



Medicare Advantage's New Supplemental Benefit for 2019: Plan Views and Responses

Executive Summary

There has been considerable interest in recent years to find ways that the Medicare program could cover non-medical services and supports for people with disabilities and functional limitations. Providing Medicare coverage of long-term services and supports (LTSS) for beneficiaries with complex care needs has the potential to prevent many of them from having to spend down to Medicaid eligibility, while reducing health care expenditures through the integration of medical care and non-medical supports.

In February 2018, Congress enacted section 50322 of the *Bipartisan Budget Act of 2018* that will allow Medicare Advantage (MA) plans, beginning in 2020, to offer supplemental benefits that are not “primarily health-related,” targeted to members with specific chronic illnesses. At the same time, the Centers for Medicare & Medicaid Services (CMS) issued similar MA rule changes to take effect in the 2019 plan year. As a result, beginning with the 2019 plan year, MA plans have greater flexibility to offer non-medical supports and services to members with specific chronic conditions and functional needs that can help improve access to care and reduce avoidable hospitalizations and institutional placements.

The Long-Term Quality Alliance surveyed a selection of seven MA organizations regarding their response to the opportunity in the 2019 Call Letter to offer a “flexible” supplemental benefit. The intent of the project was to identify challenges MA organizations faced in developing a bid, and recommend improvements for CMS in the 2020 bid process.

2019 Bid Process

The plans 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. They welcomed the idea of greater flexibility to tailor benefits to individual needs. Whether they submitted a bid with flexible supplemental benefits for 2019 or not, all of the plans were doing or planning to do the work necessary to prepare some benefits for possible inclusion in their 2020 bid.

A major challenge for all of the plans was the compressed timeframe for including a flexible supplemental benefit in the bid for 2019. However, three of the seven plans we interviewed did include the flexible supplemental benefits in their 2019 bid. These plans viewed this first offering of flexible supplemental benefits as a pilot project to test both the value of these new types of benefits, and their capacity to target the benefits to subgroups of members.

MA plans that included or considered including flexible supplemental benefits in the 2019 bids were motivated by their experience serving members with complex care needs in their MA special needs plans (SNPs) or Medicaid managed LTSS (MLTSS) plans – and having the data and knowledge to design and price the benefit. They saw potential in attracting and managing members with complex care needs and in testing ideas that could have an impact on their outcomes and costs. Plans anticipated having a competitive advantage by offering the flexible supplemental benefit in this plan year, or at least avoiding a competitive disadvantage resulting from not offering the benefits. Plans also noted that they had more margin than usual to allocate to these new supplemental benefits in 2019.

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Plans that were interested, but did not offer a flexible supplemental benefit in the 2019 bid were challenged by several factors:

- The lack of clarity in the regulatory and sub-regulatory guidance and the compressed timeframe for including these supplemental benefits in this year's bid, making it difficult to design and price a benefit;
- The rejection by CMS of benefits the plans proposed based on criteria they seemingly used in preliminary discussions or in bid reconciliation, that was more restrictive than what was implied in the guidance documents;
- Uncertainty about how to communicate to their members the details of supplemental benefits that were not universally available, and concern about the potential for members to feel misled; and
- Other challenging aspects of the flexible supplemental benefit that included the potential for benefits to vary from year-to-year affecting the members dependent on them, not having Part D benefits included, and issues of potential cost-shifting from Medicaid to Medicare with dual beneficiaries.

The benefits that were included in 2019 bids were limited and considered by the plans to be a test of the concept, since the plans lacked sufficient data to adequately design and price the benefits. Plans that did include flexible supplemental benefits in their 2019 bids ended up with fairly conservative approaches: limited personal care and homemaker services, meal delivery for members transitioning from institutions, adult day services, and non-emergent transportation to covered benefits.

Key Issues

Flexibility: The flexible supplemental benefit is intended to give plans more discretion in fitting non-medical services and supports to individual complex care needs. Plans view this new supplemental benefit as an additional tool for this purpose (along with clinical programs and value-based insurance design (VBID)).

Offering the services as a supplemental benefit ensures they are provided to any member who meets the criteria. Benefits are useful in marketing the plan. Once offered, though, there is an

expectation they will continue, which may not be the case with supplemental benefits that often change from year-to-year.

Alternatively, MA plans can offer clinical programs (as quality improvement activities) that can be tailored to meet individual needs for specific conditions. Unlike a benefit that is provided to all who qualify, practitioners can tailor the services from a clinical program to specific needs in an individual care plan without making those services available more broadly.

MA plans that are participating in the value-based insurance design (VBID) demonstration see this as an alternative for providing non-medical benefits for enrollees with specific conditions. Unlike the flexible supplemental benefit, the plans can include Part D drug benefits in VBID benefits that are targeted to specific diseases and conditions.

Adverse Selection Risk: Plans can find great value in attracting and managing care for people with complex care needs. There is a risk, though, in pioneering these benefits, of attracting too large a group of members with high health care costs without receiving adequate risk adjustment of the per-member premium to account for these costs. Enrolling a high proportion of members with complex care needs could compromise their ability to serve all of their members.

Plans can find value managing care for people with complex care needs, but are concerned about the risk of attracting too many members with high health care costs without sufficient risk adjustment in the premium to account for these costs.

Actuarial Challenges: Plans lacked the necessary data for their actuaries to apply offsetting savings to the cost of the benefits. Additional work is needed to measure the economic impact on the plan of the new benefits: both to measure the medical expenditure savings that could offset the costs of the benefits, and to measure the potential for the population attracted by these benefits to lower overall market profitability. Several of the MA plans interviewed are planning to collect the evidence they would need to more accurately price these products for inclusion in their 2020 bid.

Network Issues: MA plans do not typically maintain networks of non-medical service providers or have relationships or experience with community-based organizations (CBOs) that would provide these services. In deciding on which benefits to offer, plans had to ensure service providers were available in the relevant markets to serve their members throughout the MA plan service area.

Plans also had to ensure they were selecting CBOs able to meet their contracting requirements and provide high-quality services. Plans leveraged relationships with service providers in their organization's SNPs and MLTSS plans. They also relied on internal personnel who specialized in vendor contracting, or engaged experienced third parties to ensure the capacity and quality of potential service providers.

Determining Eligibility: For MA plans, targeting particular benefits to a specific subgroup of members is novel. The plans have to put a process in place to determine when a member meets the criteria for receiving the benefit.

The plans referenced a variety of approaches for determining eligibility, such as adapting an existing algorithm currently used to identify members in need of care management or relying on primary care providers to identify members who would benefit from services. Plans expect members to self identify a need for the benefits once information on the supplemental benefits is communicated more effectively.

Marketing the Plan: Several of the plans noted that there were substantial marketing and communication challenges with a supplemental benefit that is not universally available and may not have value for a large proportion of plan enrollees. Due to the novelty of the benefits, their inexperience with them, and the short preparation period, the plans that did decide to offer them in 2019 were viewing this as a pilot project to test the concept.

Plans were uncertain about the value that targeted supplemental benefits would have for marketing and growing enrollment in a competitive environment. Some saw value in differentiating their plan as a leader in the market – taking on the most challenging health and functional assistance needs. Plans were concerned, though, about the difficulty of effectively communicating about the limited benefits.

Measure of Success: Plans were unclear about the outcomes CMS expected to achieve or the measures that would be used to evaluate the success of this new type of supplemental benefit. In the long run, plans were looking to this new flexibility for the opportunity to impact health outcomes, health care utilization, and member satisfaction by managing complex care needs. Plans mentioned tracking metrics on hospital readmissions, member satisfaction, and self-reported improvement, and initiating longer-term studies to gauge the effect of specific benefits on cost of care and outcomes. In the immediate future, the plans were interested in measuring the market response and if the benefits would support enrollment growth and member retention.

Suggestions for the 2020 Bid Cycle

Clarity: For the 2019 bid cycle, plans assumed from the guidance documents that there would be more opportunity for creativity in offering these types of benefits. They were surprised by the restrictive criteria CMS seemed to apply in approving the benefits. With more lead-time for CMS to communicate criteria in the 2020 cycle, plans would like to see detailed guidance earlier and understand the changes in policy that will occur in 2020 – particularly with the implementation of the *CHRONIC Care Act*.

Flexibility: The plans would like to have more opportunity for creativity in structuring these supplemental benefits. Plans encourage CMS to take a more outcomes-based and less prescriptive approach on allowable benefits in relation to beneficiaries with complex care needs. CMS could provide the space for plans to work creatively with members who have complex care needs for a year or two, and then collect evidence of the plans' ability to improve outcomes.

Focus Beyond Chronic Conditions: Focusing on medical diagnoses as a condition for receiving non-medical services leaves out a population with functional limitations for whom services and supports could prevent medical events. CMS should see if there is a better way to incorporate

functional limitations (defined in terms of need for assistance with activities of daily living (ADLs)) to get beyond diagnoses and medical conditions and broaden the population that can be served.

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Part D: Plans are hoping CMS will include Part D in the targeted supplemental benefits in the 2020 bid cycle – to allow them to do more around drug benefits. Plans noted that under the VBID demonstration, plans can include Part D – providing an opportunity to offer more holistic coverage, including support for medication adherence.

Conclusion

Plans are generally interested in providing flexible supplemental benefits in the 2020 plan year bid, even if they did not include them in the 2019 bid. The plans that submitted supplemental benefits in their 2019 bid focused on being innovative and offering valuable benefits that could impact quality of life. Plans pursued a variety of supplemental benefits, but were limited by CMS in what they could ultimately offer.

The supplemental benefit is an attractive option for MA plans, compared to other approaches (clinical program or VBID) they can use to provide non-medical services and supports for members with complex care needs. The supplemental benefit is visible and more tangible to plan members; it can be communicated to its members and promoted to potential members, and can help differentiate the plan in the market. However, it is not nearly as flexible a vehicle as a clinical program that can be fitted to an individual care plan to address individual needs and preferences.

The supplemental benefit is an attractive option for MA plans to provide non-medical services and supports for members with complex care needs. However, it is not as flexible as a clinical program that can be fitted to an individual care plan to address individual needs and preferences.

The flexible supplemental benefit is a major step toward providing holistic coverage in the Medicare program. It provides a testing ground for expanded Medicare coverage and the potential to pay for these added benefits through the Medicare health savings they generate. While it is a good first step in that direction, a Medicare supplemental benefit by itself does not provide the architecture for a solution to the problem of financing LTSS for Medicare beneficiaries who are not eligible for Medicaid.

Background

Public or private insurance coverage for long-term services and supports (LTSS) needed by people of all ages with functional limitations is largely unavailable and inadequate in the United States. Most families or individuals cover these costs themselves. Those with limited resources or who exhaust their resources in the process of paying for care become eligible for LTSS through Medicaid. Medicare covers only post-acute care – care provided in a skilled nursing facility (SNF) for 100 days or through a home health agency for 90 days after discharge from a hospital. People with income or resources above the Medicaid eligibility threshold must rely on their own resources to cover long-term care provided in the home or community.

There has been considerable interest in recent years in finding ways to cover some of the cost of non-medical services and supports for people with disabilities who have some resources through the Medicare program. Interest of policymakers in recent years has been focused on allowing Medicare Advantage (MA) plans to offer non-medical services as a supplemental benefit. A report issued by the Bipartisan Policy Center in April 2017¹ recommended Medicare rule changes to enable MA plans to target health-related social supports to high-need beneficiaries and to allow MA plans to offer supplemental benefits that were not “primarily health-related.” These recommendations paralleled provisions of the *CHRONIC Care Act of 2018*, enacted in February 2018 as part of the *Bipartisan Budget Act of 2018*. Section 50322 of the Act allows MA plans, beginning in 2020, to offer supplemental benefits that are not “primarily health-related” targeted to members with specific chronic illnesses.

CMS Re-Interpretation of Supplemental Benefits for 2019

As the *CHRONIC Care Act* moved through the Congress, the Centers for Medicare & Medicaid Services (CMS) prepared similar MA rule changes to be incorporated in the regulations guiding the preparation of MA plan bids (known as the “Call Letter”) for the 2019 plan year.

The 2019 Medicare Advantage (MA) Final Call Letter and the Final Rule CY 2019 Policy Technical Changes to the Medicare Advantage Program, issued on April 2, 2018, announced the reinterpretation of the uniformity requirement and the definition of “primarily health-related” for supplemental benefits, allowing MA plans more flexibility to tailor plan benefit packages to individuals with select high-need health conditions. Beginning with the 2019 plan year, MA plans may leverage the new flexibilities to partner with community-based organizations to create services to ameliorate functional impacts of health conditions with a goal of reducing avoidable medical utilization.

On April 27, CMS issued further administrative guidance on both the reinterpretation of “primarily health-related” for supplemental benefits and the uniformity requirement. Final MA plan bids were due June 8, 2018.

¹ Bipartisan Policy Center. *Improving Care for High-Need, High-Cost Medicare Patients*, April 27, 2017; accessed October 1, 2018: <https://bipartisanpolicy.org/library/improving-care-for-high-need-high-cost-medicare-patients/#1493041786858-517d9126-4f58>

The major new flexibilities for 2019 and beyond include:

Benefit Uniformity²: In 2019, MA plans can target specific benefits to individuals with a specific health status or disease state if: 1) the benefits are available uniformly to all enrollees with the same health status or disease state; 2) the conditions are defined using ICD-10 diagnostic codes, and plans use objective measurable medical criteria to identify eligible enrollees; and 3) enrollees have been diagnosed or have their diagnosis certified by a plan medical professional. Also, MA plans can now vary supplemental benefits and out-of-pocket costs between geographical segments of a plan's service area. For example, MA plans may offer reduced cost sharing for podiatrist visits in an area with high diabetes prevalence. The uniformity flexibility specifically allows for:

- Reduction or elimination of cost sharing or deductible requirements for items or services;
- Coverage for certain supplemental benefits available only to targeted populations;
- Targeting benefits to enrollees who participate in a plan-sponsored wellness or care management program; and
- Targeting benefits to enrollees when they visit providers identified by the plan as being high value.

This flexibility may not:

- Reduce or eliminate premiums - Plan premium and Part B premium buy-down amounts must be the same for all enrollees in the plan;
- Target benefits based on socioeconomic status, or any other status except health and disease state (using specific clinical criteria); and
- Reduce cost sharing across all benefits for the targeted population.

Supplemental Benefits³: The previous "primarily health-related" definition has been expanded for supplemental benefits to permit coverage of an item or service "...if it is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization." Previously, certain services designed for daily maintenance were not considered "primarily health-related" and therefore could not be covered as supplemental benefits under Medicare. The April 27 guidance made it clear, though, that the expanded definition did not include "an item or service if it is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes."

The guidance also elaborated on the types of items and services that would be allowed. "Organizations may decide to offer some items or services that may be appropriate for enrollees who have been diagnosed with needing assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)." CMS offered a suggested list of allowable supplemental benefits, including traditional LTSS, such as: adult day care services, in-home support services, support for caregivers of enrollees, home and bathroom safety

² CMS/HPMS. Reinterpretation of the Uniformity Requirement. April 27, 2018

³ CMS/HPMS. Reinterpretation of "Primarily Health Related" for Supplemental Benefits. April 27, 2018.

devices and modifications, non-emergent transportation, and other benefits (with the exception of in-home food delivery) currently covered under the benefit flexibility policy for certain dual-eligible special needs plans (D-SNPs).

It is notable that these new flexibilities only apply to the medical benefit (Medicare Part C)⁴ and do not extend to the prescription drug benefit (Medicare Part D). Uniform benefit rules continue to apply in Part D, although plans may use rebate dollars to reduce Part D cost sharing, which could be considered a partially targeted benefit.



Supplemental Benefits Flexibility

	2019		2020
Benefit Type	“Standard”	“Targeted”	“Chronic”
Eligibility	All MA beneficiaries	Specific health status or disease state	“Chronically ill” beneficiaries (defined in statute)
Benefit flexibility	Benefits must (1) not be covered by original Medicare; (2) must be primarily health-related (new, more flexible definition); and (3) MA plan must incur a non-zero direct medical cost		Benefit that has a reasonable expectation of improving or maintaining enrollee health or overall function
Uniformity flexibility	Supplemental benefits are uniform across all beneficiaries	Ability to tailor to similarly situated beneficiaries	Ability to tailor to an individual beneficiaries' specific medical condition and needs
Benefit Type	Mandatory or optional	Mandatory-only	Unknown

Changes for 2020 from the CHRONIC Care Act

The *Bipartisan Budget Act of 2018* will further expand supplemental benefits beginning calendar year 2020, but only for enrollees with chronic conditions.⁵ CMS is planning to release future guidance concerning the additional flexibilities authorized by this act prior to the 2020 bid deadline. CMS has further explained that this new legislation does not impact or change the reinterpretation of “primarily health-related” or the uniformity requirements.

⁴ Medicare Part C governs Medicare Advantage plans. MA Plan benefits are a combination of the benefits found in traditional Medicare hospital (Part A) and physician (Part B) coverage.

⁵ Public Law No. 115-123, Section 50322.

Project Summary and Methods

The Long-Term Quality Alliance (LTQA) surveyed a selection of MA organizations regarding their response to the opportunity in the 2019 Call Letter to offer a “flexible” supplemental benefit. The intent of the project was to identify challenges MA organizations faced in developing a bid and recommend improvements for CMS in the 2020 bid process.

LTQA is an alliance of national organizations that represent stakeholders across the LTSS spectrum. LTQA’s mission is to advance the availability, affordability, and access to high-quality, person- and family-centered, integrated LTSS. LTQA is affiliated with the National MLTSS Health Plan Association (MLTSS Association), which includes 12 of the health plans that contract with state Medicaid programs to manage LTSS.

LTQA arranged interviews through its affiliated MLTSS plans with the MA plan executives and actuaries in their organizations who were involved in the MA bid process. LTQA interviewed executives in MA plans that submitted bids and those in plans that considered the opportunity but did not submit bids in the 2019 cycle. The purpose of the interview was to learn about the process the plan went through in deciding whether to include supplemental benefits in the bid, and to identify challenges and barriers that MA plans faced in preparing their MA bid and preparing to launch it.

LTQA developed an extensive questionnaire to serve as a guide in the interviews. Over a period of three months, LTQA researchers conducted seven one-hour phone interviews with staff from seven plans.

The project developed recommendations for statutory and regulatory changes, as well as modifications to the Call Letter and CMS guidance for the 2020 bid cycle. The project intends to communicate those recommendations in time to affect changes that would improve plan response in submitting a successful bid.

2019 Bid: What Happened

The plans we interviewed varied substantially in their response to the new flexibility offered by CMS for supplemental benefits in the 2019 plan year. Of the seven plans interviewed, three submitted a bid that included a flexible supplemental benefit, while four plans did not.

The plans 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. They welcomed the idea of greater flexibility to tailor benefits to individual needs. Whether they submitted a bid with flexible supplement benefits for 2019 or not, all of the plans were doing or planning to do the work necessary to prepare some benefits for possible inclusion in their 2020 bid.

A major challenge for all of the plans was the compressed time frame for including a flexible supplemental benefit in the bid for 2019. Plans typically begin the planning process to develop their plan benefit packages at least six months in advance of the bid submission. The process can be complex and multi-dimensional; reviewing several factors (e.g., market conditions, the

desirability to enrollees, value in marketing, cost) and engaging company personnel across departments, functions, and disciplines (e.g., clinical teams, product leaders, marketing and enrollment, financial, actuarial, senior executives).

All of the plans additionally raised concerns about the lack of clear and consistent detailed guidance from CMS on the types of benefits that would be acceptable in the bid. CMS issued the Final Call Letter and Final Rule on April 2, and provided guidance on the reinterpretation of the MA supplemental benefit provisions on April 27. With bids due June 8, plans had a little more than a month to develop the supplemental benefits to include in their bid.

The plans that did go ahead with a 2019 bid viewed the offering of these flexible supplemental benefits in 2019 as a pilot project to test the value of these new types of benefits and their capacity to target them to a subset of their members. The more involved analytic work needed to properly decide on and structure a supplemental benefit for the bid would only be possible with the lead time they will have for preparation of the 2020 bid.

Plans that did go ahead with a 2019 bid viewed the offering of the new supplemental benefits as a test of the value of these new types of benefits and their capacity to target them to a subset of their members.

The Decision Whether to Submit a Bid

The MA plans we interviewed identified a range of factors that influenced their decision on whether or not to include a flexible supplemental benefit in the bid for 2019.

Major Factors Encouraging a Supplemental Benefit:

- **Experience with Complex Care Needs:** MA plans that either had experience improving outcomes for members with complex care needs or whose parent organizations offered MA Special Needs Plans or MLTSS plans specializing in meeting functional needs of high-need members viewed this supplemental benefit as an opportunity to test new services in an MA plan for these members. Plans focused on being innovative and offering valuable benefits that could impact quality of life and help in managing medical risk for high-need members.

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- **Interest in Attracting a Population with Complex Care Needs:** Some plans saw the potential of attracting and then managing a population with complex care needs – given the potential to reduce unnecessary medical utilization. Plans worried, however, about the potential to attract too many (adverse risk selection), and the inadequacy of risk adjusters in accounting for the greater costs for this population that could adversely affect their costs.

- Margin in the Bid: Plans with extra room in the 2019 bid were motivated to include some of these new supplemental benefits. One plan mentioned that plans would have savings from the repeal of the “health insurance fee” (added in the *Affordable Care Act (ACA)*) that will take effect in 2019. Others pointed to the opportunity provided by bonus payments from CMS for plans receiving 4 or more STARS in their plan quality ratings.
- Competitive Advantage: Some plans saw an opportunity to add value for members and offer some benefits competitors were not offering in order to differentiate themselves and gain a competitive advantage in the market. Other plans were motivated by a concern that others would offer flexible supplemental benefits when they didn’t; these plans did not want to be left behind or viewed as a mediocre plan.
- Support for the CMS Agenda: One plan was motivated by the opportunity to engage as a partner with CMS and actively participate in new policies/ventures the government held as important to the future of Medicare.
- Ability to Prepare the Bid Adequately: Despite the compressed timeframe to prepare and submit the bid, some plans felt they had enough experience and data on hand to design and price specific, limited benefits.

Major Factors Discouraging a Supplemental Benefit:

- Compressed Timeframe: All plans complained that they did not have adequate time to develop the information normally needed to assess the market, design the benefit, and determine its net cost. Also, they said they did not have time to develop a medical management program for the benefit in advance of submitting the bid.
- Lack of Clarity: Plans commented that CMS did not provide much detail on what benefits would be allowed in the plan bid in its sub-regulatory guidance. The plans found CMS’s reaction to the benefits that were submitted in the bid was stricter than what was conveyed in the guidance. Plans experienced the rejection of many of the benefit ideas they discussed with CMS or included in their bids.

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- Questionable Marketing Value: Plans questioned the value of these benefits – available to only a subset of the members – for marketing the plan. Some plans noted that these types of benefits would be difficult to communicate and advertise. They questioned whether the benefits would appear in the Plan Finder, and whether the value of the benefits would be conveyed. Would they generate more interest or just confuse the sales strategy? Plans will focus first on the benefits that have broad appeal, are easier to communicate, and have the greatest value in marketing the plan (such as vision or dental benefits). To the extent flexible targeted supplemental benefits are offered, they would be offered in addition to the standard.

- Uncertain Sustainability: Some plans were uncertain about the future margin that would be available in the long-term for these benefits, once the plans start offering them. Despite the immediate room in the bid for these benefits in 2019, over the long-term, the margins in MA plans have been shrinking as CMS initiatives succeed in lowering fee-for-service spending, which is lowering the benchmark and raising questions about the future.
- Lack of Continuity: The populations to be served by these benefits have long-term needs. The MA supplemental benefit approach lacks the year-to-year continuity and predictability that members who rely on them will need. Specific, targeted benefits may be offered in a year when margins are high, but may disappear the next year. Or they may be changed from year to year depending on the needs of the members. Standard supplemental benefits that serve the broad membership will remain in place, while the flexible supplemental benefits are likely to come and go with favorable margins.
- Exclusion of Part D Benefits: Some plans were discouraged by the inability to include a prescription drug component (Part D benefit). Plans favored a more comprehensive, holistic approach that would allow plans to include a broad array of tools to address the needs of members with the most complex care needs.
- Potential for Cost-Shifting: MA plans with D-SNPs raised issues around providing benefits on the Medicare side that might already be available to beneficiaries on the Medicaid side, and the resulting possibility that states would see this as an opportunity to reduce Medicaid spending.
- Unique Design Issues: Prior experience these organizations had with their Medicaid plans did not translate into designing benefits to be offered through the Medicare program. Since the majority of Medicare beneficiaries are not frail, plans found it difficult to predict Medicare utilization from their Medicaid experience. It was also difficult to figure out how to design a targeted benefit – and then how to set up a mechanism to determine eligibility for it.

Benefits Considered and Submitted

All of the plans were challenged by the fact that guidance on what they could offer under the new interpretation of “primarily health-related” benefits was not provided until six weeks before bids were due, and the process did not offer opportunities for clarification.

Making the Decision Whether to Offer:

Even though only three of the plans included flexible supplemental benefits in their 2019 bids, all of the plans went through a process to develop possibilities for these benefits. The process and decision criteria varied. Plans noted that there was limited evidence to support specific benefits for specific populations and there was not time to do extensive research and analysis to identify benefits that would be most effective. Mostly they worked from their respective organization’s experience in other markets or from suggestions from their clinical teams, and relied on their own judgment. The approaches plans took included:

- Starting with benefits they were familiar with – either from their MA D-SNP or from their managed Medicaid or MLTSS plans.
- Looking for patterns in their membership – utilization patterns, provider patterns, local or regional patterns – that would suggest interventions that would be appropriate for a particular subgroup of members in a particular location.
- Determining from a person-centered perspective what two or three things would impact the health of a particular person with a particular condition, and what supplemental benefit(s) would help control or improve the condition.
- Looking at benefits that members had requested and/or needed in different parts of the country.
- Soliciting suggestions from clinical teams of benefits they thought would have the greatest clinical benefit, such as personal care services, home health aides and food delivery.
- Identifying benefits that would appeal to a broad selection of members.
- Considering the cost of the benefits and selecting what the plan could offer given the margin they had in the bid for added supplemental benefits, and after accounting for the popular standard supplemental benefits (e.g., dental, vision). Lacking evidence that the benefits would reduce health costs, the benefits had to be priced initially as added cost.

Benefits Considered But Not Offered:

The plans we interviewed tended to read the criteria that CMS put in print in the Call Letter and guidance documents expansively. Plans felt the Call Letter implied a fairly broad definition of “primarily health-related” benefits and began considering benefits that the later guidance clearly ruled out, including:

- Ongoing special meal delivery for a larger population of people without transition needs; and
- Non-emergent transportation for services not Medicare-covered.

After the guidance was issued, plans proposed benefits they felt were consistent with that guidance that were rejected by CMS either in preliminary discussions or through bid reconciliation. Plans stated that they were surprised by rejections that seemed based on criteria more restrictive than what was implied in the guidance documents.

Benefits the plans told us were rejected – either in preliminary discussions with CMS or in the bid submission process – included:

- Allowances for healthy foods;
- Expanded meal delivery;
- Non-emergent transportation for purposes they thought would be considered Medicare-covered benefits;
- Durable medical equipment;

- Equine therapy, and
- Park passes for outdoor fitness.

Benefits Included in the Bid:

Plans did go forward with some benefit ideas that made it past bid reconciliation. Some of these benefits include:

- Homemaker services;
- Assistive and safety devices;
- Adult day center visits;
- Pain management;
- Meals offered for chronically ill members and those transitioning from in-patient care (CMS would not accept a broader scope of meals benefits); and
- Non-emergent transportation to services covered by the plan, such as adult day care.

2020 Bids

All of the plans interviewed said they are in the process of preparing, or are anticipating preparing a flexible supplemental benefit to include in their 2020 bid; one plan said they were committed to doing it. Plans were focused on having benefit design completed by February 2019 in anticipation of spring guidance that would be forthcoming from CMS.

Several of the MA plans had already initiated planning activity for the 2020 bid cycle. Plans were doing preliminary data analysis to identify member needs and working on financial and logistical aspects of offering the benefits. They were anticipating changes in the rules resulting from the implementation of the *CHRONIC Care Act* provisions that would focus benefits specifically on specific chronic conditions. Some plans were anticipating being able to offer benefits in 2020 with additional flexibility to allow their case managers to individually tailor services for members with chronic conditions. Some plans noted they were paying attention to what kinds of benefits were being offered in 2019 by their competition. Competitor plans in a geographic area offering the same benefits would reduce adverse selection risk.

Plans that were offering benefits for the 2019 plan year were looking at ways they might broaden those benefits, keeping in mind that there are limited dollars available for this subset of supplemental benefits.

Plans voiced concerns that targeting particular benefits to subpopulations defined in terms of their medical conditions is still a broad-brush solution that poses administrative challenges in trying to fit benefits to individual needs. A more flexible approach would incorporate an array of services and supports in basic Medicare Advantage coverage, and authorize physicians and care managers to select services and supports that best matched specific needs addressed in individual care plans.

A more flexible approach would cover an array of services and supports in MA that physicians and care managers could match to individual needs.

Issues

Flexibility: Providing Services As Benefits or In Clinical Programs

Many MA plans are looking for ways to provide non-medical services and supports that can help people with complex care needs improve outcomes and avoid expensive medical care. Given the tremendous variation in the population with these needs, there is no single package of services and supports that will work for everyone. The stated purpose of the flexible supplemental benefit is to provide flexibility for plans to fit services to individual needs.

Plans see a number of tools, including the new flexible supplemental benefits, as avenues for achieving this flexibility – some offering greater flexibility to tailor services to the individual than others. The plans we interviewed were generally concerned that CMS was too prescriptive and limiting in structuring these benefits – particularly with the new supplemental benefit, and that greater flexibility to fit specific services and supports to individual circumstances and needs (rather than broad classes of members) is needed to achieve better outcomes.

As Benefits:

CMS's reinterpretation of the MA requirement for uniformity in benefits is intended to enable a plan to target a benefit or package of benefits to a specific sub-group of plan enrollees who share a disease-state or clinical condition (defined in terms of an ICD-10 diagnostic code or group of codes). While the plan can target a supplemental benefit to a subset of enrollees with a specific disease state or condition, it must make that benefit available to all enrollees with that disease or condition.

Offering the services in the form of a benefit provides plan enrollees who meet its requirements the certainty of receiving a particular set of services – which is useful in marketing the plan to people who need or expect they will need the benefit. It's important to note that once a benefit is offered, enrollees who need that benefit will expect it to continue in the future. Supplemental benefits, however, are contingent on having sufficient margin in the plan bid; the plan may not be able to offer the benefit in a subsequent year or it may modify the benefit offered.

In Clinical Programs:

Beginning in 2014, MA plans were required to use 85 percent or more of their premium revenue to pay for medical services claims and quality improvement activities (QIAs), or face penalties in the form of rebate payments to CMS (or if failure is sustained, enrollment prohibition or termination). QIAs are defined as activities that improve health outcomes, prevent hospital readmissions, improve patient safety, increase wellness, or enhance use of health care data to improve outcomes. Services provided must be evidence-based and require clinical expertise.

MA plans have been able to tailor clinical programs to meet individual needs for specific conditions, using certified non-medical personnel in home and community settings. Through clinical programs, plans provide care management, in-home health assessments, disease management programs, and medication therapy management. Practitioners can incorporate a clinical program in an individual treatment or care plan without making those services available more broadly.

Through Value-Based Insurance Design (VBID):

Another opportunity to provide individually-tailored benefits is currently being tested as a Demonstration of Value-Based Insurance Design (VBID) in MA plans. The MA-VBID Demonstration by CMS's Center for Medicare and Medicaid Innovation (CMMI) began with MA plans in seven states in 2017 and is growing gradually to include plans in 25 states beginning in 2019. The *CHRONIC Care Act* includes a provision (section 50321) that expands the opportunity to test different benefit packages for chronically ill beneficiaries as a VBID, beginning in 2020.

VBID is an approach borrowed from commercial insurance that structures health plan design elements including member cost-sharing to encourage members with specific chronic diseases to use clinical services that can help improve outcomes and lower costs. In the MA demonstration, plans can offer reduced cost-sharing, additional services, or other unique benefit features to enrollees who are in certain clinical categories specified by CMS.

MA plans that are participating in the VBID demonstration see this as an alternative for providing added non-medical benefits for enrollees with specific conditions. Unlike the flexible supplemental benefit, the plans can include Part D drug benefits in benefits that are targeted to specific diseases and conditions.

Adverse Selection – The Limitations of Risk Adjustment

Most of the plans said they saw great value in attracting and managing care for people with complex care needs. There is a risk, though, in targeting benefits to people with these needs, of getting caught between attracting a large group of members with high health care costs and receiving inadequate per-member premiums due to the inability to account for these costs in the risk adjustment.

Plans would like to use the flexible supplemental benefits to attract members they can serve effectively, and who will be active in their own care management. They want to avoid attracting a large number of people who are not interested in playing an active role in managing their conditions.

Plans noted that if they were the only plan offering these supplemental benefits in the community, or their benefits were communicated in a way that attracted a disproportionate number of people with high health care costs, they could easily be overwhelmed by these additional costs. Current methods for risk adjusting federal payments to the plans do not adequately adjust for high health care needs of people with functional limitations. Lack of a sufficient offsetting increase in the federal payment would compromise the plans' ability to serve all of their members well.

Actuarial Challenges

Plans responded to the opportunity to offer the flexible supplemental benefits with the aim of helping people manage their conditions more effectively, and with the belief that that would reduce expensive medical spending. They lacked the necessary data, though, for the actuaries to apply offsetting savings to the cost of the benefits. As a result, in this first year's offering,

plans acknowledged that it was easier to assume the benefits would add cost, and to price them as such, than to document the savings to the satisfaction of the actuaries and CMS.

Plans we interviewed had experience providing similar benefits in their Medicaid MLTSS products, but found they could not translate that experience to the MA products. For one thing, their MA members were not as frail, on average, as their Medicaid members. Also, MA plans could not anticipate what utilization would be; a few high utilizers could greatly affect spending and savings.

Plans that included these supplemental benefits in their bids went forward without being able to gauge their risk of loss. Without historical data, prediction was challenging. Additional work is needed to measure the economic impact on the plan of the new benefits – both to measure the medical expenditure savings that could offset the costs of the benefits, and to measure the potential for the population attracted by these benefits to lower overall market profitability. Several plans noted they were planning to collect the evidence they need to more accurately price these products for inclusion in their 2020 bid.

Network Issues

MA plans do not maintain networks of non-medical service providers and normally have no relationships or experience with the home care agencies, adult day care centers, small community-based organizations, and other providers who would provide these services.

In the process of deciding on the benefits to offer, plans had to make sure there were service providers in the markets where they wanted to offer the benefit who could provide it with scale to serve the MA plan service area. For benefits the parent organization already offered in their Medicaid MLTSS plan, the MA plan team could leverage those relationships, although it might be challenging for the community-based organizations (CBOs) to serve a greatly expanded member population. Once CBOs became aware of the opportunity that the new supplemental benefits provided, they took initiative to approach the plans.

In the process of deciding on the benefits to offer, plans had to make sure there were service providers in the markets where they wanted to offer the benefit who could provide it with scale to serve the MA plan service area.

Plans had to ensure they were selecting CBOs able to meet their contracting requirements and provide high-quality services. Some plans were able to rely on internal personnel who specialized in vendor contracting. Other plans were relying on an experienced third party to assess the capacity and quality of potential vendors.

Determining Eligibility

For benefits that are targeted to a specific subgroup of members, the plans have to put a process in place to determine when a member is eligible to receive them. Plans understand the CMS guidance to say that they can target specific diagnoses but they cannot target based on social determinants of health (SDOH) or other non-disease-related definitions of need.

The plans referenced a variety of approaches. None of the plans seemed concerned about being able to manage the benefit through existing mechanisms. One plan, for example, has an algorithm they use to identify members in their MA population who need care management. They used this approach to identify members who would benefit from the supplemental benefits. Another plan relied on its primary care providers to identify members in need of the supplemental benefits and determine that the benefits are medically necessary and fit other criteria the plan has in place.

Plans also expect that members will self-identify a need for the benefits. It cannot be purely a matter of beneficiary choice, but when members match specific criteria the plans put in place, then they can receive the benefit. Having a case manager involved can help the member make their choice.

Marketing the Plan

Several of the plans noted that there were substantial marketing and communication challenges with a supplemental benefit that is not universally available and may not have value for a large proportion of plan enrollees. Due to the novelty of the benefits, their inexperience with them in this context, and the short preparation period, the plans that did decide to offer them in 2019 were viewing this as a pilot project to test the concept.

Plans noted that there were substantial marketing and communication challenges with a supplemental benefit that is not universally available and may not have value for a large proportion of plan enrollees.

Several of the plans raised questions about the value that targeted supplemental benefits – which would not be broadly available - would have for marketing and growing enrollment in a competitive environment. Others, however, saw a potential to use these benefits as a differentiator in the market. Being the first out of the gate could convey their leadership and excellence as a plan – highlighting their experience and expertise with the most challenging health and functional assistance needs.

Most of the plans noted that this was new territory for them and expressed concerns about the challenges in effectively communicating these benefits and the limits placed on them in marketing materials. A few were uncertain about how these benefits would be listed in the Plan Finder (which they would not control), and worried that it could be misleading to beneficiaries choosing plans. Plan members needing some assistance would be attracted to benefits like homemaker assistance, personal care assistance, care management, or transportation, but many would not have the level of need to qualify for them.

Measure of Success

Responding to a question about how they would measure success, plans commented that it would depend in part on what CMS intended in issuing the reinterpretation. If the goal was to give the plans more flexibility to tailor non-medical services and supports to members with

specific conditions to improve outcomes, there was no guidance or direction from CMS on what those outcomes would be or what measures would be used to evaluate success.

Plans looking to this new benefit flexibility for the opportunity to impact health outcomes, health care utilization, and member satisfaction in managing complex care needs and particular chronic conditions would not have metrics to evaluate their success

In the immediate future, plans will be paying attention to the consumer response and how the new supplemental benefits affect their market position. Some plans were interested in seeing how competitors were using this flexibility in the 2019 benefit year as a guide to what they might offer in their 2020 bid. Those that offered these benefits in 2019 were interested in the market response and whether the benefits would provide a marketing advantage and aid with enrollment growth and member retention.

Over the longer term, plans were planning to evaluate the impact that particular non-medical benefits targeted to specific subgroups of members would have on member experience, health care outcomes, and costs. Plans mentioned metrics on hospital readmissions, member satisfaction, and self-reported improvement. Plans also talked about longer-term studies of members receiving the benefits to value the overall effect of specific benefits on the cost of care and outcomes for these members.

Suggestions for CMS for the 2020 Bid Cycle

Plans were asked for suggestions on what LTQA should recommend to CMS for the 2020 bid cycle. Based on these responses, we offer the following recommendations:

Clarity: The plans are assuming that CMS will be able to provide greater clarity in advance of the bid submission with regard to criteria for allowable benefits. In 2019, plans assumed from the guidance documents that there would be more opportunity for creativity in offering these types of benefits, and were surprised that CMS seemed to be applying more restrictive criteria in approving the benefits than what was communicated in the guidance. In the 2020 cycle, there will be more lead-time for CMS to communicate its criteria and to ensure consistent messaging. Plans would like to see detailed guidance earlier – before the end of 2018. CMS also needs to communicate the changes in policy that will occur in 2020, particularly with the implementation of the *CHRONIC Care Act*.

Flexibility: The plans would like guidance that enables them more leeway to be creative and have opportunities to provide different types of benefits. In general, plans would like the focus at CMS in working with beneficiaries with complex care needs to shift from being very prescriptive in defining benefits to being more outcomes-focused. CMS should provide the space within which the plans could work creatively with the members with complex care needs for a year or two and then collect evidence of the plans' ability to improve outcomes.

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Broader Focus: Some plans commented that focusing on chronic conditions would limit the population that needs to be served through the targeted supplemental benefits. CMS should see if there is a better way to incorporate functional limitations (defined in terms of need for assistance with activities of daily living (ADLs)) to get beyond diagnoses and medical conditions and broaden the population that can be served.

Part D Included: Plans are hoping CMS will include Part D in the targeted supplemental benefits in the 2020 bid cycle – to allow them to do more related to drug benefits. Plans noted that under the VBID demonstration, plans can include Part D – providing an opportunity to offer more holistic coverage including support for medication adherence. A VBID demo is not an option for all plans, as some lack the time and resources to participate in the VBID demonstration.

Conclusion

Plans view the targeted and expanded supplemental benefit as a useful mechanism to provide services and supports to the Medicare population with functional limitations who are not eligible for Medicaid.

The three plans (of the seven we interviewed) that submitted a supplemental benefit in their 2019 bid took the risk to do so without sufficient time or guidance from CMS to develop a well-documented bid, and without the experience with the benefits and awareness of their competition in the market. As a result, the plans largely approached the 2019 bid as a test case, with only a few benefits offered. They satisfied their actuaries and limited their exposure by pricing these benefits at full cost, with no assumption of offsetting savings, even though many believe the savings will come.

Despite the limitations of the supplemental benefit as a vehicle for providing this type of service and support, it is an attractive option as an alternative to VBID or a clinical program. In contrast to both of these other approaches, the supplemental benefit is visible and more tangible to plan members. It can be communicated to its members and potential members, and can help differentiate the plan in the market. However, it is not nearly as flexible a vehicle as a clinical program that can be fitted to an individual care plan to address a person's needs and preferences.

The flexible supplemental benefit is a major step toward providing holistic coverage in the Medicare program to support a more effective strategy to manage chronic conditions and reduce the impact on overall Medicare spending of beneficiaries with the most complex care needs. It provides a testing ground for expanded Medicare coverage and the potential to pay for these added benefits through the Medicare health savings they generate. While it is a good first step, a Medicare supplemental benefit by itself does not provide the architecture for a solution to the problem of financing LTSS for Medicare beneficiaries who are not eligible for Medicaid.

The flexible supplemental benefit is a major step toward holistic coverage in Medicare, but does not, by itself, provide the architecture for an LTSS financing solution for Medicare-only beneficiaries.

Plans seek much greater flexibility to fit the services and supports to the person than CMS will allow in this vehicle. This aim – to fit the services to the person – is more achievable in the context of a risk-based, per-capita payment that incorporates fully-integrated medical, behavioral health, and LTSS benefits and savings potential – with all of the tools, resources, and discretion an accountable care manager needs to assist a person and family with complex care needs in meeting their goals and maintaining their quality of life.

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