



Medicare Policies Expanding Access to Health Care for People Living with HIV and Viral Hepatitis During the COVID-19 Public Health Emergency

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Although the unique impacts of COVID-19 on people living with HIV or viral hepatitis are still not known, people living with chronic conditions, particularly conditions affecting the immune system, are at greater risk of developing more serious illness from the virus. Additionally, with other viral respiratory infections, we know that [risk for people living with HIV](#) is greatest if they have low CD4 counts and are not in care. People living with HIV or viral hepatitis may also have other risk factors, such as age or other medical conditions, that put them at greater risk of serious health complications from COVID-19. It is therefore important that people living with HIV and viral hepatitis maintain uninterrupted access to care and treatment for the duration of the emergency, while complying with social distancing guidelines to reduce their likelihood of exposure to COVID-19.

State, federal, and private insurance policies that expand access to COVID-19 related testing and care are critical protections for people living with HIV, viral hepatitis, and other chronic conditions who are at greatest risk of health complications from the virus. Additionally, policies that expand access to telehealth for routine visits and to

triage patients who are ill, allow 90-day supplies and/or early refills of prescription medication, allow home delivery of prescriptions, relax formulary and prior authorization requirements, require coverage of out-of-network providers, provide smoking cessation benefits, facilitate enrollment in coverage, and prevent or prohibit disenrollment from coverage are especially important for ensuring that people living with HIV and viral hepatitis can continue treatment without interruption and reduce their risk of exposure to, or adverse health consequences from, the virus. The protections and services available to insured clients depend on their source of coverage. For Medicaid and private insurance, policies may also vary by state and insurance carrier.

This fact sheet describes Medicare policies and protections that can help ensure safe and comprehensive access to health care for people living with HIV and viral hepatitis. For information about other types of coverage, refer to NASTAD's fact sheets on [Medicaid](#) and [private insurance](#) policies related to the COVID-19 pandemic.

In addition to the Medicare policies described in this fact sheet, Ryan White HIV/AIDS Program recipients and AIDS Drug Assistance Programs can consider adapting their programs in response to the COVID-19 pandemic to safely provide uninterrupted care and services to clients. Additionally, health departments can offer additional support to programs and service providers that work with people living with HIV, people living with viral hepatitis, and people who use drugs. RWHAP clinics and other medical providers can also consider expanding use of telehealth services to provide care to clients in their homes. Visit NASTAD's [COVID-19 Resource Page](#) for more information about how public health department programs and health care providers can continue to safely serve people living with HIV, people living with viral hepatitis, and people who use drugs during the COVID-19 pandemic.

Federal Protections

Prescription Drug Access

Under the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#), Medicare Part D and Medicare Advantage Prescription Drug (MA-PD) plans must cover up to 90-day supplies of covered Part D drugs. Plans may still impose utilization management requirements.

COVID-19 Testing

Medicare and Medicare Advantage plans must cover COVID-19 testing without cost-sharing. Clinical diagnostic lab services are covered under Medicare Part B and Medicare Advantage plans as a preventive service without cost-sharing.

This is true year-round, even when there is not a public health emergency.

The [Families First Coronavirus Response Act](#) imposes some requirements on Medicare and Medicare Advantage plans to expand access to COVID-19 testing:

1. **Medicare and Medicare Advantage plans must cover certain COVID-19 test-related services without cost-sharing, but only if a test for COVID-19 is actually ordered.** Medicare Part B and Medicare Advantage plans must cover, without cost-sharing, COVID-19 test-related services, including the visit to a health care provider, health care facility, or emergency room to evaluate the need for and administer the test. However, this prohibition on cost-sharing only applies if a COVID-19 test is actually ordered. Cost-sharing may be imposed if the visit does not result in a COVID-19 test. COVID-19 tests are covered without cost-sharing.
2. **Medicare Advantage plans may not impose utilization management requirements for COVID-19 tests or test-related services.** Medicare Advantage plans may not impose prior authorization or other utilization management requirements for COVID-19 tests and test-related services.

COVID-19 Vaccines

Under the CARES Act, Medicare and Medicare Advantage plans must cover COVID-19 vaccines as a Medicare Part B benefit without cost-sharing.

COVID-19 Treatment

Federal law does not require Medicare or Medicare Advantage plans to cover COVID-19 treatments without cost-sharing, and does not prohibit Medicare Advantage plans from imposing utilization management requirements for COVID-19 treatments. This means that COVID-19 treatment is still subject to all Medicare and Medicare Advantage cost-sharing and other policies.

Provider Flexibilities

The U.S. Department of Health and Human Services (HHS) has authority under Section 1135 of the Social Security Act to make certain [modifications](#) to Medicare requirements for individual providers and facilities during a declared emergency. These [1135 waivers](#) ensure that beneficiaries can access necessary Medicare-covered services during an emergency by allowing reimbursement to providers who provide such services, even if the provider cannot comply with certain requirements that would otherwise bar Medicare payment. Once CMS authorizes an 1135 waiver, providers and facilities may submit requests to CMS to operate under that authority. Providers may contact their State Survey Agency or Medicare contractor to determine whether they are eligible for waivers related to the COVID-19 emergency. HHS has issued a number of [blanket 1135 waivers](#) for Medicare providers in response to the COVID-19 emergency—providers may exercise these flexibilities without submitting an 1135 waiver request. The blanket waivers issued to date in response to the COVID-19 emergency include, among others,

flexibilities that expand access to out-of-state Medicare providers, relax certain provider enrollment and screening requirements, expedite provider applications, and expand access to telehealth.

Additionally, there are a number of policies and procedures that providers may implement in an emergency [without seeking](#) an 1135 waiver.

Frequently Asked Questions

[My client is unable to access an in-network provider due to the emergency. Can they go out-of-network?](#)

Yes. Medicare Advantage plans are required to cover services received at out-of-network facilities that participate in the federal Medicare program for the duration of the COVID-19 public health emergency. Plans may not charge enrollees who receive care at out-of-network facilities more than they would if they had received care at an in-network facility.

Part D plans must also cover medications dispensed at an out-of-network pharmacy for enrollees who cannot reasonably be expected to obtain their drugs at an in-network pharmacy due to the emergency.

[Can my client access Medicare-covered services using telehealth?](#)

Yes. The U.S. Department of Health and Human Services (HHS) has [lifted restrictions](#) on Medicare coverage of telehealth services during the emergency, allowing Medicare enrollees in any geographic area to receive telehealth

services without leaving their homes. Telehealth visits can include regular office visits, mental health counseling, and preventive health screenings. Medicare coverage of telehealth during the emergency is not limited to COVID-19-related services, and is available to enrollees regardless of their diagnosis. HHS has also relaxed requirements related to the type of equipment that can be used for telehealth, allowing services to be delivered via smartphone with real-time audio/video capabilities. Medicare-covered telehealth services are still subject to Part B deductibles and cost-sharing, although health care providers [may reduce or waive](#) cost-sharing for telehealth visits during the emergency.

Medicare Advantage plans may, but are not required to, allow enrollees to access services via telehealth in any geographic region and in any setting, including from the patient's home. Plans may reduce or waive cost-sharing for these services.

[My client is concerned about making frequent trips to the pharmacy during the emergency to refill medications. What are their options?](#)

Medicare Advantage Prescription Drug (MA-PD) plans and Part D plans are required to cover up to 90-day supplies of Part D drugs. Plans may, but are not required to, relax restrictions on early medication refills and home delivery of medications. Enrollees should contact their plan or pharmacist to ask about these policies.

Medicare Resources

- Centers for Medicare & Medicaid Services (CMS) [Medicare & Coronavirus page](#) includes information about Medicare coverage of COVID-19-related care and telehealth
- CMS [COVID-19 Resources](#), including information about submitting Section 1135 waivers, clinical and technical guidance, billing and coding guidance, Medicare coverage guidance, survey and certification guidance, and agency press releases
- CMS resources for submitting [Section 1135 Waivers](#)
- CMS Q&A explaining emergency policies and procedures that may be implemented [with](#) or [without](#) a Section 1135 waiver
- CMS COVID-19 [Emergency Declaration Health Care Providers Fact Sheet](#), including blanket Medicare waivers
- CMS [guidance](#) for Medicare Advantage Organizations, Part D Sponsors, and Medicare-Medicaid Plans
- CMS [Medicare Telemedicine Health Care Provider Fact Sheet](#)
- U.S. Department of Health and Human Services (HHS) [policy statement](#) on telehealth cost-sharing flexibilities for providers
- Kaiser Family Foundation [FAQs on Medicare Coverage and Costs Related to COVID-19 Testing and Treatment](#)