BluePeak Advisors is a division of Gallagher Benefit Services, Inc.

Client Questions Re: COVID-19

APRIL 1, 2020

COMPLIANCE

1. **Question: Do you expect CMS will relax its compliance requirements around how quickly we must answer the phone, process claims and decision appeals and grievances during this national emergency?**

   Answer: We have not seen any guidance from CMS suggesting that Plans no longer must meet established timeliness requirements. At a time when a larger than typical number of members are getting sick, it is likely more important than ever to meet timeliness requirements in order to provide members with timely direction and access to care.

2. **Question: In response to COVID-19, we are closing our public-facing office and have instructed all its personnel to work from home. Are there requirements about who should be notified?**

   Answer: During this national emergency, we recommend you keep your CMS Regional Account Manager informed of material actions you are taking in response. This includes notifying them if you are having all or most employees who normally work in the office work remotely. Also, in this situation where your public-facing office is closed, ensure you post signs for any members who attempt to visit such public-facing offices instructing them that employees are working remotely during the COVID-19 national emergency and providing them with the Member Services and TTY telephone numbers where they can timely reach assistance. Finally, be sure to forward office telephones to home/mobile phones so that calls continue to be timely received.

PART C AND D CLAIMS

3. **Question: CMS sent out a memo that stated: "When these special requirements are in effect, under 42 CFR 422.100(m)(2), the requirements for Medicare Advantage Organizations under 42 CFR 422.100(m)(1) are:**
   a. **Cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at non-contracted facilities subject to § 422.204(b)(3), which requires that facilities that furnish covered A/B benefits have participation agreements with Medicare.**
   b. **Waive, in full, requirements for gatekeeper referrals where applicable.**
   c. **Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility.**
   d. **Make changes that benefit the enrollee effective immediately without the 30-day notification requirement at § 422.111(d)(3). (Such changes could include reductions in cost-sharing and waiving prior authorizations as described below)."**
   e. **Is the memo saying we have to provide OON benefits at the cost share of INN for provider offices (for routine services)? Or is it just for "facilities" (hospitals, urgent care, etc.)?**

   Answer: Yes. Until the national or state emergency ends (whichever is later), MA Plans must cover all claims for medically necessary plan benefits furnished by OON providers and must do so at the same cost share for INN, not just those benefits furnished by facilities like hospitals, urgent care, etc.

4. **Question: Is there any data analytics plans should be reviewing relative to COVID-19?**

   Answer: In order to understand the volume of claims that plans are paying which might be related to proposed treatment therapies for COVID-19 that are being discussed, we advise that plans start to look at utilization data. This includes looking at claims for the medications; Chloroquine, Hydroxychloroquine and Azithromycin, either alone or in combination. There are other anti-viral medications also being investigated, which can be added to the reports to observe those utilization trends as well. Depending on the plan's enrollee demographic location, this should be done as frequently as daily for those in high impact areas.

PART D COVERAGE DETERMINATIONS

5. **Question: During this time, can we make decisions to lift a "refill-to-soon" restriction on a case-by-case basis until we decide whether we want to lift such edits across the board?**

   Answer: We do not recommend this. Rather, we recommend the Plan apply such changes uniformly to similarly situated enrollees who are affected by the disaster or emergency. Since COVID-19 has been declared a national emergency, this means if the Plan elects to lift such restrictions, they should be uniformly lifted across all enrollees.

6. **Q- As we continue to experience drug shortages as a result of COVID, we are identifying drug products that we want to allow to pay at the point-of-sale as the formulary alternatives. If we effectively allow members to obtain alternative products, when COVID ends, what do we do with these products? Do we continue to allow these products to pay for the remainder of the year or are we only to allow continuation of therapy for existing users? Will existing users be allowed to obtain a transition supply in the next contract year?**

   A- These can be handled as a non-formulary request at the member level, which would effectively be a coverage determination exception. The minimum approval time frame should be until the end of the plan year with that end date included in the letter. Members may incur higher copays in this solution.

   Alternatively, this could be a positive formulary change for 2020 applied to all members within a Plan. If the intent is **not** to continue to cover these drugs for 2021 then these drugs would not be submitted on the 2021 formulary in June. In this case, these medications would be treated as a negative change across contract years. This would include notification to the members taking the drug that the drug is going to be non-formulary and if the member has the drug in the look back period, they would be eligible for a transition fill in 2021.

   Plans should review the member and plan cost implications of each approach.

7. **Q-Given the evolving impact of COVID-19 and the effect it is having on Medicare Part D operations, including formulary options, is CMS looking to relax any of the following normal regulations in order to provide relief to sponsors and access to care for their enrollees? Specifically:**
   • Will CMS relax the standard and expedited Appeals timeframes to allow more time for prescribers to respond since a large portion of prescriber's offices are on limited hours or closed?

A- Plans must continue to follow current CMS regulations and guidance for processing coverage determinations and redeterminations and issue a decision within the required timeframes for Part B/D drugs. However, plans are permitted to utilize all flexibilities available in the process, such as the ability to invoke extensions for Part C requests related to items/services. Per our regulations at §422.568(b)(1)(i), §422.572(b)(1) and §422.590(f)(1), Part C plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest. If a plan believes it will be unable to meet timeframes, the plan should contact its account manager. Medicare Advantage Organizations and Part D sponsors are reminded of the requirement sunder 42 CFR 422.504 (o) and 423.505(p) to have business continuity plans to ensure restoration of business operations following disruptions, including emergencies. Medicare Advantage Organizations and Part D sponsors should review their business continuity plans to ensure that any necessary planning for business operations disruption due to a disaster or emergency is included.