NPHI POLICY BRIEF:
MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS

Similar to Medicare Fee-For-Service (FFS), health plans that provide coverage under the Medicare Advantage (MA) program must cover all Part A and B benefits. Plans bid annually on how much it will cost them to provide this coverage which is then compared against a FFS benchmark. If a plan's bid amount is below the FFS benchmark, the plan can use a portion of the difference between the bid and benchmark to offer mandatory "supplemental benefits" at no additional cost to enrollees. Plans can also opt to offer optional supplemental benefits which enrollees can purchase and pay for through increased premiums.

Supplemental benefits can be a key differentiator for Medicare beneficiaries deciding whether to purchase an MA plan or enroll in FFS Medicare. By allowing for a broader scope of supplemental benefits, MA plans should be able to increase their value to beneficiaries and offer benefits and services not available under FFS or Medicare Supplemental Insurance plans.

Supplemental Benefit Criteria

Generally, supplemental benefits must meet the following criteria:

1. they cannot be covered by Medicare Parts A or B;
2. they must be "primarily health-related;" and;
3. they must have an associated medical cost to the plan.

Historically, "primarily health-related" has meant that only those services which "prevent, cure, or diminish an illness or injury" could be provided. As a result, some of the most common benefits offered include reduced cost-sharing, dental, vision, and hearing assistance. Under this definition, services aimed at helping beneficiaries remain in their homes, for example, have not been permitted as supplemental benefits. Additionally, while plans can select which supplemental benefits to offer, historically, they have been required to offer them uniformly to all beneficiaries enrolled in the plan. However, this past spring, the Centers for Medicare and Medicaid Services (CMS) and Congress made certain changes permitting additional flexibilities for supplemental benefit offerings.

There are three significant changes that will occur over the next two years:

1. The definition of what can be considered a supplemental benefit is expanded;
2. Plans will have the flexibility to tailor benefits to beneficiaries with a specific health status or disease state; and
3. Beginning in 2020, additional and separate flexibility both in terms of the types of benefits and the ability to target sub-populations will be provided to plans that serve beneficiaries that meet the definition of "chronically ill."

Effectively, this creates three types of supplemental benefits: Standard, Targeted, and Chronic benefits.

Standard Benefits

Standard supplemental benefits will most closely reflect the supplemental benefits offered to-date in the sense that they must be offered "uniformly" to all beneficiaries that enroll in an MA plan. However, beginning in 2019, a broader definition of supplemental benefits will apply—under the new definition, a supplemental benefit:

> *"must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."*[1]

The changes permit plans to include those services that address functional limitations or reduce avoidable health care utilization. CMS will still require that benefits focus on beneficiaries' direct health care needs rather than addressing social determinants of health (e.g., meal delivery) or for cosmetic or comfort purposes. Additionally, access to the benefits must be recommended by a licensed medical professional, if not directly provided by one.[2]

CMS has provided some examples of potential supplemental benefits that fall into this new flexibility, including: adult day care services, home-based palliative care, in-home support services, support for caregivers of enrollees, medically-approved non-opioid pain management, stand-alone memory fitness benefit, home and bathroom safety devices and modifications (not capital improvements), transportation, and over-the-counter benefits. Other than these examples, the guidance that CMS has provided to-date is relatively limited in terms of specific details on what types of other benefits it will approve—we are likely to learn more as plans test the boundaries of the flexibilities through their bid submissions.

Targeted Benefits

Under targeted benefits, plans will have the ability to not only use the expanded definition of supplemental benefits as previously described, but they will be able to tailor benefits based on a beneficiary's health status and disease state beginning in 2019. Plans must use ICD-10 codes to define targeted conditions/diagnoses or a combination of conditions/diagnoses. For example, a plan could develop a targeted benefit for beneficiaries that have both diabetes and congestive heart failure. While a plan can design benefits to better serve individuals with specific condition(s) or disease state(s), the benefits must be uniform for all eligible beneficiaries that fall within that defined population (i.e., the plan must offer the same benefits to all individuals who have both diabetes and congestive heart failure, the plan cannot tailor the benefits to meet an individual's specific needs within that defined population).

Under targeted benefits, plans will have the ability to:

1. tailor cost sharing;
2. tailor the availability of supplemental benefits;
3. create a subset of their provider network with lower cost-sharing and/or additional benefit flexibility; and/or
4. condition the availability of a targeted benefit on participation in plan sponsored events. However, plans cannot make targeted benefits conditional on "achieving any specific clinical goals."

Chronic Benefits

The chronic benefit flexibility was established through the Bipartisan Budget Act of 2018 (BBA). One of the key differentiators of the chronic benefit option is that it can only be made available beneficiaries considered "chronically ill" as defined in the statute. A chronic benefit can only be offered to an enrollee who: 1) has one or more comorbid and medically complex chronic conditions that is life threatening or

[1] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf
[2] http://src.bna.com/yog

significantly limits the enrollee's overall health or function; 2) has a high risk of hospitalization or other adverse health outcomes; and 3) requires intensive care coordination.

Additionally, the supplemental chronic benefits provided to these beneficiaries are required by statute to "improve or maintain" the beneficiary's overall health and function. Thus, unlike the limitations under the targeted benefits option under which the supplemental benefits must be offered to all enrollees that fall within the defined population, under the chronic benefits option, plans will be able to tailor benefits specifically to an individual enrollee's needs. How this will operate, though, is to be seen; we are still awaiting guidance from CMS that may provide additional details.

Implications for NPHI members

CMS explicitly mentions services that align with core capabilities of not-for profit, community-based hospice and palliative care providers in the guidance memo. This indicates that the agency views these services as valuable and as an important component of the broader shift towards more efficient and affordable person-and-family centered care. Examples include home-based palliative care, adult day care services, and support for caregivers of enrollees and medically-approved non-opioid pain management.

NPHI members should begin to think strategically about how to leverage their expertise to capitalize on new MA opportunities.

- Begin or continue engaging with plans and consider developing new capabilities that can position your organization as an attractive partner to MA.
- Providing palliative care under MA may require you to modify or build novel processes and practices around staffing, care delivery, pricing services, contract negotiation, and patient enrollment and stratification.
- Thinking about other services that you provide – like alternative pain management therapies, transportation, or caregiver support – as part of a package of services you could offer as well.

Looking Forward

The changes to MA described in this brief are indeed a paradigm shift in CMS' thinking about what constitutes "health care," who is qualified to provide it, and how the government should pay for it. While MA currently serves about 1/3 of Medicare beneficiaries, enrollment is expected to continue to increase in coming years. Already in the first 6 months since the CMS guidance was released, nearly 270 plans have taken advantage of the new supplemental benefit flexibility – but it remains to be seen which benefits command the most uptake and have staying power. Details on most of these plans' benefit packages are not yet publicly available. However, Anthem, which has around a 4% MA market share, is the first major insurer to have developed a robust new supplemental benefit package.[3] Anthem's new benefits offer a number of non-medical supportive services, including home-delivered meals, transportation to health-related appointments, personal home care, adult day care, and alternative therapies.

NPHI members, with their strong palliative care and community support programs, can deliver real value to MA plans and can be well-positioned to succeed under as partners in implementing these new benefits and will set themselves up well for future opportunities.

[3] https://www.forbes.com/sites/howardgleckman/2018/10/05/what-a-medicare-advantage-personal-services-benefit-looks-like/#28d8020c6066