A Roadmap for Plans and Providers

Part 1: Background on Supplemental Benefits in Medicare Advantage

Medicare Advantage Today

As more of the Baby Boomer Generation ages into Medicare, MA plans continue to seek innovative ways to serve beneficiaries and further enrollment in the expanding program. MA enrollment continues to grow year over year, currently sitting at over 40% of total Medicare enrollment.[1] MA's growth is likely due, in part, to its ability to meet the needs of older adults who cannot otherwise afford supplemental insurance or who don't have access to employer-sponsored health insurance options. Research confirms that the MA program is more likely to serve low-income beneficiaries compared to Traditional Fee-for-Service Medicare.[2] Matching the popularity of MA as a whole, the total number of MA plans has also grown. The Centers for Medicare and Medicaid Services (CMS) reports that, for 2020, each county had an average of 39 plans per county, now increasing to an average of 47 plans per county in 2021.[3] Despite the rise of MA, however, disparities also remain, such as the low penetration of MA in rural states and counties.

New Supplemental Benefits

As the MA market has grown increasingly competitive over time, one way that plans have differentiated themselves from competitors is by offering new and innovative supplemental benefits to better meet the needs of their members. While MA plans continue to offer popular supplemental benefits like dental, vision, hearing, or fitness benefits, many have also begun exploring new, non-medical supplemental benefits.

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[1] The Centers for Medicare and Medicaid Services Enrollment Data. (October 2020). *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration*.

[2] Better Medicare Alliance. (2020). *https://www.bettermedicarealliance.org/publication/data-brief-medicare-advantage-provides-strong-financial-value-to-beneficiaries-as-compared-to-all-other-coverage-options/*.

[3] 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*.

These new supplemental benefits were recently introduced by CMS and Congress. These new benefits are available largely through two authorities: the first authority was introduced in 2018 by CMS and expanded the definition of what was considered "primarily health-related" to include services that 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. This authority allowed plans to offer a broader set of supplemental benefits, starting in Plan Year 2019, as "primarily health-related," including services like In-Home Support Services and Caregiver Supports.

The second authority was introduced by Congress in the *CHRONIC Care Act*, authorized in the Bipartisan Budget Act of 2018, and created a new set of benefits specifically for chronically ill Medicare beneficiaries, called Special Supplemental Benefits for the Chronically Ill, or SSBCI. First available in Plan Year 2020, these benefits are different from primarily health-related supplemental benefits in that they are not required to be health-related, and thus are able to include services like Pest Control and Social Needs Benefits. Like primarily health-related supplemental benefits, SSBCI receive funding primarily from MA plan "rebates," which average $122 per member per month in 2020. As such, these new, non-medical services must compete for the same rebate dollars as other popular benefits, like dental and hearing, and as cost-sharing reductions. On average, plans spend about $22 of total per member per month rebate dollars on Part A and B supplemental benefits."[4]

In addition to the two authorities discussed above, CMS has provided two additional flexibilities: uniform flexibility and the Value-Based Insurance Design (VBID) Model demonstration. Uniform flexibility was introduced and finalized in the same final rule that expanded the definition of "primarily health-related" in 2018. This new flexibility allows plans to provide services (including both benefits or reduced cost-sharing) in a way that is "tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly."[5] VBID is a Center for Medicare and Medicaid Innovation (CMMI) model that began in 2017 to test innovations in Medicare Advantage. Plans participating in VBID can provide supplemental benefits based on chronic conditions and/or socioeconomic characteristics and can provide rewards to incentivize the use of drug benefits, among other flexibilities.[6]

[4] MedPAC. (March 2020). "Report to the Congress: Medicare Payment Policy" *http://www.medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0*.

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

[6] The Centers for Medicare and Medicaid Services. (2020). *https://innovation.cms.gov/files/x/vbid-rfa2021.pdf*.

The Medicare program is over 50-years-old and is designed and frequently updated by Congress. Many of its requirements are complex; supplemental benefits are no exception.

Requirements for Expanded Primarily Health-Related Benefits:

Previously, benefits were considered primarily-health related "if [the] primary purpose of the item or service is to prevent, cure, or diminish an illness or injury."

CMS expanded the definition in 2018 to include a three-part test:

- "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."

Benefits provided under this broader interpretation must be medically appropriate and **recommended** by a licensed provider as part of a care plan if not directly provided by one and do not include items or services solely to induce enrollment.

Other Considerations for These Benefits:

These benefits must be offered uniformly, meaning similarly-situated individuals receive the same services.

Benefits under this broader interpretation cannot be solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.

Examples of These Benefits:

- Adult Day Care Services (Adult Day Health Services)
- Home-Based Palliative Care
- In-Home Support Services
- Support for Caregivers of Enrollees
- Therapeutic Massage

Sources: CMS Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter: *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf*; April 2018 CMS Guidance: *https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf*.

Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI):

SSBCI must "Have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee."

A chronically ill enrollee is defined as an enrollee who:

- "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;
- Has a high risk of hospitalization or other adverse health outcomes; and
- Requires intensive care coordination."

Other Considerations for These Benefits:

Statute also gives plans the authority to waive uniformity requirements for these benefits, meaning that they can be targeted to each beneficiary's individualized need.

Examples of These Benefits:

- Food and Produce
- Meals (beyond limited basis)
- Pest Control
- Transportation for Non-Medical Needs
- Indoor Air Quality Equipment and Services
- Social Needs Benefit
- Services Supporting Self-Direction

Sources: Bipartisan Budget Act of 2018: *https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf*; April 2019 CMS Guidance: *https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf*.

A Turning Point

For the first time in the Medicare program, insurers have the flexibility to pay for benefits that provide more holistic, person-centered care for their beneficiaries, including the ability to address both long-term services and supports (LTSS) and social determinant of health (SDOH) needs. Numerous studies have documented that addressing these needs can generate better health outcomes and cost-savings through reduced healthcare utilization.[7,8] At its core, and aligning with the spirit of the *CHRONIC Care Act*,[9] these benefits reflect common-sense changes to maintain or improve Medicare beneficiaries' health and well-being. Accordingly, it is imperative that insurers retain the flexibility to provide these kinds of services and are supported in their efforts to do so.

Recognizing that these flexibilities demonstrate an unprecedented opportunity to take small steps towards new solutions in the Medicare program, ATI Advisory and the Long-Term Quality Alliance (LTQA), supported by a grant from The SCAN Foundation, convened a diverse working group of national experts on Medicare Advantage and long-term services and supports, addressed as the SSBCI Leadership Circle. With the group's consensus, ATI Advisory and LTQA released "*Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill*" to inform how these new supplemental benefits should be designed and implemented over time.

What Are LTSS?

"Care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves."

Examples: eating, bathing, dressing, mobility, cooking, and driving

Source: Centers for Medicare and Medicaid Services (CMS)

What Are SDOH?

"…circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economic, social policies, and politics."

Examples: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context

Source: World Health Organization; Healthy People 2030

[7] Zachary Pruitt, Nnadozie Emechebe, Troy Quast, Pamme Taylor, and Kristopher Bryant. Population Health Management. Dec 2018.469-476. *http://doi.org/10.1089/pop.2017.0199*.

[8] AARP Public Policy Institute. "State Studies Find Home and Community-Based Services to be Cost-Effective" *https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf*.

[9] The *CHRONIC Care Act* was a collaborative, bipartisan piece of legislation produced between policymakers and the industry to increase flexibility to improve management of chronic disease and, ultimately, meet individual needs. Learn more on the *CHRONIC Care Act* from the Senate Finance Committee's press release: *https://bit.ly/3kzOtp7*.

Read the full Roadmap *here*.