Considerations and Opportunities for Policymakers

Part 1: Policy Context

Background

Historically, the Centers for Medicare and Medicaid Services (CMS) has required that Medicare Advantage (MA) supplemental benefits, or benefits not covered by traditional Medicare, be "primarily health-related" and available to all members uniformly. Two recent changes give MA plans new flexibility to offer a wide range of supplemental benefits under expanded or new definitions, and to target them to members with specific conditions.

In 2018, CMS re-interpreted the definition of "primarily health-related" benefits (PHRB) to include some non-medical items or services, effective in 2019. Previously, the definition was limited to "an item or service whose primary purpose is to prevent, cure, or diminish an illness or injury."[1] CMS' reinterpretation of what it means to be "primarily health-related" expanded the scope of PHRB to services that:

1. diagnose, prevent, or treat an illness or injury, compensate for physical impairments;
2. act to ameliorate the functional/psychological impact of injuries or health conditions; or
3. reduce avoidable emergency and healthcare utilization.[2]

In the same guidance from 2018, CMS also waived the uniformity requirement, permitting MA plans to offer tailored supplemental benefits for "similarly situated individuals" based on disease state or condition ("Uniform Flexibility").[3]

The second change was the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI) by Congress in the *CHRONIC Care Act*, effective in 2020. SSBCI may include services that are not primarily health-related, such as pest control or non-medical transportation, as long as the service has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. The new law also

[1] The Centers for Medicare and Medicaid Services 2019 Final Rule. (April 2018). *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf*.

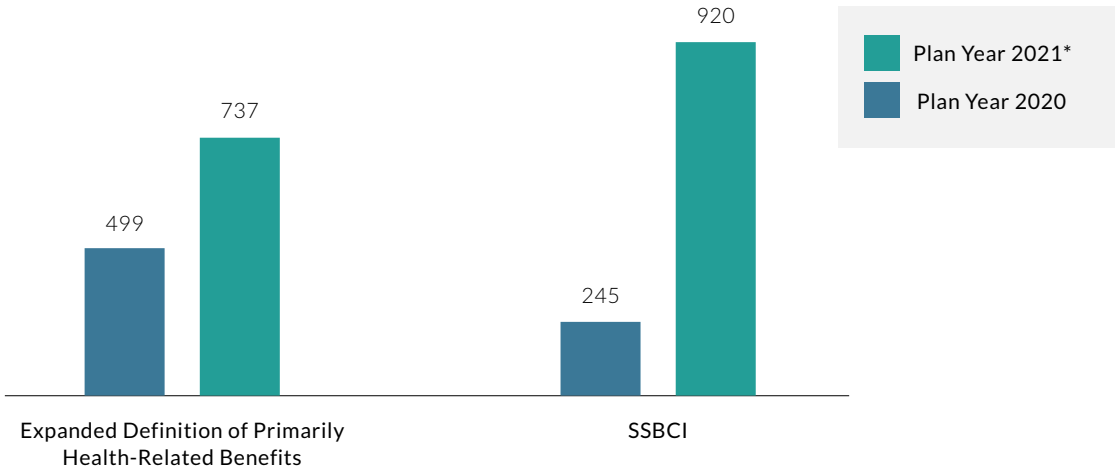
[2] Ibid.

[3] Ibid.

gave the Secretary of Health and Human Services the authority to waive, only with respect to SSBCI, uniformity requirements which necessitate that benefits be made available to all enrollees.[4] Throughout this policy brief, "non-medical supplemental benefits" refer to benefits provided under both SSBCI and the expanded definition of PHRB. (*Note: Learn more about these new benefits in this primer released by ATI Advisory.*)

The number of MA plans offering expanded PHRB and SSBCI have grown exponentially since they were first made available in 2019 and 2020, respectively (**Figure 1**).[5,6,7] The number of plans offering specific types of new supplemental benefits can be found in **Appendix C**.

Figure 1. Plans Offering New, Non-Medical Benefits In Plan Year 2020 and Plan Year 2021



**Note*: *Plan Year 2021 SSBCI numbers taken from CMS press release, which uses language "about X plans" so numbers are approximate.*
***Source(s)**: ATI Advisory analysis of CMS PBP files. CMS Press Release released September 24, 2020: https://www.cms.gov/newsroom/press-releases/trump-administration-announces-historically-low-medicare-advantage-premiums-and-new-payment-model*

[4] Separately, CMS also issued guidance providing uniform flexibility for benefits offered to all enrollees with a certain health status or disease state. The Centers for Medicare and Medicaid Services Guidance. (April 2018). *http://vbidcenter.org/wp-content/uploads/2018/05/HPMS-Memo-Uniformity-Requirements-4-27-18.pdf*.

[5] Better Medicare Alliance, analysis by Milliman. (2020). *https://www.bettermedicarealliance.org/wp-content/uploads/2020/04/MA-Supplemental-Benefits-Milliman-Brief_20200327.pdf*. Note: Milliman analysis excluded EGWPs, Cost plans, MSA plans, MMPs, and D-SNPs.

[6] ATI Advisory Analysis of CMS PBP files. For this report, expanded primarily health-related benefits include Therapeutic Massage, Adult Day Health Services, Home-Based Palliative Care, In-Home Support Services, and Home-Based Palliative Care. Analysis captures benefits filed under specific variables in the PBP files and do not capture benefits filed under "Other" categories.

[7] The Centers for Medicare and Medicaid Services Press Release. (September 2020). *https://www.cms.gov/newsroom/press-releases/trump-administration-announces-historically-low-medicare-advantage-premiums-and-new-payment-model*.

Top Plan Considerations and Challenges in Offering New Benefits

Policymakers and other stakeholders seeking to increase plan uptake and beneficiary utilization of these new benefits should be aware of the key factors that may impede MAOs from offering these benefits. While the Roadmap shares actionable steps and tactics for plans and providers to overcome challenges, this policy brief takes a broader lens on the issues to provide critical context and nuances for policymakers as they consider system-level changes.

The MAOs interviewed were generally enthusiastic about the opportunity to add benefits that could provide greater non-medical supports and services for their members with complex care needs. However, there are a range of factors that MAOs consider when deciding whether or not to include these new, non-medical benefits in plan bids. The short- and long-term policy opportunities referenced in this section are further discussed in the next section.

Culture of Medicare Advantage Organizations

"We like to fail small and win big"

The internal culture of MAOs played a role in their decisions about whether or not to offer new, non-medical supplemental benefits. Some MAOs are more open to testing new interventions with limited evidence of their impacts on health outcomes and medical utilization. Other MAOs are less willing to take on the risk of designing and administering new benefits. Given the lack of certainty around whether CMS will accept their bids, some MAOs noted hesitancy to invest significant resources in designing benefits where they have little experience. MAOs with cultures that generally support innovation and risk tend to be more comfortable moving forward in the face of the considerable unknowns in these new benefits.

Overall, many MAOs are eager to test expanded PHRB and SSBCI, collect data on their impacts, and iterate on their offerings. With more time, resources, and shared learning dedicated to this area, we expect design and administration of these new benefits to improve and grow.

Targeting of Benefits

"Being able to target benefits to those who need it – sometimes our hands are tied"

For MA plans, targeting particular benefits to a specific subgroup of members is novel. MAOs identified a specific and significant barrier in the decision to offer SSBCI related to the statutory definition of benefit eligibility. The *CHRONIC Care Act* specified the following three criteria for defining someone as 'chronically ill' for the purpose of SSBCI eligibility:

1. has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
2. has a high risk of hospitalization or other adverse health outcomes; and
3. requires intensive care coordination.[8]

Several MAOs noted uncertainty in interpreting the second and third criteria. For instance, some may interpret the second criterion on hospitalization risk as requiring a beneficiary to have had a hospitalization within the past year while others may require only a diagnosis that is associated with a higher likelihood of hospitalization, regardless of actual utilization.

Furthermore, concerns regarding how CMS will audit these new benefits has led to increased administrative burden for MA plans who are offering SSBCI. One MAO commented that the staffing and resource burden of managing eligibility documentation was high and those resources may be better spent on the benefit itself. It should be noted that although the lack of clarity around the three-part targeting criteria was identified as a challenge, MAOs appreciated the spirit of the flexibility inherent in it.

A couple of MAOs also commented on the value of targeting benefits based on functional status and income. Functional status is currently not clearly specified as a targeting criterion under SSBCI, which some MAOs felt limited their ability to target the benefit to those who need it most. CMS has noted that while it is not explicitly listed as a criterion, two of the required criteria refer to the enrollee's functional status. On the other hand, social determinants of health (SDOH) are allowable as a secondary targeting criterion (i.e., can be used as a factor to identify enrollees and to further limit SSBCI eligibility but cannot be used as the sole basis for determining eligibility).[9] From our interviews, it does not appear that this is a widely used flexibility.

While this brief is focused on expanded PHRB and SSBCI, it is important to acknowledge that some MAOs have opted to provide non-medical services through alternative pathways. Several MAOs shared a preference to test a benefit with a smaller sample

[8] Bipartisan Budget Act of 2018. (February 2018). *https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf*.
[9] The Centers for Medicare and Medicaid Services Guidance. (April 2019). *https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf*.

of members before rolling it out to a broader population. Quality Improving Programs and the MA Value-Based Insurance Design (VBID)[10] demonstration are two alternative pathways MA plans noted using to test non-medical services or benefits. **Appendix D** outlines high-level opportunities and limitations presented by each pathway as a vehicle to offer non-medical supports.

Marketability

"There's often a very strong tension point between what's going to sell and what's meaningful to the member"

Strategically, MAOs view supplemental benefits—including new, non-medical benefits—as an opportunity to differentiate their products in a highly competitive market. MAOs are also considering the extent to which these new, non-medical benefits can impact health outcomes, health care utilization, and member satisfaction. Some plans mentioned tracking metrics like hospital readmissions and self-reported member outcomes, as well as measuring the market response and whether the benefits support enrollment and member retention.

One plan noted that some benefits are viewed as more marketable than others, affecting which benefits MAOs may gravitate towards offering. There can sometimes be a tension between the benefits that are most attractive to beneficiaries and those that impact healthcare spending. For example, one MAO noted that Medicare beneficiaries shopping for plans are typically more interested in a fitness benefit than a post-discharge benefit, since most beneficiaries are not anticipating that they will be hospitalized in the near future. However, these less marketable benefits will be extremely valuable if a beneficiary's situation or care needs change.

There is a desire among MAOs to evaluate the effectiveness of non-medical benefits and build an evidence base of what is working to meet the needs of MA enrollees; however, sharing learnings among plans may present challenges since MA plans view supplemental benefits as a market differentiator.

Marketing

"The last thing we want to do is market [these new benefits] and then tell people they don't qualify"

MAOs also encountered difficulty with marketing and communicating non-medical supplemental benefits to members. Given these benefits are brand new, many beneficiaries may not know that these new benefits exist or how to access them. MAOs reported challenges with broadly marketing these benefits while effectively communicating they are limited to members meeting certain criteria. Some MAOs also commented on the need to educate their staff and contracted care managers and providers on these new benefits so they are prepared to assist beneficiaries. CMS has provided limited guidance on how these new, non-medical supplemental benefits can be marketed.

[10] VBID is a Center for Medicare and Medicaid Innovation (CMMI) model that began in 2017 to test innovations in MA. Participating plans can offer supplemental benefits based on chronic condition and/or socioeconomic status, among other flexibilities. The Centers for Medicare and Medicaid Services Request for Applications. (March 2020). *https://innovation.cms.gov/files/x/vbid-rfa2021.pdf*.

Beneficiary advocates observed that a large number of beneficiaries are learning about these new benefits through television commercials sponsored by insurance broker companies. They also noted that confusion around eligibility for these benefits can lead to beneficiaries choosing a particular plan to access a benefit that they later learn they are not eligible to receive.

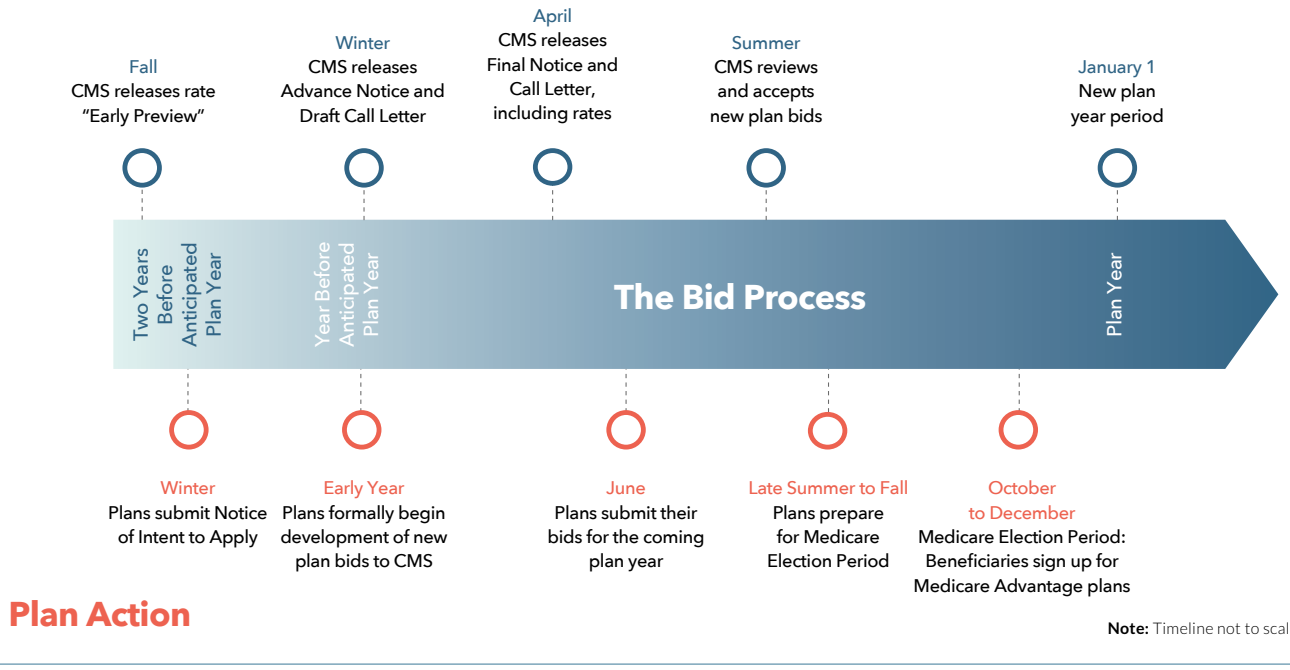
One important tool available to beneficiaries for shopping between plans is the web-based Medicare Plan Finder. However, non-medical supplemental benefits are not clearly displayed and easily navigable in this tool. On the results page, only eleven supplemental benefits are listed[11] – beneficiary advocates commented that the list of benefits seems arbitrarily selected and omits important details describing the benefits. For example, "in-home support" is displayed as a benefit but the included services and eligibility criteria are not clearly defined. Beneficiaries are also unable to filter for specific supplemental benefits in Medicare Plan Finder.

Timing of Guidance

"It is challenging for plans to estimate cost and utilization for new supplemental benefits [within a short timeframe]"

Several MAOs mentioned that the compressed timeframe for building new, non-medical supplemental benefits into plan bids hindered their ability to offer these benefits in 2019 and 2020. Benchmark development, bid submission, and determination of each plan's payment is a lengthy process, detailed in **Figure 2** below:

Figure 2. MA Plan Bid Development and Submission Timeline



Note: Timeline not to scale

[11] The "extra benefits" listed on the Medicare Plan Finder search results page are vision, dental, hearing, transportation, fitness benefits, worldwide emergency, telehealth, over-the-counter drugs, in-home support, home safety devices and modifications, and emergency response device.

In 2018, CMS issued a Final Call Letter and Final Rule on April 2nd and provided guidance on the reinterpretation of the MA supplemental benefit provisions on April 27th. With bids due June 8th of the same calendar year, MAOs had a little more than a month to develop the supplemental benefits to include in their bid for calendar year 2019. MAOs faced a similarly compressed timeframe in 2019 to develop their bids for 2020. Some MAOs felt they did not have enough time to undergo their typical processes of market analysis, vendor selection, actuarial costing, and benefit design, impacting their ability to offer these new benefits.

Sustainability

"Need to ensure that MA payment is stable and that we have the funding to innovate and experiment"

Since non-medical supplemental benefits are financed through rebate or premium dollars, funding for these benefits is not reliable year-to-year depending on the size of the rebate the plan receives. Some MAOs are concerned about offering a benefit to members that they may not be able to offer in later years since members would likely perceive this as a reduction in benefits. Furthermore, given that rebate dollars are a finite pool, MA plans must weigh the value of offering traditional supplemental benefits such as dental, vision, and hearing benefits and lowering cost-sharing against offering new, non-medical benefits.

Additionally, many stakeholders have expressed concern for the potential effects of the COVID-19 pandemic on utilization in the Medicare program that may negatively impact 2022 benchmarks. Lower benchmarks result in lower rebates, which will hinder provision and sustainability of SSBCI and expanded PHRB.

Contracting

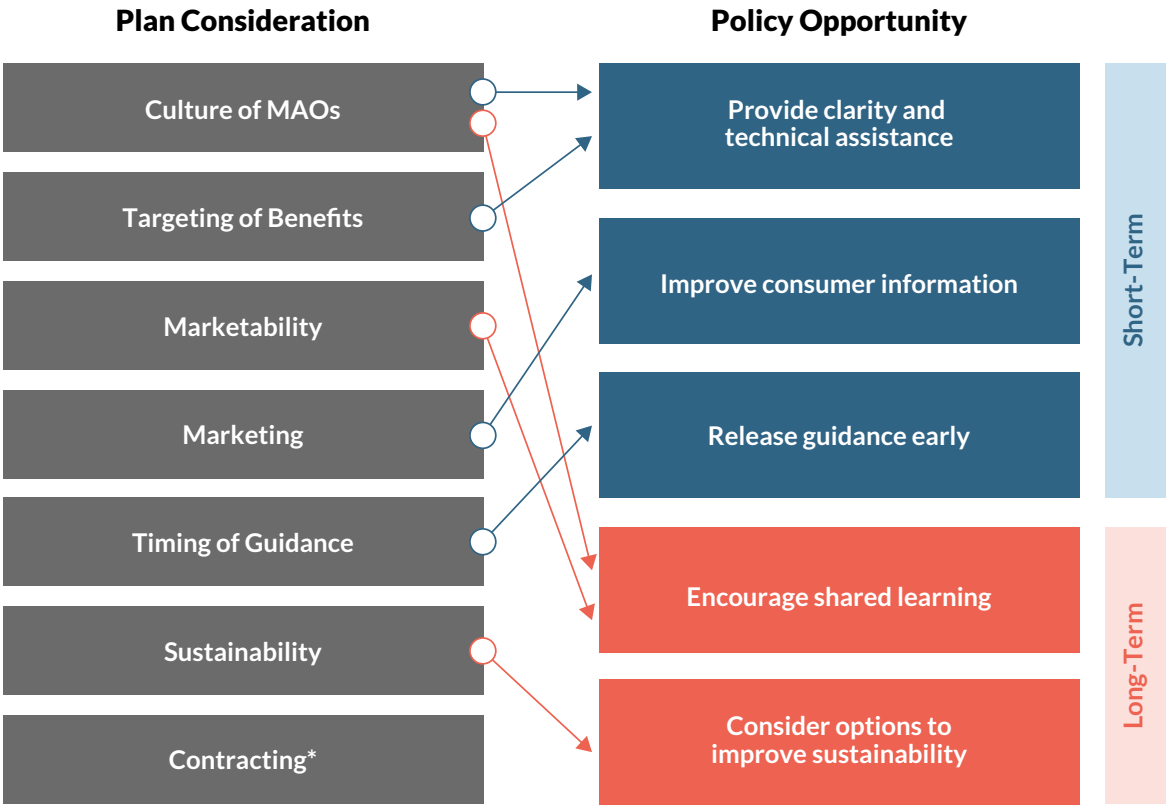
"The administrative burden on some of these contracts takes a village"

MA plans and providers attempting to implement new benefits cited contracting as a key area of concern. MAOs often had limited experience contracting with non-traditional service providers and observed gaps in these providers' readiness for contracting with them. Some of these challenges include information technology infrastructure, high liability in contracts, confusion around whether Medicare certification and licensure are required for providers, and differences in geographic service area coverage. MA plans also noted additional administrative burden around authorizing payments to these providers.

While no clear policy opportunities have emerged to address contracting at this time, this is a promising area for potential policy recommendations in the future. Please see the accompanying Roadmap in the "For Plans and Providers" section of *this page* for best practices for mitigating contracting challenges at the plan and provider level.

Based on the key considerations and challenges outlined above, several short- and long-term policy opportunities were identified. **Figure 3** below maps each consideration and/or challenge to a policy opportunity to address it (further described in the next section).

Figure 3. Mapping Plan Considerations to Policy Opportunities



**No policy opportunity identified to address this challenge at this time.*

Read the full Policy Brief *here*.