Navigating COVID-19: Medicare Advantage and Part D Prescription Drug Plans

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As the COVID-19 pandemic has emerged over the past month, state insurance departments have issued directives in reaction to the crisis, requiring such actions as a temporary moratorium on cancellations and coverage for telehealth in a variety of circumstances. But one major market segment of health insurers and HMOs—Medicare Advantage plans offering benefits pursuant to Part C of the Medicare laws (MA Plans), and Medicare prescription drug plans under Part D (PD Plans) (collectively MAPD Plans)--must follow federal, not state, directives in such operational matters. Federal law preempts state oversight of MAPD plans, except in the areas of licensing and solvency.[1] Because of preemption, state directives issued to date mostly do not apply to MAPD plans, with the exception of directives relating to business continuity plans, which may address solvency.

This post summarizes key CMS action to date and key CARES Act provisions in the MAPD context. It also reviews public data MAPD plans' actions thus far and provides perspective on states directives on MAPD plans, despite preemption.

CMS's COVID-19 Memorandum. CMS first issued COVID-19-specific direction for MAPD plans on March 10. In "Information Related to Coronavirus Disease 2019 - COVID-19" (COVID-19 MAPD Memo, or the Memo), CMS emphasized that upon declaration of an emergency by a state or the United States, MAPD plans must uniformly implement the following special requirements in a disaster or emergency, per 42 CFR §422.100(m):

- Cover Parts A, B, supplemental C, and D benefits offered by a non-contracted provider at the in-network rate, as long as the provider is enrolled in Medicare;
- Waive, as a prerequisite to services, any prior referral requirements from a gatekeeper primary care provider; and
- Implement changes benefitting enrollees immediately, without providing the 30 days' notice normally required for changes by 42 CFR 422.111(d)(3).

The Memo then discusses a number of permissive actions that CMS "advises that [MAPD Plans] may" undertake:

- Waive or reduce cost-sharing for COVID-19 lab tests, telehealth services, or other services related to the pandemic;
- Expand access to Medicare Part B services via telehealth in any geographic area and from various places, including the beneficiary's home;
- Consistent with flexibility already afforded to MA plans, an MA Plan may waive prior authorization requirements that otherwise would apply to COVID-19-related tests.

Focusing specifically on PD Plans or the PD benefits in MAPD Plans, the Memo states that plans:

- May relax "refill too soon" denials and permit maximum extended day supply for prescriptions (even past the emergency declaration);
- Must permit beneficiaries to obtain prescription drugs from out-of-network or mail order pharmacy if reasonably necessary during the emergency because of the lack of access to a network pharmacy or the need for the beneficiary to stay at home;
- Must cover the COVID-19 vaccine when one becomes available.[2]

CMS expressly states in the COVID-19 MAPD Memo that it does not address MAPD plans' relationship with providers or payment to MAPD plans.

CMS blanket waivers since the COVID-19 MAPD Memo. Beginning March 13, in conjunction with the President's declaration of a national emergency, CMS has issued blanket waivers under sections 1135 and 1812(f) of the Social Security Act relating to *fee-for-service* Medicare and providers. These waivers permit hospitals to screen patients at offsite locations despite EMTALA requirements, remove some limits on verbal orders, expand the ability to provide services through telehealth, and temporarily relax a number of other criteria to enhance response to the pandemic. Although most of these do not directly apply to MAPD plans, two declarations expressly do:

- Waiver of laws which require hospitals to provide information about their advance directive policies to patients; and
- Permitting extensions for filing appeals, and, if good cause exists, permitting waivers of other appeal provisions to assist enrollees during the pandemic.

The Impact of the CARES Act. Several provisions of the CARES Act, which became law on March 27, provide additional legal authority to expand Medicare telehealth services during the emergency:

- *Section 4404*: Expands HHS's authority to waive telehealth requirements by deleting the definition of "qualified provider" in 42 USC 1395b and permitting broad authority to waive payment limitations under section 42 USC 1395m(m);
- *Section 4405*: Expressly permits federally qualified health centers and rural health clinics to provide services through telehealth to enhance remote treatment of patients;
- *Section 4406*: Temporarily waives requirement that end stage renal disease patients on home dialysis receive an in-person provider visit as a prerequisite to continued telehealth services;
- *Section 4407*: Temporarily waives need for an on-site visit to recertify continuation of hospice care and allows broad flexibility to enhance home health care through telehealth during the public emergency.

On March 30, in a memorandum specifically addressed to MAPD Plans, CMS summarized "Flexibilities to Fight COVID-19." In addition to confirming the telehealth expansions, prescription refill and delivery alternatives, and appeal process flexibility referenced above, this memorandum announced that CMS was putting patient care first by pausing or reprioritizing audit activities and pausing collection of HEDIS data and other key components of the MAPD Star Ratings System, with the process anticipated to recommence in 2021.

Navigating federal guidance and active state regulators. Public information on MAPD markets to date evidence that plans, at least during the emergency, typically are waiving cost-sharing for COVID-19 testing and some other procedures, permitting more lenient prescription refill policies, expanding telehealth services as encouraged by CMS's COVID-19 MAPD Memo, among other steps. In regards to state directives, MAPD plans should particularly pay attention to those requiring updates to business continuity plans, because of these requests' possible relationship to solvency. *See, e.g.*, directives recently issued by Florida, Oklahoma, and West Virginia. Federal law preempts most other directives, and, in any event, some will not be as relevant to MAPD plans as commercial plans. For example, because MAPD plans receive a significant amount of monthly payments directly from CMS or through deductions from an

enrollee's Social Security payments, nonpayment of premium is a lower risk than with many commercial plans.

Federal preemption, however, does not always stop states from seeking to enforce laws or bulletins against MAPD plans, and our firm has helped clients to navigate such circumstances.

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[1] 42 CFR §422.402 (preemption - MA plans); 42 CFR §423.440 (preemption - PD plans).

[2] The Memo states that the Medicare benefits offered by Medicare Medicaid Plans--pilot programs covering both Medicare and Medicaid benefits for dual eligible beneficiaries—must also comply with direction or guidance in the Memo.