**LeadingAge Summary of Large Medicare Advantage Plans’ COVID-19 Policies**

***This information was late updated April 8, 2020.***

**Aetna**

[Aetna’s Provider resource page related to COVID-19](https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html)

* **COVID -19 Related Changes:** Aetna will waive cost sharing for all diagnostic testing related to COVID-19. That includes all member costs associated with diagnostic testing for Commercial, Medicare, and Medicaid lines of business. Self-insured plan sponsors will be able to opt-out of the program at their discretion. Aetna is also waiving member cost-sharing for inpatient admissions at all in-network and out-of-network facilities for treatment of COVID-19 or health complications associated with COVID-19. The coverage of COVID-19 testing and inpatient hospital treatment applies to all Aetna Individual and Group Medicare Advantage members and is effective March 25, 2020 for any such admission through June 1, 2020.   
    
  Aetna is offering its Resources For Living®, its employee assistance program, to individuals and organizations who have been impacted by COVID-19, whether or not they have RFL included as part of their benefits. People diagnosed with COVID-19 will receive a care package. CVS Health is also offering several programs to help people address associated anxiety and stress.
* **Expediting hospital discharges:** Aetna is working closely with partner hospitals to help transfer and discharge members with issues unrelated to COVID-19 from hospitals to safe and clinically appropriate care settings where they can continue to have their needs addressed. This will help hospitals and emergency rooms make room for more patients, especially those suffering from COVID-19. LeadingAge was unable to find additional details on actions Aetna is taking in this regard and as such would encourage members who contract with Aetna plans to contact their plan representative for further details.
* **Prior authorizations:** As of April 6 and through May 6, Aetna is adopting temporary changes to prior authorizations. Waiving all prior authorizations for admission to post-acute care settings (including SNFs and extended acute rehabilitations) for all commercial and Medicare Advantage plan members. PAC providers are still required to notify the plan of the admission within 48 hours. These notifications can be provided electronically or telephonically. In addition, the PAC facility must electronically submit or fax medical records for concurrent review within 3 days of the initial admission. Current plan policies don’t require precertification for contracted/in-network home health providers.
* **3-day stay waivers**:Aetna will continue to waive the 3-day prior hospitalization requirement for SNF stays as it normally does.
* **Telehealth:** Until further notice,Aetna is offering $0 cost sharing for telemedicine visits for any reason, and it is extending its Medicare Advantage virtual evaluation and monitoring visit benefit to all fully insured members. This applies to in-network providers offering these services.

**Anthem**

[**Anthem’s page for Medicare Advantage updates**](https://www.anthem.com/wps/portal/ca/provider?content_path=provider/f5/s4/t1/pw_a122594.htm&label=Important%20Medicare%20Advantage%20Updates&rootLevel=2&)

* **COVID-19 Related Policies:** In a March 24 [memo](https://www11.anthem.com/ca/shared/f2/s2/t1/pw_g397175.pdf?refer=provider), Anthem announced it would waive member cost sharing for COVID-19 testing and related visits**.** As of [April 1](https://www11.anthem.com/ca/shared/f2/s2/t1/pw_g397586.pdf?refer=provider), Anthem expanded coverage for its members undergoing treatment related to COVID-19 diagnoses. Waiving cost sharing for treatment received through May 31, 2020. Anthem states it will reimburse health care providers at in-network rates or Medicare rates, as applicable. There is no further clarification, but it would seem that in-network providers would receive their negotiated rates with the plan and out of network providers would likely be reimbursed at Medicare FFS rates. LeadingAge encourages members to check with their local Anthem plan to obtain clarification on this point. This policy covers affiliated health plan fully insured, individual, Medicaid and Medicare Advantage members.
* **Claims processing;** In a [April 1 memo](https://providernews.anthem.com/california/article/information-from-anthem-for-care-providers-about-covid-19-5), Anthem announcedit was suspendingretrospective utilization management review during this 90-day period, and Anthem reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required. In other words, it appears they won’t seek additional information from during this suspension timeframe but may look back at claims from this time period after the suspension is lifted. So, providers should continue to document the necessary information to support their claims.
* **Prior authorization(PA):** As of March 16,2020, [Anthem removed PA requirements for skilled nursing facilities (SNF) f](https://www11.anthem.com/ca/shared/f2/s2/t1/pw_g397580.pdf?refer=provider)or the next 90 days to assist hospitals in managing possible capacity issues. SNF providers should continue to notify Anthem of admissions in an effort to verify eligibility and benefits for all members prior to rendering services and to assist with ensuring timely payments.   
    
  Anthem is also extending the length of time a PA is in effect for elective inpatient and outpatient procedures to 90 days. This will help prevent the need for additional outreach to Anthem to adjust the date of service covered by the authorization.   
    
  Hospital inpatient transfers “to lower levels of care (by land only)” do not require prior authorization but Anthem asks providers to provide a voluntary notification of their occurrence through “usual channels”. Also, suspends Pas for COVID-19 Durable Medical Equipment including oxygen supplies, respiratory devices and SPAP devices for COVID-19 patients. [For additional details on prior authorizations, cost sharing, claims review protocols](https://www11.anthem.com/ca/shared/f2/s2/t1/pw_g397580.pdf?refer=provider)
* [**Telehealth**](https://www11.anthem.com/ca/shared/f2/s2/t1/pw_g397175.pdf?refer=provider)**:** For 90 days effective March 17, 2020, Anthem health plans will waive member cost shares for telehealth visits, including visits for mental health or substance use disorders, for its Medicare Advantage plans. This applies to both Anthem’s LiveHealth Online – authorized telemedicine service – as well as telehealth (video + audio) received from other providers delivering virtual care. As of March 19 (notice the different date) and effective for 90 days, Anthem will cover telephonic-only visits and waive Medicare member cost sharing for these visits when they occur with in-network providers. Out-of-network coverage for these visits will only be covered, if required. However, chiropractic care, physical, occupational or speech therapies aren’t covered for telephonic visits as it is not appropriate for the care being delivered.
* **Prescriptions**:Anthem will cover an extra 30-day supply of medications for its members and is encouraging members who obtain their medications through home delivery to switch from a 30-day to 90-day delivery schedule.

**Blue Cross Blue Shield Association plans:** A network of 36 independent and locally operated Blue Cross and Blue Shield companies have jointly taken the following actions in response to the current COVID-19 emergency.

[BCBS Association website for COVID-19 Updates](https://www.bcbs.com/coronavirus-updates) Once at this link, members can look up state-specific updates, too.

* **COVID-19 related policies:** $0 cost sharing for members for COVID-19 tests and covered services. As announced April 2, BCBSA will be waiving cost sharing for COVID-19 treatment through May 31, which includes testing, and inpatient hospital stays. Providers of these services will be reimbursed at in-network or Medicare rates, as applicable and consistent with relevant state regulations.
* **Prior Authorizations (PAs):** BCBSA is waiving prior authorizations, [as of a March 6 announcement,](https://www.bcbs.com/press-releases/blue-cross-and-blue-shield-companies-announce-coverage-of-coronavirus-testing) for diagnostic tests and related covered services that are medically necessary for those diagnosed with COVID-19. These plans will cover the associated cost sharing “where it is not covered as part of the Public Health Services response.”
* **Telehealth:** According to a [March 19 announcement](https://www.bcbs.com/press-releases/media-statement-blue-cross-and-blue-shield-companies-announce-coverage-of-telehealth-services-for-members)**,** BCBSA plans are expanding access to telehealth for the next 90 days The expansion is described to include waiving associated cost sharing for fully-insured members and applies to in-network telehealth providers.
* **Prescriptions**: BCBSA plans are waiving early medication refills for prescription maintenance medications and encouraging members to use their 90-day mail order benefit.

These changes apply to fully insured, individual, and Medicare Advantage plan members, and plans are working with state Medicaid and CHIP agencies to ensure people have access to needed testing and services.

**Humana**

[For the latest updates on Humana policies related to COVID-19](https://www.humana.com/provider/coronavirus)

* **COVID-19 related policies:** Humana will waive plan member out-of-pocket costs associated with COVID-19 testing and for treatment related to COVID-19-covered services. This applies to Medicare Advantage, Medicaid, and commercial employer-sponsored plans. Self-insured plan sponsors will be able to opt-out. Costs related to treatment for COVID-19, including inpatient hospital admissions, will be waived for enrollees of Medicare Advantage plans, fully insured commercial members, Medicare Supplement, and Medicaid. The waiver applies to all medical costs related to COVID-19 treatment, as well any FDA-approved medications or vaccines. There is no current end date for the waiver.
* **Claims processing and payments:** [Effective April 1](https://www.humana.com/provider/coronavirus/continuity-of-service), Humana will suspend all medical records requests for pre- and post-paid claim review processes for Medicare Advantage, Medicaid, and commercial plans. This suspension applies to all in-network and out-of-network professional and facility claims. Humana is also releasing any claims currently under medical review as of April 1 and issuing payment to providers. However, they note that they “may request medical records retrospectively once the suspension is lifted.” They will continue to monitor and reassess the need for this suspension as the COVID-19 crisis. LeadingAge recommends providers continue to document all information necessary to support each claim should a future dispute arise over the claim and associated payment.
* **Prior Authorizations (PAs):** Initially, Humana suspended prior authorizations only for COVID-19-related diagnoses, excluding post-discharge for both in- and out-of- network providers. As of [April 3](https://www.humana.com/provider/coronavirus/continuity-of-service), they have now expanded the suspension of “nearly all pre-authorizations requirements for participating/ in-network providers” under Medicare Advantage, Medicaid and commercial group plans. The PA suspension applies to inpatient acute and post-acute, outpatient and all referrals. Prior authorizations are still required for: out-of-network providers for non-COVID-19 related diagnoses; all providers for drug/pharmacy related requests; and transplant and genetics-related pre-authorization requirements. Additionally, Humana still requests that providers notify them within 24 hours of inpatient (acute and post-acute) and outpatient care. These notices will be automatically approved. Finally, any prior approvals of elective or non-emergent services will be extended for a 90-day approval with the exception of home health approvals, which are only being extended 60 days.
* **Telehealth:** [As of March 23,](https://www.humana.com/provider/coronavirus/telemedicine)Humana is also waiving member cost share for all telehealth services delivered by participating/in-network providers, including telehealth services delivered through MDLive to Medicare Advantage members and to commercial members in Puerto Rico, as well as all telehealth services delivered through Doctor on Demand to commercial members. They will pay for telehealth visits at the same rates as in-office visits to participating/in-network providers. For providers unable to use both audio and video, they are making a temporary exception to allow for audio-only/telephonic visits to be reimbursed as telehealth visits. Member cost sharing is waived when these services are provided by in-network/participating providers so providers should not collect these fees at this time.
* **Prescriptions:** The company is allowing early refills on regular prescription medications.

**Kaiser**

[**For up-to-date information on Kaiser Permanente’s COVID-19 policies**](https://about.kaiserpermanente.org/our-story/news/our-perspective/coronavirus-and-covid-19)

* **COVID-19 related policies:** Kaiser Permanenteannounced on March 5 that it was waiving all member costs for diagnosis and testing related to COVID-19 when referred by a Kaiser Permanente doctor. According to an [April 3](https://about.kaiserpermanente.org/our-story/news/our-perspective/costs-waived-for-members-receiving-covid-19-treatment) communication, the plan announced that its elimination of member out-of-pocket costs will apply to all fully insured benefit plans, in all lines of business, in all markets, unless prohibited or modified by law or regulation. It will apply for all dates of service from April 1 through May 31, 2020, unless superseded by government action or extended by Kaiser Permanente. This waiver was in effect for Mid-Atlantic States Region as of March 19 and is now extended to all Kaiser members.
* **Telehealth:** Kaiser hasextended the use of telehealth appointments via video and phone, where appropriate.
* **Prescriptions**: Encouraging the use of mail-order pharmacy service to help members avoid unnecessary outings.

**UnitedHealth**

[For up-to-date COVID-19 information from UnitedHealth](https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html)

* **COVID-19 related policies:** UnitedHealthcare is waiving costs for COVID-19 testing provided at approved locations in accordance with the CDC guidelines, as well as waiving copays, coinsurance and deductibles for visits associated with COVID-19 testing, whether the care is received in a physician’s office, an urgent care center or an emergency department. This coverage applies to Medicare Advantage and Medicaid members as well as commercial members. United is also expanding provider telehealth access and waiving member cost sharing for COVID-19 testing-related visits.  
    
  [UnitedHealthcare](https://www.uhc.com/health-and-wellness/health-topics/covid-19) is waiving member cost sharing for the treatment of COVID-19 through May 31, 2020 for its fully insured commercial, Medicare Advantage, and Medicaid plans.
* **Prior Authorizations (PAs):** UnitedHealthcare is suspending [prior authorization](https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/pa-covid19-updates.html) requirements for admissions to a post-acute care (PAC) provider or setting. The admitting facility will still need to notify the plan within 24 hours for weekday admissions or by 5 p.m. local time the next business day for weekend and holiday admissions. Length of stay reviews are still required. Discharges to home health will not require a PA. UHC has set up an email box ([COVID-19dischargeplanning@uhc.com](mailto:COVID-19dischargeplanning@uhc.com) ) to assist providers with patient discharge planning to lower levels of care settings. UHC is also suspending PAs when a health plan member transfers to a new but similar site of care or same service through May 31. The same notification requirements apply to transfers that apply to PAC admissions during the PA suspension timeframe.
* **Claims processing:** UnitedHealth is extending timely filing deadlines for claims during the COVID-19 public health emergency period for Medicare Advantage, Medicaid, and Individual and Group Market health plans. LeadingAge encourages members to contact their UnitedHealth plan contact for further details to ensure they understand and meet the new requirements.
* **Provider payments:** [UnitedHealth Group](https://newsroom.uhc.com/news-releases/accelerating-provider-payments-COVID-19.html), through UnitedHealthcare and Optum, [announced April 7](https://newsroom.uhc.com/news-releases/accelerating-provider-payments-COVID-19.html) that it is taking steps immediately to accelerate nearly $2 billion in payments and other financial support to health care providers in the U.S. to help address the short-term financial pressure caused by the COVID-19 emergency. This will be achieved through accelerated claim payments to medical and behavioral care providers and applies to UnitedHealthcare’s fully insured commercial, Medicare Advantage and Medicaid businesses. Other financial support currently includes the provision for up to $125 million in small business loans to clinical operators with whom OptumHealth is partnered. LeadingAge members who contract with any United Health plans are encouraged to reach out directly to their plan contacts to understand how they may access the accelerated payments or additional dollars.
* [**Telehealth**](https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-services-telehealth.html)**:** From Feb. 4, 2020 and throughout this national emergency, UnitedHealth will waive member cost sharing for in-network and out-of-network COVID-19 testing-related telehealth visits, including both interactive audio-video and audio-only.

From March 18 until June 18, UHC is waiving the originating site and audio-video requirements for telehealth. Eligible care providers can bill UHC for telehealth services performed using interactive audio-video or audio-only, except in the cases where UHC has explicitly denoted the need for interactive audio/video, such as with PT/OT/ST, while a patient is at home.    
  
For all UnitedHealthcare Medicare Advantage plans, including Dual Eligible Special Needs Plans, any originating site or audio-video requirements that may apply under Original Medicare are waived, so that telehealth services provided by a real-time audio-video or audio-only communication system can be billed for members at home or another location. All CPT/HCPCS codes, payable as telehealth when billed with modifier 95, GT or GQ and using the same place of service as if the services been rendered in person, will be covered on our Medicare Advantage plans.

As of April 8, UnitedHealth [announced](https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services.html) it will also waive cost sharing for in-network telehealth services for medical, outpatient behavioral and PT/OT/ST services from March 31, 2020 until June 18, 2020 for Medicare Advantage, Medicaid, and Individual and fully insured Group Market health plan with opt-in available for self-funded employers. Behavioral health providers are able to use both audio + video and audio only for these visits. PT/OT/ST providers must use audio+video technology in order to qualify. Out-of-network providers may provide these services, too. but plan members will be responsible for applicable cost sharing in these cases.

UnitedHealth also expanded the list of services it will cover using telehealth and virtual check ins and provides a list of related reimbursement codes.