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Expansion of Medicare Advantage Supplemental Benefits: A New World of Opportunities for Providers

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Hospitals, health systems, provider groups, and residential and community-based long-term care providers (collectively, "Providers") should revisit their relationships with Medicare Advantage plans ("MA Plans") in light of recent federal legislative and regulatory developments in the rules related to Medicare Advantage supplemental benefits.[1] In particular, Providers should consider how they can partner with MA Plans operating in the Florida market to jointly offer new categories of supplemental benefits, including offering new types of support services for people with chronic conditions and services targeting populations with certain diagnoses.

Regulatory Changes

The Centers for Medicare & Medicaid Services ("CMS") recently finalized Medicare Advantage regulatory changes ("Final Rule") that allow MA Plans to offer "targeted"

[1] Regulatory changes include the following: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Final Rule (83 FR 16440), *available at*: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07179.pdf; and the Announcement of Calendar Year 2019 MA Capitation Rates and MA/PD Payment Policies and Final Call Letter ("Final Call Letter"), *available at*: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf. The important legislative change was through the Bipartisan Budget Act of 2018 (H.R. 1892), *available at*: https://www.congress.gov/bill/115th-congress/house-bill/1892/text.

supplemental benefits that are medically related to a specific disease condition, provided that a plan continues to comply with the non-discrimination requirements. MA Plans are now allowed to choose which diagnoses or health conditions will be offered these targeted benefits, and they may vary such benefits at the county level. Under the Final Rule, MA Plans are also expressly allowed to have different cost sharing for benefits covered by specific providers. It will be important for MA Plans to identify in their bids and in their Evidence of Coverage documents, which supplemental benefits are offered as "standard" or "targeted" supplemental benefits.

Legislative Changes

The Bipartisan Budget Act of 2018 expands the changes from the Final Rule further to allow for supplemental benefits targeting beneficiaries with specific chronic conditions. The biggest change from the Bipartisan Budget Act of 2018 is that these chronic-condition-targeted supplemental benefits do not need to be expressly health-related, provided that the services "have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee." This is a new exception to the long-standing medical necessity rules for Medicare Advantage and allows MA Plans to design supplemental benefits that address social determinants of health and, in some cases, appear more like traditional long-term care services.

Implications for Providers

The new flexibility in the scope and design of supplemental benefits gives Providers new business opportunities to offer a full spectrum of newly reimbursable services. The new supplemental benefit rules will create new streams of funding for services targeting high-risk populations and for non-medical services that can help reduce unnecessary utilization. In addition, because supplemental benefits are not subject to network adequacy requirements, they can be covered through a single Provider. This allows for a new focus on "single source" care where plan members may seek care from a Provider for all of their services, supplemental and otherwise.

MA Plans are interested in partnering with sophisticated providers for the supplemental benefit offerings. Providers should consider the populations they currently serve, or can serve, and explore which supplemental service offerings best align with their care model and competencies. Providers should then take a proposal to the MA Plans in their region. Although MA Plans will not be able to implement the new supplemental benefits created by the Bipartisan Budget Act of 2018 until plan year 2020, MA Plans will be submitting bids defining these services in less than a year. Considering the timeline for implementing projects like this, Providers should immediately begin assessing the potential for their market and work with experienced Medicare Advantage counsel to begin discussions with MA Plans as soon as possible.

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