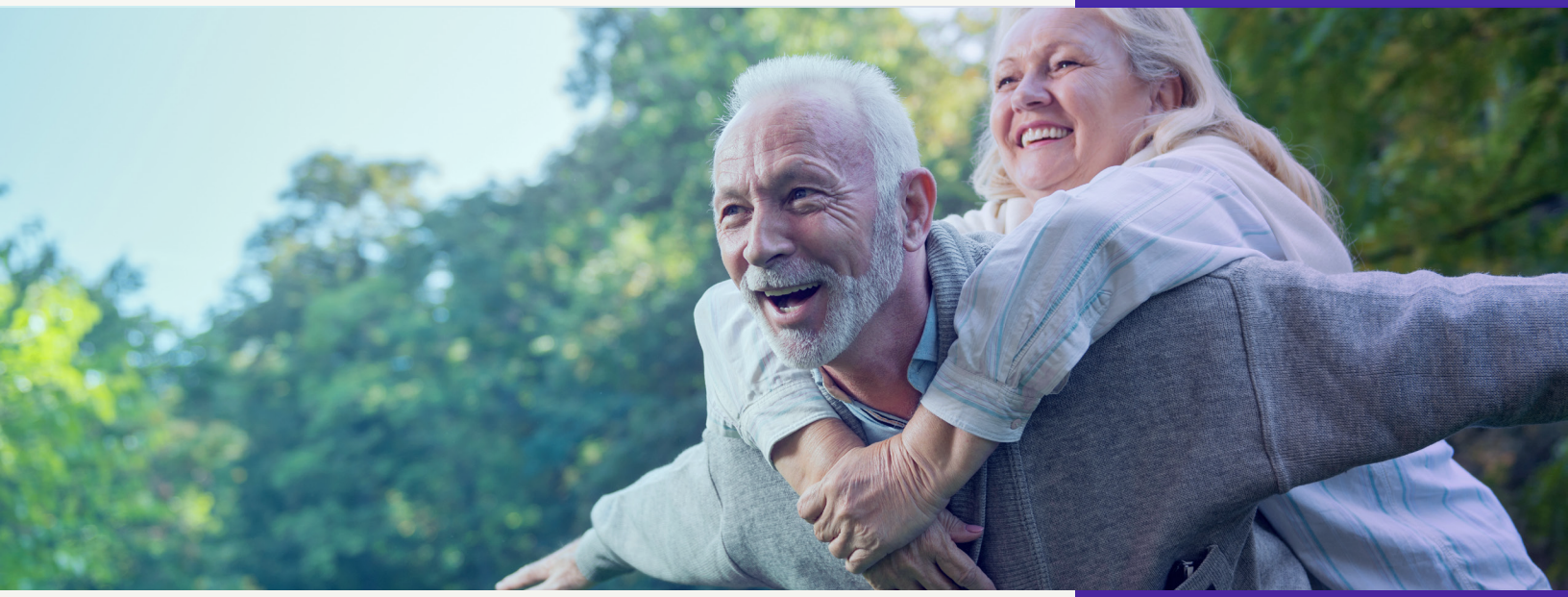

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ABOUT RAM TECHNOLOGIES

RAM Technologies is a leading provider of enterprise core administrative processing solutions for healthcare payers. For over 39 years RAM Technologies has led the way in the creation of comprehensive, end-to-end solutions for health plans administering Medicare Advantage (from Enrollment to Encounter Submissions). RAM Technologies provides the premier solutions for MA and has merited a top spot in the Philadelphia Business Journal's "List of Top Software Developers" for nine consecutive years, has been featured in Inc. Magazine's List of Fastest Growing Private Companies for five years and has been named Most Promising Insurance Technology Solution Provider by CIO Review. To learn more about RAM Technologies call (877) 654-8810 or visit www.ramtechinc.com.

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