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Improving Serious Illness Care in Medicare Advantage: New Regulatory Flexibility for Supplemental Benefits

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KEY THEMES

- **Medicare Advantage plans have new flexibilities to offer supplemental benefits that support members' broader health needs. In the first two years, only a small number of plans are offering new benefits, in large part due to the time it takes to design and implement a new supplemental benefit.**
- **The launch of new supplemental benefits has been slowed by operational challenges, such as establishing contracts with community-based organizations that can offer meals, transportation, and other services; ensuring services are available in sparsely-populated rural areas; and understanding where to target new benefits given that plans do not have new funding to implement these benefits.**
- **To design and implement new supplemental benefits, plans require rigorous evidence for how they will impact clinical care quality, the health and quality of life of enrollees, and overall health care costs.**

Introduction

Starting with their 2019 offerings, Medicare Advantage (MA) plans have new flexibility to offer benefits that improve people's health and ability to live independently, even if those benefits are not traditional medical services. Many of the newly permitted benefits are aimed at helping plan members with chronic conditions, and some, such as home-based palliative care, in-home support services, and support for caregivers,[1] are particularly valuable for members with serious illness. People with serious illness have multiple health and social needs given they often have multiple chronic or debilitating conditions, face complex care needs, and are at risk of high utilization and associated costs.[2,3,4,5]

The Medicare Advantage market is a fertile testing ground for new benefit designs, given that many plans are already implementing new payment models[6,7] as well as new care delivery models for people with serious illness.[5] The program's capitated payment structure allows for plans to try new approaches because plans share in cost savings, earn bonus payments, and receive rebates (that they can use to offer enhanced benefits or reduce member cost sharing) if they are able to reduce costs while maintaining or improving the quality of care delivered, as measured by the Star Ratings program.

The goal of this brief is to report on early trends in supplemental benefit offerings for serious illness populations; summarize what we have learned from Medicare Advantage plans about their strategies, decision making, and early implementation experiences; and identify future goals and policy changes that may further expand supplemental benefit offerings. This brief draws on an analysis of longitudinal supplemental benefits data published by the Centers for Medicare & Medicaid Services (CMS), key informant phone interviews with Medicare Advantage plan leaders, and builds on prior research into supplemental benefits.[8,9,10,11,12]

Recent Policy Changes for Medicare Advantage

Medicare Advantage plans are required to cover all of the services offered by the traditional Medicare program, but may also offer supplemental benefits to their enrollees.[13] In the past, those supplemental benefits had to be "primarily health related"[1] and typically included coverage for medical services like vision and dental care.[13]

The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act,[14] passed by the Congress in 2018, enacted several policy changes that allow MA plans to offer new benefits designed to address their enrollees' overall health. First, it broadened the range of supplemental benefits that could be offered to include benefits that could help improve or maintain health or function. In addition, it allowed plans to target those benefits to particular groups of people who would benefit most from them.[12,15] Prior to this change MA plans were required to offer any supplemental benefit to *all* of their enrollees, but now they may offer services tailored to specific subsets of their population, such as members with serious illness. Leaders from the plans that we spoke with emphasized that this change is especially important, since they can now offer targeted benefits to their highest need population that would be cost prohibitive to offer to all members.

It is important to note that the new flexibilities provided by the CHRONIC Care Act and associated CMS regulations are aimed at standard MA plans. Other types of MA plans, such as Medicare-Medicaid Plans (MMPs), Dual Eligible Special Need Plans (D-SNPs), and Programs of All-Inclusive Care for the Elderly (PACE) plans, operate under different regulatory requirements; have additional flexibilities compared to traditional Medicare; and, in many cases, were able to offer enhanced supplemental benefits prior to the rule changes.

To accelerate implementation of the CHRONIC Care Act (much of which does not go into effect until plan year 2020), in spring 2018 the Centers for Medicare & Medicaid Services announced two reinterpretations of the rules governing supplemental benefits that MA plans may offer their members, starting with the 2019 Medicare Advantage plan year. The first broadened the definition of "primarily health related," a key criteria for any supplemental benefit offering, to include 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."[1] CMS identified specific services that would now be permitted as supplemental benefits following the change, including adult day care services, home-based palliative care, in-home support services, support for caregivers of enrollees, medically-approved non-opioid pain management, stand-alone memory fitness benefit, and home and bathroom safety devices and modifications.[1] In addition, CMS announced a reinterpretation to the uniformity requirement, as explained above, which enables plans to offer targeted benefits to subsets of their members with specified health status or disease states.[16]

As further implementation of the CHRONIC Care Act, CMS released additional guidance in its Call Letter to MA plans for the 2020 plan year.[17] CMS has given greater direction on supplemental benefits for people with chronic diseases, referred to as Special Supplemental Benefits for the Chronically Ill (SSBCI).[18] This change takes effect for the 2020 plan year and enables plans to target benefits to people with chronic conditions that are life threatening, limit health, or limit function; have high risk of hospitalizations or other poor health outcomes; and require care coordination. CMS has identified the specific conditions that fit these criteria (those defined in Chapter 16-B of the Medicare Managed Care Manual), which include heart failure, dementia, diabetes, and stroke.[19] Approximately three-quarters of people enrolled in MA plans have one or more of these conditions.[17] In the guidance CMS has provided for this change, example benefits that would qualify include services like

food, pest control, indoor air quality equipment, and structural home modifications, as long as the benefits have a reasonable expectation of improving or maintaining the health or function of the person receiving the benefit.[18]

The plan leaders we interviewed generally expressed support for these regulatory flexibilities around supplemental benefits, but they also indicated that they were navigating implementation with unclear guidance. As plans deliberate over what kinds of supplemental benefits to add, they would like more detailed guidelines for what types of benefits will be allowed and how to define subpopulations that qualify for supplemental benefits in the wake of these rule changes.

Evolving Supplemental Benefit Landscape: Some Plans Offering New Benefits, Room to Grow

To assess how MA plans have reacted to the new flexibilities for supplemental benefits, we analyzed the plan benefit package (PBP) data, which includes supplemental benefits offerings, published by CMS from 2015 through the first quarter of the 2020 contract year (the most recent available).[20] For the purposes of our analysis, which is focused on serious and advanced illness, we evaluated only supplemental benefits that were most relevant to people with serious illness *and* were allowable given the 2019 and 2020 regulations.

To further the analysis, we linked the plan benefit package data to MA enrollment data by plan and by county; Census data on how urban individual counties are; and CMS data on MA penetration by county. These linked datasets were used to develop maps that show the geographic impact of the new policy changes.

There are a few limitations to note regarding the use of the plan benefit package data source. First, it only includes short names for each of the benefits, and plans used different naming conventions (especially for their 2019 new supplemental benefits). Furthermore, it does not include more detail on what services are covered under a benefit, so in practice there is likely variation between plans in terms of the specific services they offer enrollees for a given benefit, such as caregiver support. Lastly, due to different regulations governing Medicare-Medicaid Plans (MMPs), Dual Eligible Special Need Plans (D-SNPs), and Programs of All-Inclusive Care for the Elderly (PACE) plans, we have generally excluded them from our analyses unless otherwise noted. Given the number of potential supplemental benefits, we have aggregated and analyzed the plan benefit data with a focus on supplemental benefits more relevant to the serious illness population. Finally, it is important to note that other analyses, which may use different methods, assumptions, or exclusion criteria, may produce slightly different results. However, our analyses were benchmarked against other prior research to ensure accuracy.

More Plans Offer Supplemental Benefits Following Rule Changes and Mix of Benefits Is Evolving

As illustrated in Table 1, there has been an overall increase in the number of plans offering some type of supplemental benefit applicable to their serious illness population since 2018. In 2019, the first year in which plans were able to expand their supplemental benefit offerings, a total of 507 standard MA plans offered one of the five supplemental benefits highlighted in Table 1 below, which account for approximately 11% of the approximately 4,500 standard MA plans in 2019. In 2020, 377 standard MA plans offered at least one of the five benefits listed below, or approximately 7% of the over 5,200 standard MA plans. For 2020, many plans will offer multiple supplemental benefits, in contrast to 2019 when no plans offered more than one supplemental benefit.

It is important to note that this table presents data for supplemental benefits relevant to serious illness care, and it does not capture other new supplemental benefits that plans can offer but that are applicable to people with less severe chronic diseases, such as transportation, home and bathroom safety modifications, or food and produce. The implementation of these SSBCI benefits is difficult to calculate from the publicly available data, but the fraction of plans offering some type of new supplemental benefit likely exceeds 10%.

Overall, a modest proportion of plans are offering one or more new supplemental benefits for their members with serious illness. In 2019, the largest increase was in the number of plans offering a benefit for caregiver support, with a much smaller number of plans offering palliative care, in-home support services, and non-opioid pain management, and no plans offering adult day care. By 2020, we see an almost 80 percent decrease in the number of plans offering caregiver support. Examining the benefits data, this sharp decline was driven almost entirely by one large national insurer that dropped the caregiver support benefit from its plans. In contrast, we observe significant increases from 2019 to 2020 in benefits that more directly address the needs of members with serious illness, including adult day health services, palliative care, non-opioid pain management, and in-home support services.

Table 1. Number of plans offering supplemental benefits for seriously ill beneficiaries			
Supplemental Benefit	*Before New Flexibilities: 2018*	*Early Implementation: 2019*	*Full Chronic Care Act Implementation: 2020*
Adult day care/Adult day health services	0	0	63
Palliative care (including home-based palliative care)	2	23	58
Non-opioid pain management	0	24	201
In-home support services	0	71	148
Caregiver support (including respite care)	0	389	82

Note: Counts in this table exclude MMP, D-SNP, and PACE plans.

Palliative Care versus Hospice in the Medicare Advantage Context

Palliative care generally refers to services delivered to patients with serious illness that are designed to relieve their symptoms, improve their comfort and quality of life, and ensure that their goals of care and care preferences are met.[21,22] These services are typically delivered by a specialized and interdisciplinary care team, including doctors, nurses, social workers, and chaplains; can be offered to patients at any stage of their disease progression; and do not require forgoing any curative treatments.[21,22]

Hospice care includes similar kinds of services delivered by a similar care team, although it is often more intensive. Further, hospice is limited to patients near the end of life by two specific requirements, as defined by the Medicare hospice benefit.[23] First, the patient must have received a terminal diagnosis with a prognosis of six months or less to live. Second, the patient must elect to forgo curative treatments while receiving hospice care.[22,23]

Although there is much overlap between the services delivered under palliative care and hospice, and some provider organizations offer both kinds of care, there is a meaningful difference between the two within the Medicare program. Traditional Medicare offers a hospice benefit, but it is currently carved out of the Medicare Advantage program, so that patients who elect hospice must disenroll from their MA plan and back into traditional Medicare (Part A). This policy explains why MA plans do not cover hospice services but may offer a palliative care supplemental benefit to their enrollees with serious illness who do not yet qualify for or have not elected hospice care.

The information we gathered from plans during our key informant interviews (discussed below) may add some insight into what has driven the trends we see in the benefits data. First, the low initial uptake of supplemental benefits may be explained by the short turnaround times that plans had to develop and implement new offerings. For the 2019 plan year, MA plans had only a few months between when CMS announced its rule reinterpretations and when plans had to submit their bids for what they would cover the next year. Many interviewed plans emphasized that it can take two to three years to develop and price a new benefit (especially true for those benefits that incur high costs but have limited available evidence for their estimated savings), so only plans that had already been working on benefit design for serious illness were able to take advantage of the new flexibility immediately.

Furthermore, we heard from plans that their efforts to roll out supplemental benefits were complicated by the drug rebate rule that was proposed during the 2020 MA bid cycle (occurring in spring 2019). Operationally, this meant that many plan actuaries were tasked with pricing two simultaneous bids, pending the ultimate fate of the rebate rule, and plans simply did not have the bandwidth to consider adding a new supplemental benefit during the same bid cycle.

In response to these constraints, leaders from the plans we spoke with explained that in the first years of new flexibility, plans may start by offering benefits that they consider to be "low-hanging fruit" that are less costly and easier to deliver. In subsequent years, we may expect an increase in the number of plans offering supplemental benefits that are more resource intensive but also have potential for greater impact. This consideration may help explain, at least in part, the increase we see from 2019 to 2020 in the number of plans offering more intensive benefits like palliative care and in-home support services.

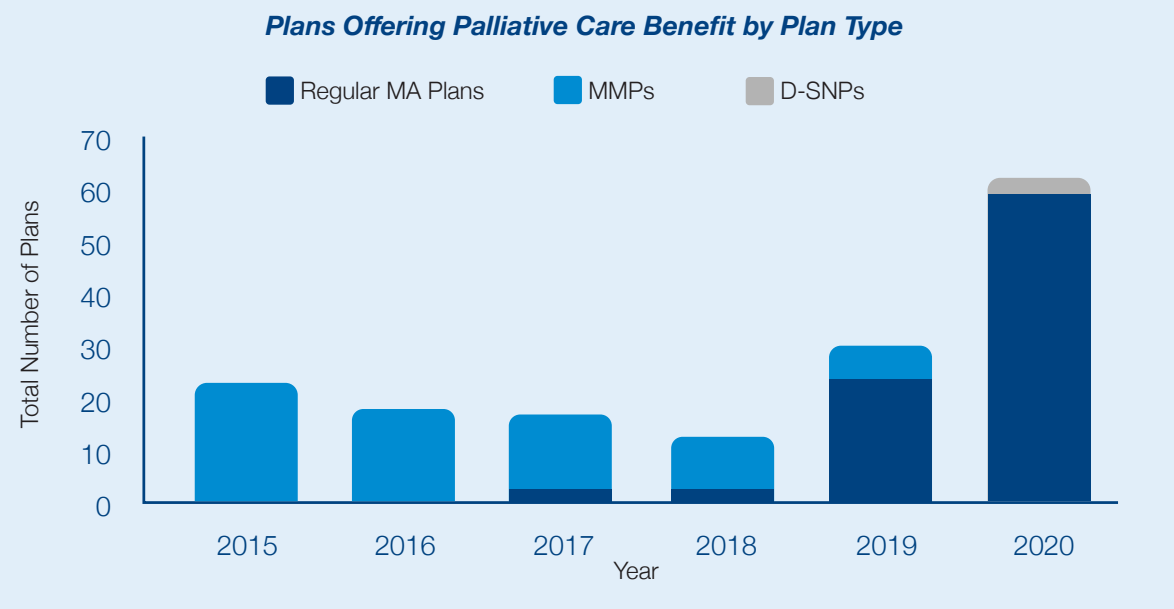
As noted above, it is important to explain that the benefits data are self-reported by plans, and it is not possible to identify the detailed services provided under each benefit. For example, one plan may offer a holistic suite of services under its palliative care benefit, including home-based services by specialty-trained palliative care clinicians, a 24/7 call center, a multidisciplinary team with social workers and chaplains, and integrated pain management. Another plan's palliative care benefit may only include more basic services, such as a hospital-based consultation with a clinician (regardless of training) who discusses a person's goals of care. It is not possible to discern any such differences with this data set.

Competing Trends in MA Plans Offering Palliative Care Benefits

In years prior to the policy changes governing supplemental benefits, a palliative care benefit was almost exclusively offered by Medicare-Medicaid Plans (MMPs), and the number of MMPs offering the benefit was steadily declining. In 2019, the first year following the CMS guidance on expanding supplemental benefits, 15 standard MA plans noted that they offered a "palliative care" benefit, and 8 indicated they offered a "home-based palliative care" benefit. For 2020, a total of 61 (including 58 standard MA plans) plans noted they offered a palliative care benefit, with all plans specifying it as "home-based palliative care." As illustrated in Figure 1, although the number of MMPs offering a palliative care benefit has declined to zero, this trend occurred at the same time as there was a significant increase in the number of standard MA plans with a palliative care offering.

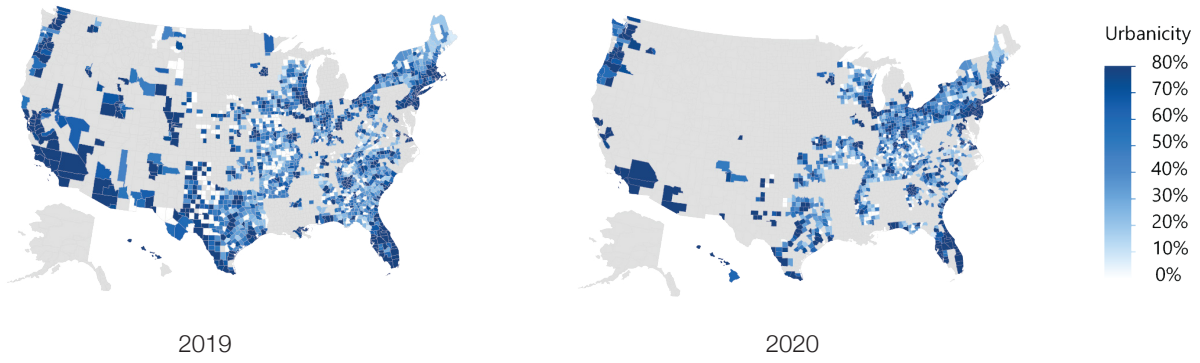
While we do see an uptake of palliative care services to date, we note that there is another policy change on the near horizon that may encourage greater adoption of palliative care benefits amongst MA plans. Starting in 2021, the Medicare Advantage Value-Based Insurance Design (VBID) pilot will allow participating MA plans to offer hospice benefits, which have otherwise been carved out of the Medicare Advantage program.[24] Once this VBID change is implemented, it will enable plans to consider offering their members a longer continuum of serious illness care, with palliative care preceding hospice.

Figure 1. Number of plans offering any palliative care benefit



Note: This figure includes data for all MA plan types, including standard, MMP, D-SNP, and PACE plans.

Figure 2. Urbanicity of counties with new supplemental benefit offerings for serious illness



Note: Data in this figure exclude MMP, D-SNP, and PACE plans.

Serious Illness Supplemental Benefits More Prevalent in Urban Areas

We also examined where new supplemental benefits relevant to serious illness were offered across the country. Figure 2 illustrates the counties where one or more plans offered supplemental benefits relevant to serious illness (the five benefits in Table 1) for the 2019 plan year.*

As the maps demonstrate, only some states and counties have MA plans offering supplemental benefits for serious illness; many other areas of the country do not have any plans offering these new options.

*Again, excluding MMPs, D-SNPs, and PACE plans. The maps in Figures 2 and 3 also exclude Puerto Rico, American Samoa, Guam, and Virgin Islands, as well as plans with enrollment less than 10 in 2019, whose numbers were suppressed in the enrollment and penetration data.

As shown in Figure 2, new supplemental benefits aimed at serious illness care are more likely to be offered in more urban counties. In counties where a new supplemental benefit for serious illness was offered in 2019, the average urbanicity, or proportion of the population residing in an urban area,[25] was almost 50%.[†] In comparison, the average county that had more than nominal MA enrollment but with no serious illness supplemental benefit offering was approximately 34% urban. In 2020, this trend held, with 50% average urbanicity for counties with plans offering a new supplemental benefit for serious illness, while counties without a serious illness benefit offering were only 37% urban. This finding is consistent with what we heard during our interviews with MA plan leaders about the challenges of delivering new services in rural areas.

Supplemental Benefits More Common in Areas with Higher MA Penetration

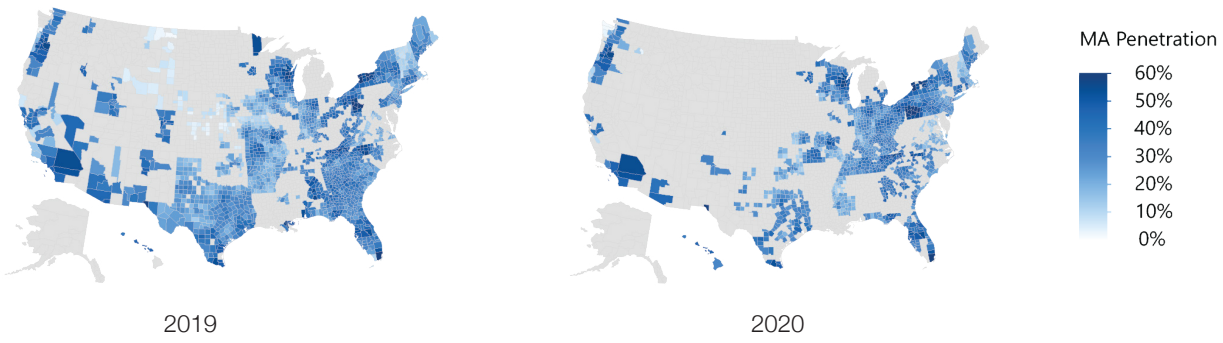
As shown in Figure 3, new supplemental benefits for serious illness were more likely to be offered in regions of the country where higher proportions of Medicare beneficiaries were enrolled in Medicare Advantage. In counties where a new supplemental benefit relevant to serious illness was offered in 2019,[†] the average MA penetration was 30%, compared to 20% penetration in counties with more than nominal MA enrollment but without an MA plan that offered any new supplemental benefits for serious illness. This finding was observed again in the 2020 benefit data, as counties with plans offering a new supplemental benefit for serious illness have an average MA penetration of 32%, compared to 22% penetration in counties without an MA plan offering any new supplemental benefit for serious illness.

While the data alone does not explain what drives this difference, we know from our interviews that plans consider their benefit offerings based on what attracts prospective enrollees. Therefore, we hypothesize that plans operating in counties with a higher MA penetration may be using new supplemental benefits as a differentiator to appeal to beneficiaries. This point was also confirmed in our interviews with MA plan leaders, who noted that any new plan benefit was analyzed based on its potential impact on overall plan enrollment.

Practical Challenges in Implementing New Supplemental Benefits

In addition to analyzing the plan benefit data to gauge the uptake of new supplemental benefits relevant to serious illness, we also interviewed leaders from MA plans to gain insights into plans' strategies and decision making following the regulatory changes, as well as to learn about their early implementation experiences in the first years after they may offer new benefits. We conducted these interviews in June and July of 2019, as plans were assessing their experience in the first year of implementation of new supplemental benefits and shortly after they submitted their bids with benefits for the 2020 contract year. We spoke with plan leaders who manage both the design and implementation of benefit offerings, as well as those who lead their organization's strategies for serious illness.

Figure 3. MA penetration in counties with new supplemental benefit offerings for serious illness



Note: Data in this figure exclude MMP, D-SNP, and PACE plans. Both 2019 and 2020 maps use MA penetration data from September 2019, since 2020 data are not yet available.

[†] This calculation only looks at MA plans with at least 10 enrollees in 2019 and only at counties where the enrollment in an MA plan with a new supplemental benefit exceeded 10 enrollees in 2019.

New Flexibility but No New Funding

While they appreciated the new regulatory flexibility allowed by CMS, plan leaders stressed that no new funding is available for offering these benefits. Broadening the types of supplemental benefits allowed is, in practice, a re-programming of finite existing funds rather than an investment of new resources. As a result, plans noted that it is unrealistic for them to offer more than a small number of supplemental benefits, and that the addition of new benefits may require tradeoffs with other potential offerings, such as dental services, hearing aids, and wellness programs that are more commonly covered by MA plans.

MA plans can pay for supplemental benefits with funds provided by Star Ratings bonuses or from rebates if their bids (for how much they expect it will cost to provide benefits that year) are below the benchmark CMS set for their local area. To give a sense of the amount of funding that may be used for supplemental benefits, $6.3 billion total in Star Ratings bonus payments were made to plans in 2018, more than doubling the approximately $3 billion in 2015, which was a result of the increasing number of enrollees in Medicare Advantage and the increasing number of plans receiving bonuses.[26] In addition, in 2019 MA plans on average received $107 in rebates per member per month, which would amount to $28 billion annually.[10] This is not an insignificant amount, but star bonuses and rebates combined account for only 15 percent of the total money spent by Medicare Advantage plans ($232 billion in 2018).[27]

Challenges in Contracting and Working with Community-Based Organizations

Leaders from multiple plans also cited unique challenges associated with contracting with the kinds of local and community-based organizations that may be best suited to deliver non-medical supplemental benefits. Following the rule changes, plans are interested in offering services like meal delivery, transportation, and respite care—the types of services that are typically offered by locally organized social service agencies or community-based organizations. However, these types of organizations may have limited experience and capacity to contract with health insurance plans. For example, these organizations may not meet the liability insurance requirements to contract with plans or may not have the technical capacity to receive, store, and share any health-related information on beneficiaries in a manner required by Health Insurance Portability and Accountability Act (HIPAA) regulations. As one interviewee noted, "it's a lot of work to teach organizations how to contract with a health plan," and this is not in most community organizations' skill sets or business models.

In addition, because these small organizations often deliver services to small local areas, plans may struggle to contract with enough organizations to cover members across their entire geographic service area, and the plans face high administrative costs in contracting with such a large number of community-based organizations. Leaders from the plans we interviewed expressed an interest in collaborating with aggregator organizations that could support contracting with a network of community-based organizations, but few such entities currently exist.

Access Challenges in Rural Areas

The plans we spoke with also cited access barriers in rural areas. First, these areas often have a smaller relevant workforce (such as clinicians knowledgeable in palliative care), and they may have fewer community-based organizations that could offer services for patients with serious illness. Even when services may be available, there may be long travel times to deliver them, especially for services delivered in the home.

Some plan leaders highlighted telemedicine as a potential strategy to alleviate these challenges, and there are some early examples where it has been useful (e.g., tele-palliative care). However, leaders noted that the technology remains under development, many rural areas have poor broadband access, and regulations vary by state. More standardized telemedicine requirements from CMS and states would help plans assess how to leverage this delivery mechanism.

Aligning Benefits across Lines of Business

Some of the MA leaders we interviewed emphasized that they did not want to create a social determinants strategy for their MA line of business, using supplemental benefits as the mechanism for delivering nonmedical services, that was separate from their company's other lines of business (like commercial insurance or Medicaid managed care). Given that social drivers of health has become a strategic focus for many types of payers, such as the North Carolina Medicaid program, which is starting *Healthy Opportunities* pilots for covering three specific social services,[28] it is understandable that companies would want a common approach across their lines of business in terms of contracting with community-based organizations, offering services in-house, and designing benefits. Other insurance companies had diametrically opposed viewpoints, and thought that the MA market was fundamentally different from others and that there was not a way to align. While plans have varying approaches right now, this does highlight a strategic decision that plans leaders will need to make.

Strategies for Promoting Greater Adoption of Supplemental Benefits

Increase the Amount of Evidence Available to Develop New Benefits

When developing and implementing any new benefit, health plans must understand how many of their enrollees will utilize the benefit; how often they will use it; the impact the benefit will have on their enrollee's health, functioning, and medical utilization; and whether the benefit will affect their Star Ratings. Plan actuaries need this evidence while the benefit is under development so that they can accurately price the benefit, and this evidence also helps the plan line up the necessary providers and community-based organizations so that their beneficiaries have access to the benefit offerings.

Generating evidence is complicated by the fact that the imposition of costs and realization of benefits are likely not temporally aligned. The plans we interviewed explained that when a new benefit is offered they anticipate high uptake from their members, along with a spike in associated costs in the first year(s) of the offering. However, any savings that result from the benefit may take more time to materialize and not be realized by the plan until years later. In addition, offering a new benefit may attract enrollment by new and/or different kinds of beneficiaries, potentially altering the plan's risk pool. If the addition of a new supplemental benefit significantly increases costs to the plan, it can result in higher premiums or higher cost sharing for its members.

In the face of this uncertainty, many of the plans we spoke with—especially plans with product offerings in multiple MA regional markets—explained that their strategy was to start by developing and piloting small-scale *programs* for services like home-based palliative care. This approach allows the plans to carefully monitor implementation and gather data that can inform benefit pricing. If these efforts are successful, they can be brought to scale and to different markets as formal *benefits*. However, there are challenges associated with this approach. First, plans are not allowed to advertise programs to beneficiaries in their benefits materials, which may limit uptake. Second, operating these services as a program requires greater administrative effort than offering a benefit with clearly defined parameters that facilitate claim adjudication. Third, many clinicians are unlikely to be aware of pilot programs, and therefore are unlikely to refer their appropriate patients to take advantage of the services.

As plans gain more experience with these pilot programs and draw useful data to construct new supplemental benefits and set pricing, we may gradually see proliferation of supplemental benefits for serious illness across more MA products.

Improve Clarity on What Is Allowed Under Current Regulation

The leaders we interviewed were unanimous in their enthusiasm for the recent regulatory changes that allow plans greater flexibility to target nonmedical services to their enrollees with serious illness. However, a common message was that the rule changes and guidance were still vague, resulting in some uncertainty about the limits of what would be permitted in this new landscape. For example, it is easy to understand why caregiver support would be an attractive benefit to enrollees with serious illness, but plans need to operationalize this concept and make decisions about what services should be included and what kinds of providers or vendors are best-suited to deliver them. Benefit design and implementation may be facilitated with more clearly defined boundaries and examples of what CMS expects from plans.

Furthermore, plans are being offered new flexibilities and opportunities on multiple fronts. For example, plans across the country now have the opportunity to participate in the Value-Based Insurance Design (VBID) model, which allows tailoring benefits to enrollees based on chronic conditions and socioeconomic factors.[24] With all of these avenues for providing new benefits available to them, plans may need to make complex strategic decisions about how to best respond. CMS may help plans navigate this new landscape by providing more insight into the policy strategy and objectives driving various programs and changes.

Conclusion

With new statutory authority, CMS is taking action to afford Medicare Advantage plans much greater flexibility than they have had in the past to offer new benefits outside of traditional medical services. In this new environment, several Medicare Advantage plans are testing new supplemental benefits, but any widespread change will likely be gradual given the time it takes to design and implement new benefits. Moreover, MA plans face practical barriers that slow implementation, including challenges contracting with community-based organizations to deliver services, expanding access in rural areas, and targeting benefits without expanded funding. To accelerate this process, CMS can help promote evidence for what works and more clearly define what is possible.

References

1. Centers for Medicare & Medicaid Services. Reinterpretation of "Primarily Health Related" for Supplemental Benefits. Baltimore, MD: Centers for Medicare & Medicaid Services; April 27, 2018. https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf. Accessed October 8, 2019.

2. Hayes SL, et al. The Commonwealth Fund Issue Brief: High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? August 2016. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/aug/1897_hayes_who_are_high_need_high_cost_patients_v2.pdf. Accessed October 16, 2019.

3. Coalition to Transform Advanced Care. Toward a Serious Illness Program Design & Implementation Framework. August 2017. https://www.thectac.org/wp-content/uploads/2017/08/CTAC-SIP-Framework-2017.pdf. Accessed October 16, 2019.

4. Kelley AS, Covinsky KE, Gorges RJ, et al. Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care. *Health Serv Res.* 2017;52(1):113-131.

5. Olson A, Harker M, Saunders R, Taylor Jr. DH. Innovations in Medicare Advantage to Improve Care for Seriously Ill Patients. The Robert Wood Johnson Foundation and Duke Margolis Center for Health Policy; July 2018. https://healthpolicy.duke.edu/sites/default/files/atoms/files/innovations_in_medicare_advantage_to_improve_care_for_seriously_ill_patients.pdf. Accessed October 8, 2019.

6. Japinga M, Bleser W, Olson A, Saunders R. Gauging Payment Reform Progress in Medicare Advantage: Current State and Opportunities for Improvement. The Robert Wood Johnson Foundation and Duke Margolis Center for Health Policy; May 2018. https://healthpolicy.duke.edu/sites/default/files/atoms/files/duke_ma_combined_050118_final.pdf. Accessed October 8, 2019.

7. Health Care Payment Learning and Action Network (HCP-LAN). APM Measurement Progress of Alternative Payment Models: Methodology and Results Report. McLean, VA: The Mitre Corporation; 2018. http://hcp-lan.org/workproducts/apm-methodology-2018.pdf. Accessed October 8, 2019.

8. Murphy-Barron C, Buzby, E. Review of Contract Year 2019 Medicare Advantage supplemental health care benefit offerings. Milliman; December 2018. http://www.milliman.com/uploadedFiles/insight/2018/MA-Supplemental-Benefits.pdf. Accessed October 8, 2019.

9. Creighton S, Young J. Medicare Advantage plans will see a jump in new supplemental benefit offerings in 2019. Washington D.C.: Avalere Health; October 19, 2018. https://avalere.com/press-releases/medicare-advantage-beneficiaries-will-see-a-jump-in-new-supplemental-benefit-offerings-in-2019. Accessed October 8, 2019.

10. Skopec L, Ramos C, Aarons J. Are Medicare Advantage plans using new supplemental benefit flexibility to address enrollees' health-related social needs? Urban Institute; September 2019. https://www.urban.org/research/publication/are-medicare-advantage-plans-using-new-supplemental-benefit-flexibility-address-enrollees-health-related-social-needs-0. Accessed October 8, 2019.

11. Meyers DJ, Durfey SNM, Gadbois EA, Thomas KS. Early Adoption of New Supplemental Benefits by Medicare Care Advantage Plans. *JAMA*. 2019;321(22):2238–2240.

12. Thomas KS, Durfey SNM, Gadbois EA, et al. Perspectives of Medicare Advantage Plan Representatives on Addressing Social Determinants of Health in Response to the CHRONIC Care Act. *JAMA Netw Open*. Published online July 12, 2019;2(7):e196923.

13. Centers for Medicare & Medicaid Services. Medicare Advantage Plans Cover all Medicare services. Medicare.gov Web site. https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services. Accessed October 8, 2019.

14. Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, S 870 115th Congress, 1st Sess (2017).

15. Willink A, DuGoff EH. Integrating Medical and Nonmedical Services—The Promise and Pitfalls of the CHRONIC Care Act. *N Engl J Med*. 2018 Jun 7;378(23):2153-2155.

16. Centers for Medicare & Medicaid Services. Reinterpretation of the Uniformity Requirement. Baltimore, MD: Centers for Medicare & Medicaid Services; April 27, 2018. https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Uniformity-Requirements-4-27-18.pdf. Accessed October 8, 2019.

17. Centers for Medicare & Medicaid Services. Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Centers for Medicare & Medicaid Services; April 1, 2019. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf. Accessed October 16, 2019.

18. Centers for Medicare & Medicaid Services. Implementing Supplemental Benefits for Chronically Ill Enrollees. Baltimore, MD: Centers for Medicare & Medicaid Services; April 24, 2019. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf. Accessed October 8, 2019.

19. Medicare Managed Care Manual Chapter 16-B: Special Needs Plans. Centers for Medicare & Medicaid Services Web site. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf. Accessed October 8, 2019.

20. Benefits Data. Centers for Medicare & Medicaid Services Web site. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Benefits-Data.html. Modified October 17, 2013. Accessed October 8, 2019.

21. Center to Advance Palliative Care. About Palliative Care. Center to Advance Palliative Care Web site. https://www.capc.org/about/palliative-care/. Accessed October 14, 2019.

22. National Institute on Aging. What are Palliative Care and Hospice Care? U.S. Department of Health and Human Services Web site. https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care. Reviewed May 17, 2017. Accessed October 14, 2019.

23. Centers for Medicare & Medicaid Services. Hospice Care. Medicare.gov Web site. https://www.medicare.gov/coverage/hospice-care. Accessed October 14, 2019.

24. Medicare Advantage Value-Based Insurance Design Model. Centers for Medicare & Medicaid Services Web site. https://innovation.cms.gov/initiatives/vbid/. Updated July 30, 2019. Accessed October 8, 2019.

25. 2010 Census Urban and Rural Classification and Urban Area Criteria. United States Census Bureau Web site. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html. Updated November 26, 2018. Accessed October 8, 2019.

26. Jacobson G, Damico A, Neuman T. A Dozen Facts About Medicare Advantage. San Francisco, CA: Henry J Kaiser Family Foundation; November 2018. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/. Accessed October 8, 2019.

27. Medicare Advantage. Henry J Kaiser Family Foundation; June 6, 2019. https://www.kff.org/medicare/fact-sheet/medicare-advantage/. Accessed October 9, 2019.

28. North Carolina Medicaid. Healthy Opportunities Pilots Fact Sheet. North Carolina Department of Health and Human Services; November, 2018. https://files.nc.gov/ncdhhs/SDOH-HealthyOpptys-FactSheet-FINAL-20181114.pdf. Accessed October 16, 2019.

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