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CY 2023 Medicare Advantage Proposed Rule: Impacts on Non- Medical Supplemental Benefits

Last Updated: January 26, 2022

Background and Purpose

On January 6, 2022, CMS released its Medicare Advantage and Part D proposed rule: *Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs* [CMS-4192-P].

This deck is intended to provide stakeholders with a summary and insights into the key provisions impacting non-medical supplemental benefits in Medicare Advantage (MA).

Non-medical supplemental benefits include benefits provided under both the expanded definition of primarily health-related benefits and Special Supplemental Benefits for the Chronically Ill (SSBCI). For more information on these benefits, please visit our [landing page](#).

Navigate directly to a section of this Rule summary:

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Key Definitions and Acronyms (current/pre-Rule)

D-SNP	Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid. States cover some Medicare costs, depending on the state and the individual's eligibility.
Primarily Health-Related Benefits (PHRB)	In 2018 (to go into effect for Calendar Year 2019), CMS expanded the scope of "primarily health-related" from simply <i>an item or service whose primary purpose is to prevent, cure, or diminish an illness or injury</i> to also include services that <i>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.</i> ¹
HRA	All SNPs are required to conduct an initial and annual (re)assessment of each enrollee's physical, psychological, and functional needs via a comprehensive risk assessment tool, the Health Risk Assessment (HRA).
LTSS	Long-Term Services and Supports (LTSS) are services, such as personal care, that individuals may require to perform activities of daily living, such as bathing and dressing.
MLR	The <i>Affordable Care Act of 2010</i> amended section 1857(e) of the Social Security Act to add new Medical Loss Ratio (MLR) requirements for MA plans. A plan's MLR is reported at the contract level and is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for such other items as administrative expenses or profit. ²

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. The Centers for Medicare and Medicaid Services Website. Medical Loss Ratio. <https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio>.

Key Definitions and Acronyms (current/pre-Rule)

MOOP	Maximum Out-of-Pocket (MOOP) limit that all Medicare Advantage plans must establish, beyond which amount the MA plan pays 100 percent of service costs
MA Supplemental Benefits	MA Supplemental Benefits provide coverage for services that are not available in original, fee-for-service Medicare, such as dental care.
SSBCI	The <i>CHRONIC Care Act</i> , included in the <i>Bipartisan Budget Act of 2018</i> , created a new MA supplemental benefit category in statute: Special Supplemental Benefits for the Chronically Ill (SSBCI). A chronically ill enrollee is defined as <i>having one or more complex chronic conditions that are life threatening or reduce the health and functioning of the enrollee; having a heightened risk of hospitalization or other negative health outcomes; and requiring coordination of care.</i> ³ 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.
TPMO	Third-party marketing organizations (TPMOs) are entities such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a Plan's/Part D Sponsor's Medicare products on the Plan's/Part D Sponsor's behalf either directly or through sales agents or a combination of both. ⁴

3. Bipartisan Budget Act of 2018. <https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>.

4. Medicare Communications and Marketing Guidelines. (September 2018). https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf.

Provision: Standardizing Social Determinants of Health Questions in the Health Risk Assessment

Summary

Starting in 2024 or 2025, all SNPs will be required to include in their Health Risk Assessment (HRA) one or more standardized questions on the topics of housing stability, food security, and access to transportation. While SNPs will not be accountable for resolving all risks identified in the assessment questions, SNPs will be required to incorporate the results of the HRAs in individualized care plans and consult with enrollees about their unmet social needs. This may include taking steps to maximize access to supplemental benefits that may help address these issues.

Impact

SNPs will have actionable information on Social Determinants of Health (SDOH) but lack authority to address the issues through SSBCI given that SDOH cannot currently be used as primary targeting criteria for SSBCI. These standardized data could inform supplemental benefit design and can be useful for risk adjustment in the future.

Provision: Maximum Out-of-Pocket (MOOP) Limits

Summary

CMS proposes to modify MOOP limits for dually eligible beneficiaries to include third-party payments (such as the State), even in instances where state lesser-of payment policy results in the State not paying an out-of-pocket cost.

Impact

State spending on dually eligible beneficiaries will decrease as a result of MOOP limits being attained sooner. Providers may be more willing to serve dually eligible beneficiaries, increasing their access to care. However, spending by MA plans will increase, with a higher impact on MA plans with lower MOOPs as part of their benefit package. This is estimated to cost MA organizations an additional \$22.99 per member per month (PMPM), or \$9.43 PMPM when accounting for the percentage of dually eligible enrollees with cost-sharing protections above the mandatory MOOP level. D-SNPs serving a large population of full benefit dually eligible individuals will be disproportionately impacted. Higher PMPM costs will potentially result in a reduction in the rebate dollars available for plans to spend on supplemental benefits.

Provision: Coordination of Supplemental Benefits

Summary

With the expansion of MA supplemental benefits to include non-medical services (i.e., LTSS and services to address social needs), there is increased opportunity for overlap in the benefits covered by D-SNPs and Medicaid. Supplemental benefits might be used to complement or fill gaps in Medicaid coverage. Currently, Medicare is the primary payer whenever Medicare and Medicaid cover the same services. CMS is seeking comment on how states and D-SNPs can further coordinate supplemental benefits.

Impact

States will become increasingly aware of their ability to influence D-SNP supplemental benefits and clinical models, and in turn, Medicaid rates. However, supplemental benefit funding is considerably more limited than the cost of LTSS and services to address social needs. Therefore, these benefits should not become a substitute for Medicaid coverage. Additionally, this proposed change may be complex for states, plans, and providers to operationalize given the dynamic nature of supplemental benefit structure and eligibility determination.

Provision: Marketing and Communications

Summary

CMS has seen a significant increase in third-party marketing and in marketing-related beneficiary complaints attributed to third-party marketing organizations (TPMOs) activities. As such, CMS proposes to define TPMOs more broadly and explicitly to capture the full range of types of entities that may be in a position of marketing Medicare health and drug plans. TPMOs will be required use a standardized disclaimer that states that they do not offer every plan available in beneficiaries' area. Plans will also be responsible for greater oversight of TPMOs.

Impact

In general, TPMOs will be more tightly regulated, and plans will be responsible for greater oversight. Supplemental benefits are often cited in marketing activities to attract beneficiaries to certain plans. There is an opportunity for new requirements and increased accountability for these entities to be leveraged to help address confusion around the availability of and eligibility criteria for supplemental benefits.

Provision: Medical Loss Ratio (MLR) Reporting

Summary

Starting in 2023, plans will be required to submit to CMS the data needed to calculate and verify the MLR and remittance amount, if any, for each contract, including the amounts of incurred claims for Medicare-covered supplemental benefits. For the first time, expenditures will be separately reported for the following supplemental benefit types or categories:

- Dental
- Vision
- Hearing
- Transportation
- Fitness Benefit
- Worldwide Coverage / Visitor Travel
- Over the Counter (OTC) Items
- Remote Access Technologies
- Meals
- Routine Foot Care
- Out-of-network Services
- Acupuncture Treatments
- Chiropractic Care
- Personal Emergency Response System (PRS)
- Health Education
- Smoking and Tobacco Cessation Counseling
- All Other Primarily Health Related Supplemental Benefits
- Non-Primarily Health Related Items and Services that are Special Supplemental Benefits for the Chronically Ill (SSBCI)

Provision: Medical Loss Ratio (MLR) Reporting (Continued)

Summary (continued)

Expenditure data will be publicly reported no sooner than 18 months after the end of the applicable contract year. Data will not be released when they would reveal plan-level expenditures for a specific benefit offered under a single plan.

Impact

Collection and public release of expenditure data would provide greater transparency into spending and utilization for supplemental benefits, which will be valuable data for policymakers, researchers, beneficiaries, and the general public. This information will allow beneficiaries to compare spending on supplemental benefits between plans. However, since all benefit categories would be rolled up into a single line each for expanded primarily health-related benefits and SSBCI, insights into spending on and utilization of specific benefit types within these categories will be limited.

For More Information:

HOME ABOUT US OUR WORK

- For more information on these benefits including...
 - How plans and providers partner to offer these benefits
 - Policy opportunities for these benefits
 - Past analyses, and
 - Additional resources

See the “Advancing Non-Medical Supplemental Benefits in Medicare Advantage” landing page on ATI’s website

OUR WORK

ADVANCING NON-MEDICAL SUPPLEMENTAL BENEFITS IN MEDICARE ADVANTAGE

Many non-medical supplemental benefits are available in Medicare Advantage (MA) for the first time in 2019 and 2020. These benefits provide an unprecedented opportunity to deliver valuable non-medical services to Medicare beneficiaries to improve their health. ATI Advisory and the Long-Term Quality Alliance, with support from The SCAN Foundation, have developed a set of resources for plans, providers, and policymakers to advance the availability and implementation of these benefits and the Guiding Principles in practice. Learn more below.

FOR PLANS AND PROVIDERS	FOR POLICYMAKERS	BENEFIT DATA AND RESOURCES
<p>NEW: Non-Medical Supplemental Benefits FAQ</p> <p>Data Insights</p> <ul style="list-style-type: none"> Data Insight: Special Supplemental Benefits for the Chronically Ill in Plan Year 2021 Data Insight: New Primarily Health-Related Benefits in 2021 Medicare Advantage Plans Data Insight: Meeting Medicare Beneficiary Needs During COVID-19: Using Medicare Advantage Supplemental Benefits to Respond to the Pandemic <p>Chartbooks</p> <ul style="list-style-type: none"> Chartbook: 2021 Special Supplemental Benefits for the Chronically Ill Chartbook: 2021 Expanded Primarily-Health Related Benefits Chartbook: 2020 SSBCI and New Primarily-Health Related Benefits <p>Blogs</p> <ul style="list-style-type: none"> Blog in the Better Care Playbook (Part 1): Special Supplemental Benefits for the Chronically Ill: An Opportunity to Provide Comprehensive Supports for Medicare Beneficiaries with Complex Needs Blog in the Better Care Playbook (Part 2): A Roadmap for Health Plans to Provide Special Supplemental Benefits to Medicare Advantage Members Blog in the Better Care Playbook: Medicare Advantage Plans have a Unique Opportunity to Provide Needed Non-Medical, Health-Related Services During COVID-19 <p>Other Resources</p> <ul style="list-style-type: none"> NEW: Non-Medical Supplemental Benefits FAQ LTQA Webinar (Part 1) Recording: Advancing Non-Medical Supplemental Benefits in Medicare Advantage LTQA Webinar and Panel (Part 2) Recording: Advancing Non-Medical Supplemental Benefits in Medicare Advantage Insights from the Roadmap Report with ATI’s Allison Rizer and Tyler Overstreet Cromer Insights from the Policy Brief with ATI’s Tyler Overstreet Cromer and LTQA’s Mary Kaschak 		

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- The SCAN Foundation is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence.
- For more information, visit www.TheSCANFoundation.org.

