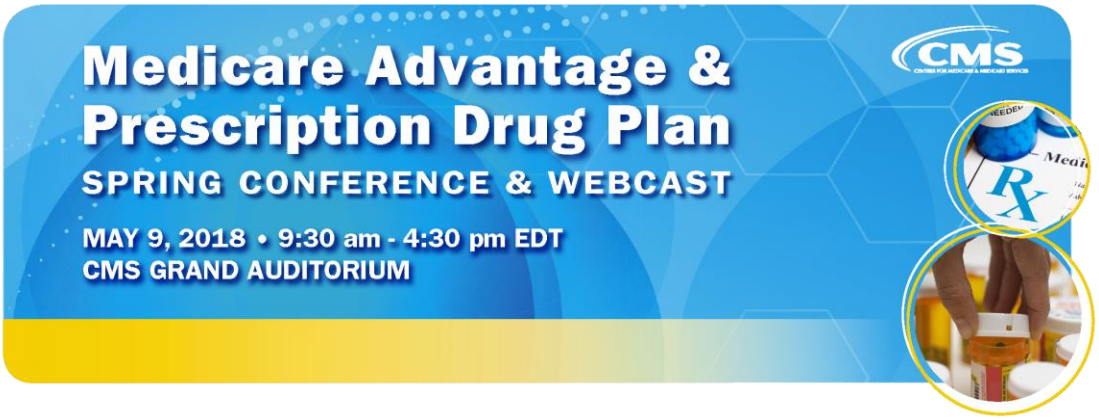

Medicare Advantage Benefit Flexibility
(Supplemental Benefits and Uniformity)

Heather Kilbourne, CM
Brandy Alston, CM

Stacey Plizga: Our next speakers will be providing a summary of the new policy for Medicare Advantage. I am happy to introduce to you, from the Division of Policy Analysis and Planning, Heather Kilbourne and Brandy Alston.

Heather Kilbourne: Good morning everybody. Thanks for coming. So, today, Brandy and I are going to talk about Medicare Advantage supplemental benefit flexibility and general benefit uniformity flexibility. More specifically, we'll be doing the supplementals and the uniformity. There we go. So, first, I'll do a quick overview, then I'm going to go through the supplemental benefit aspect. My colleague, Brandy, will go through the uniformity and flexibility aspect. I'll do a quick mention of the Bipartisan Budget Act of 2018, and then we'll open it up for Q&A.

So, in beginning of CY2019, but moving forward after that, there are two ways Medicare Advantage organizations are going to have greater flexibility when designing their plan benefit offerings. The first way is the expanded supplemental benefit option, and the second way is through benefit uniformity flexibility. We announced the uniformity first in the 2019 Part C and D rule as part of the preamble, and then we did the supplemental benefits in the call letter. I believe we had a mention of the uniformity in the call letter as well, and then I think it's almost two weeks ago, it was April 27th, we released two guidance documents in HPMS. So, if you haven't gotten those, please check those out on HPMS. They're

pretty useful and beneficial, and I think they go into more detail than I think we'll go into today. So, if you have any other follow-up questions that would be a good resource to use.

All right, so with supplemental benefits and uniformity, we also want to know -- we've gotten a few questions. These are both optional, so plans don't have to use the supplemental benefits uniformity flexibility or the expanded supplemental benefit options, but they are now open as options for plans.

Another few questions we've had is that if they have to use them together. We want to reiterate that these are both separate policies. So, for the expanded supplemental benefits, plans can offer the new supplemental benefit options for everyone in their plan. They don't have to use uniform flexibility to do that. They can just go ahead and do that. They can also use uniform flexibility separately. So if you want to use a supplemental benefit that has already previously been allowed but target it to people with certain diseases, that's now available.

The third option would be to combine them. So, if you want to use a new available supplemental benefit -- bear with me. Sorry. If you want to use the supplemental benefit, one of the newly eligible ones, one example would be transportation, nonemergency transportation for a supplemental benefit, you could combine that and only offer it to people with certain disease states. That would be combines the uniformity flexibility with the supplemental benefit expansion. The fourth option is you don't have to use either. So, we are just opening up flexibility for plans, and we're pretty excited about this. We think that this is going to allow plans to really target their benefit offerings and really focus on their different target populations, because we know the demographics are variable everywhere.

And one other not we wanted to mention is that with our presentation today and with the guidance memos we did not intend and nothing in

those guidance memos rolled back anything we mentioned in the preamble and the call letter. They just built upon them. So we were more specific and gave more specific requirements. But the intention of those was not to take anything back from what we announced in the call letter, so if anybody needs clarification there.

All right, so I'm going to a little deeper into the supplemental benefits. First, I'm going to go over the primarily health-related health definition for everyone, then we'll talk about some of the supplemental requirements surrounding by that, and then I will talk about some of the examples of newly eligible supplemental benefits.

All right, so, first, CMS defines a mandatory or optional supplemental healthcare benefit as an item or service; one, not covered by original Medicare; two, that is primarily health related, and that's what we're going to be focusing on today; and three, for which the plan must incur a non-zero direct medical cost. So, essentially, there are three pillars to a supplemental benefit, and for your supplemental offering to be allowable through the MA program, all three pillars have to be met. And that's a good note to take while you're thinking of proposed new supplemental benefit options, that even if it meets what you might interpret as a primarily operate a definition, it still has to incur direct medical costs. So it's a good test to see if you have any questions about potential supplemental benefit.

All right, so now I'm going to read you the primarily health related definition. It's kind of a mouthful, so if you bear with me. A primary live health related, per CMS, is an item or service that is used to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional or psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization, so that's quite a bit. It's an expansion on what we had previously, and we think that this opens up the playing field a little bit and,

actually kind of a lot. We're pretty excited about it, so we hope everybody else is too.

So, let's talk about some of the requirements on what that definition means for supplemental benefits. First, as always, a supplemental benefit must be medically appropriate, and it must focus directly on an enrollee's healthcare needs. So, even if it's something that's primarily health-related, it might focus on one enrollee's healthcare needs more than it would on another. So, it has to basically directly draw a line back to whatever condition or medical issue or healthcare issue that beneficiary is in need of. And then finally, it needs to be recommended by a physician or a licensed medical professional as part of a care plan if it's not a service that's already being directly provided by a medical professional, and this could be in the case of over the counter. That's a good example there.

More requirements: For the newly expanded, or all supplemental benefits, actually, they must not be used primarily for comfort, general use, or other non-medical reason. That's not to say that ancillary result of an item or survey doesn't provide comfort, can't be used for other reasons, but the primary use of the supplemental benefit needs to be for health and not for comfort, not for general use, and not for non-medical reasons. And then finally, it must not include items or services to induce enrollment. That one I think is pretty standard, so I doubt we will get any questions on there.

And finally, we have CMS expectations. So, we would expect organizations that will establish reasonable safeguards, as always, to ensure that enrollees are appropriately directed to care, and we also expect organizations will use this new expansion to make adjusts to their annual offerings based on the healthcare needs of their plan population. That's more to say -- and I know this is what everybody has been looking forward to -- is that you will use the new offerings to focus your care plans and your benefit packages on the needs of your population, not to get

enrollment, not for marketing reasons but to better serve our beneficiary, which is, I think, why we're all here.

Okay, so, now I'm going to go through some examples of newly eligible supplemental benefits. These are examples of benefits that we would have previously denied but now, under the new definition, plans are able, all MA plans, even non-sent, are able to offer them. I also do want to point out -- oh, wait, never mind. That's the next slide. Sorry. Okay. So, first it will be adult daycare services, and adult daycare services are provided outside of the home at a specified location, and we expect those to be people who need assistance with ADLs and IADLs, and for those who are not familiar with these acronyms, that's activities of daily living and instrumental activities of daily living. And all of the examples that I'm providing today are examples that we have, by far, had the most request for. So I'm highlighting the ones that I think that plans are probably most interested in. We've gotten in a lot of feedback in the RFI. We've gotten a lot of feedback and comments from the call letter, and also in our mailbox about these examples.

So, anyway, adult daycare services are now permitted. We also have home-based palliative care as a new addition, and this allows for Medicare Advantage plans to offer palliative care to those who would need it but don't quite qualify for the original Medicare hospice service. To clarify, once somebody does qualify or opts into hospice, then Medicare fee for service would take over, but anything that's not covered under Medicare part A, Medicare Advantage plans are now able to offer as an option. And this next one is a big one.

We've had a lot of feedback or questions about this one. But in-home support services are now going to be permitted to an MA plan. As long as, again, it meets the three pillars of a supplemental benefit, we'll go ahead and approve that. The big definition here is that the services need to be performed within the home only. But otherwise, a personal care

attendant, all the state licensing requirements, or any other requirements given by the state need to be met. I think that one's pretty straightforward otherwise. Next, we have transportation. I mentioned this one earlier. So, we'll be expanding the non-emergent transportation benefit. It now can be open to Part D services, as well as if you're a Part D plan an MAPD, or also for supplemental benefits and items and services.

So, this means that you can provide transportation to a pharmacy to pick up prescription medication, Part D medication. You cannot provide transportation to a grocery store or a bank because those are not primarily health related. They're more general use items. So, just for clarification. Okay.

And lastly, we have one final example. This would be the home and bathroom safety devices and modifications. Previously we had -- it's outlined in Chapter 4, where bathroom modifications were allowable for MA supplemental benefits. We are expanding that into the rest of the home. So, as long as it's specific, it's nonstructural, and it's not Medicare covered, and it prevents injuries in the home or the bathroom, you are allowed to cover it. We think that this will help with fall prevention, and we understand and recognize from the research and all of your input that fall prevention is kind of a big deal, so we're expanding that throughout the rest the home. And we really think that these expanded supplemental benefits are going to help improve health care outcomes, and we're looking forward to seeing what plans have to offer and what you guys can come up with from the expansion. And so with that, I'm going to pass it on to my colleague, Brandy, and she's going to go over the uniformity flexibility. Thank you.

Brandy Alston: Hello everyone. My name is Brandy Alston, and I will be discussing our new uniformity flexibility policy, some details regarding this reinterpretation, conditions and limitation that is apply, and allowable benefits.

First, as you are all away, CMS regulations require that all plan benefits and cost sharing must be uniformly offered to all enrollees in the plan. Previously, we've interpreted this to mean that MA plans must offer the same benefits and cost sharing to all enrollees. Effective contract year 2019, we have reinterpreted uniformity to allow plans to reduce cost sharing for certain covered benefits, to offer specific tailors supplemental benefits, and to offer reduced deductibles to enrollees that meet specific medical criteria.

There are certain conditions that apply to this flexibility. Target benefits must, and I repeat must, be offered uniformly to all enrollees with the specified condition or disease state, and all targeted benefits must be equally assessable to all enrollees in the targeted population. This is what preserves the uniformity of the benefits package. In identifying eligible enrollees, these targeted benefits must use objective and measurable criteria. So, plans must follow the Medicare marketing guidelines for communication and marketing of these benefits to potential enrollees. Cost sharing reductions and targeted supplemental benefits must be for healthcare services that are medically related to each condition. Finally, MA plans must ensure compliance with non-discrimination rules and regulations when implementing this benefit.

So, finally, I'm going to talk about some dos and don'ts. Plans may reduce or eliminate cost sharing or deductible requirements for items or services. Plans may make coverage for certain supplemental benefits available only to targeted populations. Plans may offer targeted benefits to enrollees who participate in a wellness or care management program. Plans may offer targeted benefits to enrollees when they visit providers identified by plans as being high value. Plans may not reduce or eliminate premiums. Plan premium and part B premium buy-down amounts must be the same for all enrollees. Plans may not offer target benefits based on socio-economic status or any other state, other than health status or

disease state. And finally, plans may not reduce cost sharing across all benefits for the target population. So, with that, I will turn it back over to Heather to close it out.

Heather Kilbourne: Thanks, Brandy. Okay, so, finally, I do have to mention the bipartisan Budget Act of 2018. As most of you know, it's going to further expand supplemental benefits, but for the chronically ill beginning CY2020. So, we just wanted to reiterate that the new legislation doesn't impact or change our interpretation of primarily health-related benefits that we're doing now, but we will be adding on expanded supplemental benefits even further for the classic chronically ill, and we'll issue future guidance concerning anything additional that we decide or find that has been authorize by the bipartisan budget of 2018, so we definitely wanted to mention that. We've gotten a few questions, I think, earlier in the year. I think everything's clarified now, but just a head's up that there are be guidance reduced, and we'll probably have another presentation next spring about this, so I'm looking forward to that.

So, I think we're ready for questions, if anybody has any. I think Stacey is going to come out to moderate. But I will say, before we ask questions, something we do want to avoid today is asking about specific benefits that your MA plan wants to offer and whether or not we'll approve them. We have a whole team of people that goes into approving the bids, and so I am just, frankly not qualitied to do on the spot today. But feel to ask any questions, just if you're ask, like, will you approve this, I can't answer that. But I am happy to answer anything I can or explain anything. Hi.

Howard Shapiro: Good morning. Thanks very much for a very, very clear presentation. My name is Howard Shapiro from the Alliance Community Health Plans. Heather, your examples did not mention two areas that I think have been of interest. One of them is a nutrition assistant, and food program plans are already sort well down the road in relating food assistance to diseases such as diabetes as an obvious one, or other diseases that may

involve preventing weight loss. And then the other area is use of telehealth-based services. Now I know that that issue is complicated a bit by the fact that there is recent legislation that will expand use in telehealth in 2020, but what about for 2019, in terms of using these new flexibilities?

Heather Kilbourne: Those are really great questions. So, the first question to address the food or nutrition aspect, we do have weight management currently available as a supplemental benefit that's allowable, and all of this is outlined in Chapter 4. And we also have nutritional food and nutrition benefit that is already allowable under Chapter 4 too, but it's temporary. So, it's for directly after a disease situation or hospitalization, and then also I think it's for, you have to read Chapter 4. I'm very sorry. But it's definitely right after on temporary basis. So, it's basically part of a care plan.

And we have looked into the food, and you are absolutely right that it's definitely a big area of interest for MA plans, and I can tell you that we're still currently reviewing all of that and looking into finding ways to see what we can do for MA plans to allow that. But, for right now, the food benefit for CY19 is not expanding. It's staying the way that it is. I think another aspect to that is that there's a lot of other agencies that deal with food, and we sort of see it -- not that we see it as, but it's something we're trying to figure out the difference between right health and general use, and everybody has to eat. So, there will be more on that topic, I guess, is what I can say that.

As far as telehealth, telehealth is also currently allowed as a supplemental benefit as remote access technology. So, plans can still offer their benefits via telehealth, via storing forward technology, email, all of that. But it has to be as a supplemental benefit. You are correct that there's new legislation. The Bipartisan Budget Act also allows for telehealth, expanded telehealth benefits in 2020, so I can also say that

there is more to come on that topic, and we're really excited about that one too.

Kaye Rabel: So, at this time, we are opening up to the in-house audience for questions, and also, webcast participants, if you have questions, please be sure to submit them via the SurveyMonkey link that you received this morning. And as you step up to ask questions, please let us know where you're from, as well as state your name, and we'd be happy to take your questions. So, next question.

Martin Corry: Hi. Martin Corry. I'm not sure which of you wants to field this question. Could you speak a little bit to the requirement for a recommendation from a physician or other clinician? I think it was in the call letter you drew a distinction between that and what we would normally expect in terms of an order. So, if you can just elaborate a little bit as to what you're looking for and what wouldn't apply.

Heather Kilbourne: Sure. I'll do my best, but I would suggest also submitting that question to our mailbox. You can submit it to the policy mailbox so that I have time to collaborate on that. But I know that in the call letter, we don't have any orders required for over the counter, because that would be more limiting than what it previously was. But it does need to be recommended, and there needs to be, I think, some sort of notation or something about why any of these benefits, if you guys are covering them, that they're directly related to a beneficiary's health in that they are medically appropriate, and so our way of making sure that that is complied with is making sure that it's recommended by a physician or a licensed medical provider, and that's really just to help us delineate the difference between primarily health related and some of these general use item, because as you know, it's like with the food, once we start getting into different ADL services or assisted services, safety device is another one, the line is a little blurry, and so we want to make sure that it is directly related to a care plan, and then it's helping improve the beneficiary's health outcomes. I hope that

helped. But if you would like, and you definitely deserve a better answer than that, please go ahead and submit it to the mailbox. Thank you.

Kaye Rabel: Next question, please.

Shelia Fuse: Yes, hi. Sheila Fuse from Nawis Healthcare, and we're very excited about both of these new benefits. We think it's going to be really good for the beneficiaries and really allow them to address some of the needs in the communities. One of the questions that I have is both for the primarily health-related and the supplemental benefits for the home support, in-home support. Some of these activities are going to require a manager to be able to be supervising or scheduling the care for the beneficiaries. Would that be something the management or the scheduling of it be able to be a medical expense?

Heather Kilbourne: Okay, I would also ask that that go to the mailbox. But I think, generally, in management, it would be treated as if any downstream entities in management of supplemental benefits. So, the way plans are organizing their non-emergent transportation for Part A and B, that's how it would be the same. It would be the same. Okay.

Kaye Rabel: Thank you. Sure. Next question, please.

Michael Adelberg: Mike Adelberg, Faegre Baker Daniels. There's been a lot of discussion around the benefit flexibility and the uniformity rules for specific health conditions. There's also some discussion in the guidance around geographic units. I'm wondering if you could talk a little bit about the specificity around creating geographic specific benefits.

Brandy Alston: So, I think you're asking if plans are allowed to target benefits based on a particular geographical location. The answer to that is no. It has to be based on a specific disease state or health status. So, everyone in the

plan or segment with that disease state or health status would have to access to the targeted benefit.

Kaye Rabel: Thank you for that question. Are there any more questions for our in-house participants? Okay. Well, thank you, Heather and Brandy, for providing a summary of the new policy for Medicare Advantage.

If you would like to evaluate this session, please take out your phones and text your response or go to the poll EV link on your iPad, tablets, or computer, and enter "A" in response to question 1, "I would like to evaluate this session," and go ahead and send your response. When you receive the link, click on it and follow the instructions.

So, at this time, we are going to go ahead and go to lunch, and we will begin sessions promptly this afternoon at 12:30 p.m. For our in-person guests, please visit the cafeteria downstairs. If you preordered your lunch, you can pick it up at Jasmine's café, which is right outside of the cafeteria. So, go ahead and enjoy your lunch, and we'll start back at 12:30 p.m. Thank you.