WHITE PAPER

MA Unleashed: CMS Issues Guidance on Newly Established Benefit Design Flexibility

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Overview

On Friday April 27, 2018, the Centers for Medicare and Medicaid Services (CMS) released its long-awaited guidance on newly established benefit design flexibility for Contract Year (CY) 2019. There are two key areas of new benefit flexibility that CMS has introduced for 2019:

1. CMS Reinterpretation of the Benefit Uniformity Requirement; and
2. CMS Reinterpretation of the definition of "Primarily Health Related" for supplemental benefits.

Taken together, these policy reinterpretations meaningfully broaden the options available to Medicare Advantage Organizations (MAOs) in designing benefit packages for 2019 and beyond. With the added flexibility, MAOs will be able to tailor benefits to promote clinical and care management goals for beneficiaries afflicted with specified conditions (e.g. reduced PCP copays for diabetics), and will also be able to offer an expanded menu of supplemental benefits (e.g. bathroom safety devices). While the focus of this report is newly established 2019 benefit flexibility, note that the Bipartisan Budget Act of 2018 further expands CY2020 flexibility with respect to supplemental benefits for chronically ill beneficiaries as well as telehealth services.

Many MAOs are already in the final stages of benefit plan design for CY2019, so taking advantage of the newly available flexibility may be a CY2020 discussion. Whether your MAO is considering taking advantage of the newfound benefit flexibility guidance in 2019 or later, there are several important considerations to navigate.

Exciting times and innovation lie ahead for the MA industry as the US health care system continues the evolution from volume focus to value/quality focus.

The MA industry has weathered the storm of Affordable Care Act (ACA) payment rate cuts from 2012 through 2017 and emerged stronger than ever, with penetration at a record high (~34% of eligible Medicare beneficiaries). Per the CY2019 Final Rate Announcement, "CMS is committed to unleashing and strengthening the Medicare Advantage and Part D programs by giving Medicare beneficiaries flexibility so that they can make informed healthcare choices[1]." Exciting times and innovation lie ahead for the MA industry as the US health care system

[1] CMS 2019 Medicare Advantage and Part D Rate Announcement and Call Letter Fact Sheet available online at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02-2.html

continues the evolution from volume focus to value/quality focus. The options available to MAOs to accelerate that progression just became broader as key benefit restrictions have been removed, and there is a clear line of sight to even more flexibility in 2020.

Benefit Uniformity Reinterpretation

First announced as part of the CY2019 Proposed Policy and Technical Changes released in November 2017, and formalized in an April 27 Health Plan Management System (HPMS) memo, CMS has reinterpreted the uniformity requirement. Effective in CY2019, MAOs may offer access to supplemental services or reductions in member cost sharing based on the health status or disease state (e.g. diabetes) of individuals. Previously CMS would have interpreted such benefit customization as violating benefit uniformity requirements.

Key Guidance Parameters

Each customized benefit offering must satisfy two key criteria: 1) the target population for customized benefits must be objectively identified based on health status, disease state (e.g. diabetes) or clinical condition (or combination thereof), and 2) a reduction in cost-sharing or offering a non-Medicare supplemental service (collectively referred to as additional benefits) must be medically-related to the target condition.

The clinically-targeted enrollee type can be selected from a preset list of specified diseases or specifically identified using diagnoses codes. CMS guidance explicitly noted diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stroke history, hypertension, coronary artery disease, lower back pain, kidney disease, obesity, asthma, tobacco use, opioid addition and hypercholesterolemia as specific examples of allowable target populations. CMS also explicitly notes that combinations of conditions can be targeted for benefit customization.

While a seemingly unlimited variety of additional benefits can be offered under the new interpretation, CMS clarified a few specific restrictions. First and foremost, members with the same health status/disease state must be treated consistently. Also, additional benefit packages to be offered must "only apply to the healthcare services that are medically related to each health status or disease state" and must be a Part C benefit. Member and Part B premium buy-downs, as well as changes to Part D benefits do not qualify as valid benefits for customization.

Examples of acceptable customized benefit packages include: 1) Elimination of copays for endocrinologist visits for enrollees with diabetes or 2) Offering diabetic enrollees a lower deductible.

CMS identified a few alternatives to defining the targeted enrollees and additional benefits. Rather than defining the additional benefit as a reduction in cost-sharing or supplemental benefit offered by *any* provider, MAOs may choose to define the additional benefit based on *selected providers*. If the MAO identifies a provider as being "high-value", the MAO may reduce or eliminate cost-sharing for the targeted enrollee, regardless of the specific service delivered by the provider. The MAO could also eliminate cost-sharing for specific services delivered by the "high value" provider. While CMS generally prohibits MAOs from requiring enrollees to opt in[2], MAOs can limit targeted enrollees to those

[2] An exception to the opt-in requirement is for a Wellness Program participation. MAOs can require enrollees to opt-in to the Wellness Program.

who meet non-discriminatory prerequisites. For example, an MAO can target enrollees who regularly meet with a case manager. Participation in wellness, care management, or similar programs can be required as long as there is equal access to the program(s) for all members with the health status or disease state.

Submission/Technical Requirements

The disease states/clinical conditions as well as the additional benefit packages must be defined in section B19 of the Plan Benefit Package (PBP) submission component of the June benefits and bid filing. Up to 15 packages for reduced cost-sharing and 15 packages for supplemental benefits can be included.

The PBP is pre-populated with nine disease states[3] while other disease states can be defined using specified ICD-10 diagnoses codes. The ICD-10 codes may reflect subsets of the pre-populated disease states, different disease states or combinations of disease states. While the options for disease states are unlimited, social determinants such as homelessness and food insecurity are not allowable clinical categories for targeting customized benefits. Any codes used for identifying eligible enrollees must be diagnosed by a physician or medical professional.

Additional benefits and any related limitations are also required to be listed in the PBP. Limitations can include provider type, annual maximums on the aggregate amount of cost-sharing reductions, and participation in care programs. Additional benefits cannot be dependent on the cumulative number of visits for a member (a restriction that already applies to MA benefit designs). All additional benefits will then be included in Annual Notice of Change (ANOC), Evidence of Coverage (EOC), and Summary of Benefits documents.

Operational Challenges

Customized benefit package will come with operational challenges in many areas: identification of members, benefit adjudication, benefit pricing, and member communications.

Most claims systems depend on the PBP and segment number to drive automated benefit adjudication. In a customized benefit offering, benefit adjudication would need to be based off of historical member diagnoses. Identifying targeted population members and ensuring that claims adjudication procedures are in place to vary by disease state will require operational modifications to claims systems. One area where CMS has provided some relief to the operational challenges of benefit adjudication is that CMS is allowing retroactive adjudication of reduced cost sharing. For example, if a previously un-diagnosed diabetic member pays full cost sharing at the point of service, the MAO can reimburse the member retrospectively for the reduced cost-sharing under the customized benefit (having newly identified the member as being afflicted with a target condition).

As part of the original bid submission, actuaries will need to predict who will be eligible, how many will participate, what their utilization rate will be, and whether other service category utilization will be impacted (e.g. reduced inpatient admits due to more effective case management of particular disease states). Projecting the effective cost sharing for an MAO

[3] The 2019 PBP includes the following pre-populated disease states: Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Patient with Past Stroke, Hypertension, Coronary Artery Disease, Mood Disorders, Rheumatoid Arthritis, and Dementia.

newly implementing such customized benefits becomes meaningfully more complicated.

MA VBID Distinction

The Value Based Insurance Design (VBID) option, previously available under demonstration authority, provides MAOs similar opportunities as the uniform benefit flexibility. In general, the same PBP requirements for defining the VBID package exist. However, the VBID option allows reduced cost-sharing on Part D, requires an application prior to bid submission, limits geographic offerings, and requires three years of experience.

Primarily Health Related Definition

In a separate HPMS memo issued on April 27, 2018, CMS expanded the supplemental benefit definition of "primarily health related" to include items or services that are 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." The benefit must focus on the enrollee's health care needs and be recommended or provided by a licensed medical professional.

In the memo, CMS listed nine benefits allowable under the new definition of "primarily health related." These benefits, the descriptions, and their associated PBP categories are listed in Table 1. Of particular note are benefits around home-based services, caregiver support and assistance with activities of daily living (ADL).

While this list is extensive, the HPMS memo indicates that the list is not exhaustive, and MAOs are permitted to establish other benefits. MAOs must be prepared to explain how any new or novel benefit is primarily health related and how the MAO will limit coverage to only those circumstances.

Strategic Considerations

These benefit reinterpretations drive exciting opportunities for MAOs to create benefits that facilitate cost-savings, drive more accurate risk scores, and improve star ratings.

Customized benefits could be used to reduce financial barriers to accessing care by removing copays for chronically ill enrollees with multiple disease states, potentially reducing the frequency of acute episodes and overall MAO cost. Combining customized benefits for target disease states with the expanded definition of "Primarily-Health Related" introduces a wide array of targeted supplemental benefit options, e.g. non-emergent transportation to primary care visits for enrollees with CHF.

In addition to developing innovative benefits that can reduce costs, additional benefits can be developed with the specific intent of improving particular star rating measures. For example, reduced cost sharing for diabetics who regularly meet with a case manager would likely improve a HEDIS measure like "C15 Diabetes Care – Blood Sugar Controlled." As another example, a non-emergent transportation benefit (to physician offices or pharmacies) could serve to improve drug adherence measure performance.

Lastly, we believe that innovative benefits can lead to more accurate risk scores. For example, incenting enrollees with certain disease states to participate in home risk assessments or case management in order to gain access to reduced cost sharing will likely result in more accurate risk scores for a higher proportion of the targeted population.

Next Steps

Benefit planning opportunities for 2019 are limited due to the fast approaching bid

submission deadline. However, do not overlook the potential of adding a customized benefit during rebate reallocation (to be determined whether this will be permissible by CMS). For most plans, now is the time to plan ahead for 2020.

1) Identify problematic star measures, poorly managed enrollee cohorts, and services where cost containment or quality is challenging.
2) Develop potential targeted benefit enhancements that may yield improvement.
3) Determine associated costs of new benefits relative to the potential cost savings or increased revenue related to risk score increases or star rating improvement.
4) Select benefits with the highest return on investment, considering both clinical and financial perspectives.

Wakely is equipped to lead you through these steps and take advantage of these new benefit options. Consult with your Wakely contact today!

Please contact Tim Murray at tim.murray@wakely.com with any questions or to follow up on any of the concepts presented here.

Table 1: Primarily Health-Related Reinterpretation Summary

Benefit Category	PBP Category	Administrative/ Clinical Requirements	Examples of Permissible Benefits	Benefits that are explicitly NOT permitted
Adult Day Care (OUTSIDE home)	B13 (d,e, or f)	Primary purpose of adult day care services must be health related and provided by licensed staff	• Assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) • Education to support ADL/IADL performance • Physical maintenance/rehabilitation activities • Social work services to ameliorate impact of injuries or health conditions • Ancillary recreational/social activities and meals • Transportation to/from adult day care facility	
Home-Based Palliative Care	B13 (d,e, or f)	Beneficiary must be terminally ill with > 6 months life expectancy	• Palliative nursing • Social work services	• Hospice benefits for terminally ill patients with < 6 months to live (covered by Medicare) • Palliative nursing and social work services covered by Medicare Part A
In-Home Support	B13 (d,e, or f)	Must be provided by staff licensed to provide personal care services	• Assistance with ADLs/IADLs	
Caregiver Support	B13 (d,e, or f)	Respite care permitted for short periods of time (e.g. a few hours per week, 2 weeks, 4 weeks)	• Respite care provided through personal care attendant • Short-term institutional-based care • Counseling	
Non-Opioid Pain Management	B13 (d,e, or f)	Must be ordered by a physician or medical professional, and must treat/ameliorate impact of injury or illness (e.g. pain, stiffness, loss of range of motion)	• Therapeutic massage furnished by a state-licensed massage therapist	• Services primarily for comfort/relaxation of enrollee • “Massage” should not be singled out as a particular aspect of other coverage (e.g. chiropractic care or occupational therapy)
Memory Fitness Benefit	B13 (d,e, or f)		• Stand-alone memory fitness benefit • Memory fitness benefit as component of health education benefit	
Home Safety	B14c	Plan must briefly describe proposed benefit and enrollee criteria for receiving benefits (e.g. enrollee at risk of falls), Covered safety inspection must be conducted by qualified health professional in accordance with state/Federal requirements	• Home/Bathroom Safety Devices and modifications o Shower stools o Hand-held showers o Bathroom and stair rails o Grab bars o Raised toilet seats o Temporary/portable mobility ramps o Night lights o Stair treads • Installation of safety devices • Safety inspection services	• Medicare-covered safety devices • Capital improvements to home • Structural improvements to home • Easy-to-use door knobs • Easy-to-use faucets • Permanent ramps • Widening hallways or doorways • Smoke detectors • Fire alarms
Transportation	B10b	Must be arranged or directly provided by the plan	• Non-emergent transportation to obtain Part A, Part B, Part D, and supplemental benefit items/services. o e.g. trip to physician office visit • Health aide to assist enrollee to destination	• Transportation for purposes that are not health-related, e.g. trips to: o Grocery store o Bank
Over-the-Counter (OTC) Benefits	B13b	Health-related items/medications available without a prescription	• Items already included in Chapter 4 of Medicare Managed Care Manual • Assistive devices such as pill cutters, pill crushers, pill bottle openers • Personal electronic activity tracker (stand-alone or part of fitness benefit)	• Items covered by Part A, Part B, or Part D