Health. Virtually. Everywhere.

Medicare Advantage Background

Medicare Part C or Medicare Choice plans were introduced through the Balanced Budget Act of 1997, with coverage beginning in 1999. In 2003, Medicare Part D was created, and Medicare Choice plans were renamed Medicare Advantage (MA) plans. MA plans are offered by private insurance companies that contract with Medicare. MA plans cover everything original Medicare covers, including extra benefits such as hearing, vision, dental, and prescription drug coverage.

The rates paid to MA health plans are determined annually through a bidding system largely based on traditional Fee-For-Service (FFS) Medicare spending patterns. MA basic bids include all FFS services, but MA plans often choose to use their profit or admin fees to offer value-add services and benefits (not included in FFS) because they trust it will lead to improved outcomes, thus reducing costs. MA plans often use supplemental benefits plans to provide innovative or non-traditional benefits such as transportation or other benefits intended to address social determinants of health. For more information on MA bidding and payments, see here.

Medicare Advantage plans have become more popular over the years. Only 13% of the Medicare population enrolled in a MA plan in 2003. Today, an estimated 42% of Medicare recipients, or 27 million are enrolled in an MA plan, and experts project the majority of beneficiaries may get their medical coverage through one by 2030. With MA plans continuing to grow, CMS is interested in ensuring beneficiaries have access to providers within close proximity anytime and anywhere.

How Has Telehealth Evolved with the Medicare Advantage Program?

As MA plan benefits are based on FFS benefits, telehealth benefits have historically been subject to 1834m geographic and originating site restrictions, meaning patients have to be in a rural area within a certain location such as a hospital or doctor's office. In 2013, MA plans could begin offering telehealth as a supplemental benefit without those restrictions. Although it was great that telehealth was allowed to be offered without the restrictions, telehealth benefits competed with other possible supplemental benefits a plan could offer.

In February 2018, Congress passed the Bipartisan Budget Act of 2018 (Public Law 115-123), which allowed MA plans to provide "additional telehealth benefits" to enrollees and treat them as basic benefits, rather than supplemental benefits, without regard to the 1834m requirements. CMS implemented this provision starting in plan year 2020. The ATA supported updating the policy because telehealth should be considered part of the basic benefit, not treated as a supplemental service.

Network Adequacy

The Centers for Medicaid and Medicare (CMS) requires that MA plans contract with a sufficient number of providers and facilities to ensure that at least 90 percent of enrollees within a county can access care within specific travel time and distance maximums, otherwise called network adequacy requirements. Beginning in plan year 2021, CMS, through its Medicare Advantage and Part D Flexibility Final Rule (CMS-4185-F), updated its network adequacy criteria to include telehealth as an exception. Generally, organizations use the exception process to identify when the supply of providers/facilities is such that the organization can't obtain contracts that satisfy CMS's network adequacy criteria. As a result of the final rule, MA plans now have the ability to receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when they contract with telehealth providers in the following specialties: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases.

Risk Adjustment

Risk adjustment is an essential mechanism used in health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan. In April 2020, CMS clarified its policy that telehealth encounters can be used to count toward risk adjustment in Medicare Advantage (MA), Accountable Care Organizations (ACOs), and other Medicare risk-adjusted programs. By enabling telehealth services to be used for risk adjustment, plans and CMS have a more accurate depiction of the beneficiary's health status and the healthcare services obtained. If telehealth encounters did not count toward risk adjustment, it would be a significant barrier for plans to offer telehealth benefits.

ATA's Recommendations

The ATA appreciates CMS's efforts to expand access to virtual care for Medicare Advantage beneficiaries. In 2022, virtually all MA plans (98%) offer a telehealth benefit. During the first year of the COVID-19 pandemic, 49% of Medicare Advantage enrollees used telehealth services. MA plans and patients recognize the value of telehealth, and it is critical that CMS continue to support plans' ability to include telehealth services in their offerings in the future. The ATA recommends a few additional changes to ensure beneficiaries can continue to be offered these critical services and get access to care where and when they need it:

- The ATA recommends CMS convene stakeholders to discuss how additional telehealth benefits (ATB) are evolving/being utilized and what else should be done to ensure these plans can meet the needs of their members. The regulations broadly state that additional telehealth benefits must be provided through an electronic exchange, defined as electronic information and telecommunications technology." CMS provided examples of electronic information and telecommunications technology in the final rule but made clear that the list of examples is not intended to be a comprehensive list of permitted technologies. Rather, it is intended to allow for the flexibility needed based on the service offered and technological advances that may develop in the future. We urge CMS to follow through with its statement and work with plans and innovators to allow room for technological advancement and innovation.

- The ATA supports the ability of MA plans to receive 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when they contract with telehealth providers. We also urge CMS to consider expanding the list of specialty types for which the additional telehealth benefits credit applies. The ATA is neutral concerning the modalities, services, and providers, meaning all providers should be able to see their patients via telehealth (any modality) as long as the visit meets the standard of care.

- The ATA urges CMS to collect and understand the outcomes of how telehealth is being utilized within MA and cross over flexibilities to Medicare FFS. For example, telehealth services under Medicare fee for service (outside of the Public Health Emergency) are still subject to antiquated and arbitrary 1834m geographic and originating site restrictions. Understanding how MA plans utilize telehealth without these restrictions could be insightful and push FFS to alter its restrictions.