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Medicare Advantage: Changes and Updates to Enhanced Benefits

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Medicare Advantage (MA) plans must provide all medical services that are covered under original Medicare and must have cost sharing that is no greater, in aggregate, than the cost sharing that would be charged under original Medicare. The Centers for Medicare and Medicaid Services (CMS) also permits MA organizations (MAOs) to reduce cost sharing below original Medicare levels and/or provide items and services that are not covered under original Medicare. MAOs offer these additional items and services to attract and retain members, encourage healthy behaviors and incentivize the appropriate use of health care services.

The primary avenue for providing such items and services is through supplemental (i.e., non-Medicare-covered) benefits. Other avenues include rewards and incentives (for healthy activities) or nominal gifts. CMS requires a supplemental benefit to meet three conditions:

1. Not be covered by original Medicare.
2. Be primarily health-related.
3. Incur a medical cost for providing the benefit.

CMS also requires all plan benefits to be offered uniformly to all plan enrollees.

Recent laws and regulatory changes have relaxed the requirements around supplemental benefits in ways that provide MAOs greater flexibility in benefit offerings and plan designs. The remainder of this article discusses those changes.

VALUE-BASED INSURANCE DESIGN

The MA Value-Based Insurance Design (VBID) model was the first of CMS's recent easings of benefit requirements. CMS first offered the VBID model option for MA plans in seven states in 2017. An additional three states were added in 2018, and 15 more were added for the 2019 plan year. The CHRONIC Care Act, included in the Bipartisan Budget Act of 2018, expanded the VBID model to all states in 2020.

According to CMS,

> The Medicare Advantage Value-Based Insurance Design (VBID) Model is an opportunity for Medicare Advantage plans to offer supplemental benefits or reduced cost sharing to enrollees with Centers for Medicare & Medicaid Services (CMS)-specified chronic conditions, focused on the services that are of highest clinical value to them. The model tests whether this can improve health outcomes and lower expenditures for Medicare Advantage enrollees.[1]

MAOs electing to participate in the VBID model are granted flexibility around the uniformity requirement of supplemental benefits. VBID plans can reduce cost sharing for certain services or select providers or offer additional services for members with targeted chronic conditions.

To date, only 13 MAOs from 10 parent organizations have elected to participate in the VBID model.[2] The limited participation is partially because of the current limited geographic footprint and marketing restrictions in place during the first two years of the program. In addition, applicants had to overcome robust cost-savings metrics and administrative hurdles associated with filing and certifying a VBID.

With the introduction of nonuniform benefit requirements in 2019 (discussed later), VBIDs may be less attractive to MAOs because MAOs can now offer nonuniform Medicare Part C supplemental benefits for any plan without the filing requirements of the VBID. However, only a VBID plan may offer nonuniform Part D benefits for select enrollees.[3]

SUPPLEMENTAL BENEFITS: REINTERPRETATION OF "PRIMARILY HEALTH-RELATED" DEFINITION

Beginning in 2019, CMS is expanding its interpretation of which benefits satisfy the "primarily health-related" requirement for supplemental benefits. Previously, CMS maintained a stricter interpretation of the term such that benefits were required to prevent, cure or diminish an illness or injury, but could not serve only daily maintenance purposes.

Chapter 4 of the *Medicare Managed Care Manual* (*MMCM*) offers a nonexhaustive list of permitted supplemental benefits under the previous interpretation of "primarily health-related."[4] Example benefits include acupuncture, chiropractic services, fitness benefits, meals and weight management programs. Each benefit has specific limitations. For example, meals may be offered after a surgery or inpatient stay or to help a member with a chronic condition transition to a healthier lifestyle. Any use of benefits must be primarily medically related. The *MMCM* also provides examples of benefits not permitted, such

as cosmetic services, maid services, massages or cellphones, as these benefits are not sufficiently health-related.

The 2019 Final Call Letter formalized CMS's reinterpretation of "primarily health-related" and outlined three options for qualifying as a supplemental benefit under the expanded definition:[5]

1. Diagnose, prevent or treat an illness or injury, or compensate for physical impairments.

2. Act to ameliorate the functional and/or psychological impact of injuries or health conditions.

3. Reduce avoidable emergency and health care utilization.

In a follow-up memo, CMS provided examples of supplemental benefits that are permitted under the reinterpretation of "primarily health-related."[6]

- **Adult day care services.** Assistance with activities of daily living (ADLs) and social work services provided at an adult day care center that help with specific injuries or health conditions are permitted. Services that are primarily recreational or social are not permitted.

- **Home palliative care.** Home palliative care that is used to reduce symptoms for terminally ill members and is not already covered by Medicare is now permitted.

- **In-home support services.** These services assist individuals with disabilities or medical conditions in performing ADLs or instrumental ADLs (IADLs).

- **Respite care.** Respite care may be provided for caregivers of members for a short duration to improve injuries or health conditions of members or to reduce avoidable health care utilization.

- **Nonopioid pain management.** This pain management may be provided to assist a member to treat or improve an injury or illness. The treatment must be medically approved and may include therapeutic massage (i.e., must have a medical focus and may not be primarily for relaxation).

- **Memory fitness benefit.** Memory fitness may be provided as long as the primary focus is medical, such as improving the functional or psychological impact of an injury or health condition.

- **Home and bathroom safety devices.** Some non-Medicare-covered safety devices (such as shower grab bars or stair treads) may be offered, as well as safety inspections.

- **Transportation.** Nonemergency transportation (including a health aide to assist the member) may be provided to obtain plan-covered health care services.

- **Over-the-counter (OTC) benefits.** Non-Medicare-covered OTC items that are available without prescriptions may be provided. CMS has clarified OTC items may include pill cutters, pill crushers, pill bottle openers or personal electronic activity trackers in addition to OTC items historically permitted.

The follow-up memo further clarified some limitations of the expansion of supplemental benefits. Services that are "solely or primarily used for cosmetic, comfort, general use, or social determinant purposes" do not satisfy the expanded definition. Rather, CMS clarified that the service must "focus directly on an enrollee's health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one." Thus, a given benefit may be approved by CMS but, for a beneficiary to receive the benefit, it will need to be recommended by a licensed medical professional.

Recent laws and regulatory changes have relaxed the requirements around supplemental benefits in ways that provide MAOs greater flexibility in benefit offerings and plan designs.

REINTERPRETATION OF BENEFIT UNIFORMITY REQUIREMENT

In addition to the reinterpretation of "primarily health-related," CMS is also using regulatory guidance to reinterpret the benefit uniformity requirement. In the 2019 final rule, published in the Federal Register in April 2018, CMS stated that plans would be permitted to provide different benefits or cost sharing based on a member's health status as long as "similarly situated individuals are treated uniformly."[7] This is a significant departure from prior guidance, which required MAOs to provide identical services and cost sharing for all members within a plan. CMS permits MAOs to offer nonuniform benefits for members with common medical conditions beginning in 2019.

The new regulation allows plans to tailor Part C benefits (but not Part D benefits) based on the health status of a member.

Any flexibility must be uniformly applied to all members with a certain health status, and plans may only change benefits, not plan premiums. For example, a plan may offer to all members with diabetes:

- Reduced cost sharing for endocrinologist visits.
- More frequent foot exams (a supplemental benefit).
- A lower deductible.

Any benefit enhancement must be for health care services related to the specific disease or condition. Members receiving the enhanced benefits must have their disease or condition documented by a plan provider.

In the final rule, CMS emphasized that such flexibility is not unlimited. For example, MAOs cannot deny or limit services based on health criteria. CMS reiterated its obligation to protect high-risk beneficiaries and intends to review plan offerings to ensure that discriminatory benefits are not offered.

SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL

The CHRONIC Care Act further relaxes both the "primarily health-related" and uniformity requirements starting in 2020. The act permits MAOs to offer additional supplemental benefits for chronically ill members and requires only that supplemental benefits "have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee."

This benefit does not need to be offered to every chronically ill member, but only those the MAO believes will be helped by the supplemental benefit. The member must have a documented medical condition by a plan provider to be eligible. Chronic supplemental benefits (such as social support) do not need to be primarily health-related.

As of January 2019, CMS has not yet provided additional guidance on the permitted benefits for 2020 but has communicated an intent to do so before the 2020 MA bid deadline.

Through the three changes discussed in this section, beginning in 2020, MAOs may offer three types of supplemental benefits:

1. **Standard** (permissible for 2019 benefit year): The benefit satisfies the expanded definition of "primarily health-related" and is available to all members.

2. **Targeted** (permissible for 2019 benefit year): The benefit satisfies the expanded definition of "primarily health-related" and is available to all members with a particular disease or health status.

3. **Chronic** (new for benefit year 2020): The benefit is available to chronically ill members the plan believes will benefit from the supplemental benefit. Chronic supplemental benefits do not need to be primarily health-related.

REWARDS AND INCENTIVES

MAOs may offer rewards and incentives to enrollees for participating in activities designed to improve health, prevent injuries or encourage the efficient use of health care resources. For example, a rewards and incentives program may be used to encourage enrollees to get preventive screenings. All members of a plan must be eligible to participate, and the rewards or incentives must be available based only on participation, not on outcomes (such as weight loss).

Rewards and incentives may be included in marketing materials but are not considered a plan benefit. The expense for the program is included in the nonbenefit expense portion of the bid. There is no dollar limit for rewards and incentives; however, the value for a reward and incentive may not exceed the value of the associated health activity.

Beginning in 2019, MAOs may include a reward or incentive to members for completing a health risk assessment.[8] Previously a health risk assessment was not permitted to be part of a rewards and incentives program.

NOMINAL GIFTS

Nominal gifts are designed to attract the attention of prospective enrollees and/or encourage retention of current enrollees. They may not have a value exceeding $15; must not be cash, meals, or a drug or health benefit; and must be offered to all current and prospective enrollees. Unlike a rewards and incentives program, they are not required to be tied to an activity that requires participation.[9] There are no recent changes to the guidelines for nominal gifts.

CONCLUSION

Through the expansion of the VBID model to all states, regulatory and statutory changes to the "primarily health-related" and benefit uniformity requirements for covered benefits, and an expansion of permissible rewards and incentives, MAOs have considerable additional flexibility in providing benefits to MA enrollees in 2019 and 2020.

Because of the relatively late timing (with respect to MA bid filing deadlines) of guidance from CMS on the reinterpretation of "primarily health-related" and benefit uniformity, many MAOs may have found it difficult to incorporate new benefits into their 2019 plan designs. With an additional year of preparation and increased flexibility for 2020, it is possible that more MAOs will incorporate additional supplemental benefits into their 2020 plan designs. As the 2020 MA bid season approaches, MAOs should consider how to utilize this flexibility to improve health outcomes for current enrollees and attract new enrollees. ■

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ENDNOTES

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4 CMS. Chapter 4: Benefits and Beneficiary Protections. *Medicare Managed Care Manual,* April 22, 2016. *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf* (accessed October 19, 2018).

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