



## **Uniformity Requirements and Benefit Flexibility Changes Highlights**

(Key excerpts from CMS MA rule, 2019 ANCL and CMS guidance memos issued 4-27-2018.)

**This paper summarizes CMS’ recently issued policies and guidance revising its uniformity of benefit requirements and its definition of the term “primarily health related” as it applies to supplemental health benefits. This paper also summarizes changes made by the Bipartisan Budget Act of 2018 to expand the VBID demonstration and to allow MA plans to offer supplemental benefits that are not “primarily health related” to enrollees who are chronically ill. As part of the recent rulemaking process, the SNP Alliance raised several questions that CMS has said they will address in future subregulatory guidance (i.e., Manual chapter revisions). Those outstanding issues are noted at the end of this paper.**

### **I. Uniformity Requirements Flexibility** (from the CMS “Reinterpretation of the Uniformity Requirement” memo 4-27-2018)

As announced in the 2019 Call Letter and newest MA regulations, CMS is reinterpreting its uniformity requirements starting with the 2019 bids. CMS determined that providing access to services (or reductions in specific cost sharing and/or deductibles for services or items) that are tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in the MA regulations at §422.100(d). The guidance will be incorporated into the Medicare Managed Care Manual, Chapter 4.

These targeted benefits must provide for equal treatment of enrollees with the same health status or disease state for whom such services and benefits are useful and consistent with equal access and anti-discrimination provisions in section 1852 of the Act. The requirement for uniform bids and premiums in section 1854(c) of the Act remains applicable, and therefore, plan premium and Part B premium buy-down amounts must be the same for all enrollees in the plan or plan segment. CMS’s reinterpretation of the uniformity requirements applies only to Part C benefits.

Coverage requests from enrollees and providers related to targeted benefits should not be treated differently from requests for other benefits furnished by an MA plan. If a request concerning coverage of an item or service submitted to a plan fits within one of the actions defined as an organization determination under 42 CFR §422.566(b), then the MA plan must treat the request as an organization determination. If a request is an organization determination under 42 CFR §422.566(b), then the coverage decision is subject to the Subpart M appeals process. (This provision also applies to the changes in Health Related Supplemental Benefits outlined below.)

CMS notes that MAOs may also vary premium, cost sharing, and supplemental benefits within each segment of an MA plan’s service area. Plan segments are defined in the MA regulations at §422.262(c)(2). Although an MA plan may segment Part C benefits, if the plan offers Part D it must offer the Part D benefit uniformly within the plan’s service area including any segments.

The cost sharing and benefit flexibility must be furnished uniformly to plan enrollees that are similarly situated (that is, all plan enrollees who are diagnosed with the identified, specified health status or disease state(s) are treated the same and enjoy the same access to these targeted benefits). Section 1852(b)(1)(A)

prohibits an MA plan from denying, limiting, or conditioning the coverage or provision of a service or benefit based on health-status related factors. CMS will review benefit designs to make sure that the overall impact of the benefit design is non-discriminatory and that higher acuity, higher cost enrollees are not being excluded from these targeted benefits in favor of healthier populations. Organizations must ensure that the cost sharing reductions and targeted supplemental benefits only apply to healthcare services that are medically related to each health status or disease state. CMS will not permit cost sharing reductions across *all* benefits for an enrollee; cost sharing reductions must be for specific benefits or services related to a specific health status or disease state.

Consistent with other benefits, CMS expects plans to follow Medicare marketing guidelines in communicating these benefits to potential enrollees. For example, plans may include these benefits in the Summary of Benefits. Specific instructions related to uniformity flexibility have been included in the Annual Notice of Changes/Evidence of Coverage (ANOC/EOC) model materials to summarize information in the benefits chart. This will serve as the required communication of targeted benefits to potential enrollees.

Organizations offering targeted benefits are responsible for clearly identifying the clinical categories selected by an organization using ICD-10 codes. Plans are encouraged to select ICD-10 codes that map to the CMS Hierarchical Condition Category (HCC) risk-adjustment model when defining the targeted conditions. Targeted benefits offered under MA Uniformity Flexibility should be entered in PBP service category B19 VBID/MA Uniformity Flexibility. Plans have the option to create up to 15 separate disease state packages under B19a Reduced Cost Sharing for VBID/MA Uniformity Flexibility, and also under B19b Additional Benefits for VBID/MA Uniformity Flexibility. Plans may choose from the list of disease states identified, or may select “other” and clearly describe up to five additional disease states for which the plan chooses to offer targeted benefits.

Plans that target benefits for the disease states identified in the PBP are not required to cover all ICD-10 codes associated with the disease, but may offer targeted benefits to a subset of diagnoses within the targeted condition. Organizations also may identify combinations of clinical conditions and establish targeted benefits for each group using objective measurable medical criteria to identify eligible enrollees. Social determinants may not be used as a means to target benefits, even those benefits related to health. Enrollees must be diagnosed by a plan physician/medical professional or have their existing diagnosis certified or affirmed by a plan physician/medical professional. Eligible enrollees cannot be required to opt-in, unless there is a prerequisite for participation in a wellness or care management program.

Organizations may select from two types of targeted benefit offerings: reduced cost sharing and additional supplemental benefits. An organization may vary benefits from one target population to another and from one PBP to another. However, organizations may not reduce benefits or increase cost sharing for targeted enrollees, as compared to the base benefits offered to all enrollees in the plan year.

#### *Reduced Cost Sharing*

Organizations can choose to reduce or eliminate cost sharing or deductible amounts for items or services for the target population. Organizations have flexibility to choose the items or services that are eligible for cost sharing reductions. However, there must be some relationship between the health status or disease state and the specific benefit package designed for enrollees meeting that health status or disease state. For example, uniformity flexibility will allow an MA plan to offer an enrollee with diabetes reduced cost sharing for endocrinologist visits;

The items or services must be clearly identified and defined in the bid, and reductions in cost sharing must be available to all enrollees within the target population. Reductions in cost sharing could include elimination or reduction of copays, coinsurance, deductibles, and/or exemption of a given service from

the plan or service category deductible. If the targeted cost sharing benefit structure differs from the base plan benefit structure (e.g. the base benefit is coinsurance but the targeted benefit is copay), the organization must apply the cost sharing benefit that results in the lowest out-of-pocket cost to the enrollee.

#### *Additional Supplemental Benefits*

Organizations may offer certain supplemental benefits to targeted populations only, so long as the benefits are consistent with existing rules for supplemental benefits. Examples might include: nonemergency transportation to primary care visits for enrollees with CHF, and additional sessions of tobacco use cessation counseling for enrollees with COPD (See Managed Care Manual, Ch. 4, section 30 for additional guidance on supplemental benefits). Targeted supplemental benefits must be health care items or services that are medically related to the health status or disease state of the targeted enrollees.

Organizations have the option of limiting targeted benefits to enrollees who agree to participate in a plan-sponsored wellness, care management, or similar program as long as there is equal access to the disease management program based on objective criteria related to the health status or disease state.

Organizations using this approach can condition cost sharing reductions or access to targeted supplemental benefits on enrollees meeting certain milestones based on participation. However, plans cannot make cost sharing reductions or access to targeted supplemental benefits conditional on achieving any specific clinical goals. Organizations also may choose to offer targeted benefits to enrollees when they visit providers identified by the plan as being high-value. Plans also may vary their approach by target population, provider type, or certain services.

These benefits will be treated as mandatory supplemental benefits and are subject to the same rules as any other benefit in that service category. Although these benefits are available only to certain clinically-targeted enrollees, they are funded by rebate and/or premium dollars from all PBP enrollees.

Additional instructions for completing the PBP section B19 can be found in the Bid Submission User Manual for Contract Year 2019, Chapter 4. Policy questions related to the information in this memorandum, may be submitted at: <https://dpap.lmi.org/dpapmailbox/>.

## **II. Health Related Supplemental Benefits** (from 2019 NCL and CMS memo “Reinterpretation of “Primarily Health Related” for Supplemental Benefits”, April 27, 2018)

Beginning in CY 2019, CMS is expanding the definition of “primarily health related” to consider an item or service as primarily health related 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. A supplemental benefit is **not** primarily health related under the previous or new definition if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes. In order for CMS to approve a supplemental benefit, the benefit must focus directly on an enrollee’s health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one. Coverage requests from enrollees or providers, including requests for supplemental benefits, should be treated the same as requests for other benefits furnished by a plan.

Organizations are responsible for clearly identifying what will and will not be covered and any limitations in the plan’s Evidence of Coverage (EOC). Organizations are encouraged to provide explanations to establish how a supplemental benefit, particularly a new or novel benefit, is primarily health related or how coverage of an item or service will be limited to when it is primarily health related. CMS also reminds organizations that supplemental benefits cannot include items or services used to induce enrollment.

In its guidance, CMS cites as an example “some items and 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)”. The guidance provides a list of possible supplemental benefit examples, but notes that the list is not exhaustive. The list includes: health related adult day care including certain social services, meals and transportation; home based palliative care not covered by Medicare under hospice for those with life expectancies over 6 months; in home support service such as personal care consistent with state requirements; caregiver support such as short term respite care in the home or institution; medically approved non-opioid pain management; stand-alone memory fitness benefit; home and bathroom safety devices and modifications including installation, (but not structural improvements to the home); transportation for health related purposes such as doctor’s visits, including for a home health aide for assistance; over the counter medications and devices such as pill cutters and activity trackers;

CMS also states that all benefits, with the exception of in-home food delivery for certain dual eligible special needs plans (D-SNPs) under the current benefit flexibility policy at 42 CFR § 422.102(e), will now be available to all MA plans under the expanded health related definition. This change will be incorporated into the next version of Chapter 16b of the Medicare Managed Care Manual.

### **III. Expansion of Supplemental Benefits Available to Chronically Ill Enrollees (from CMS statements in the new Medicare rule)**

The Bipartisan Budget Act of 2018 expands supplemental benefits available to chronically ill enrollees effective CY 2020 to include benefits that “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.” These additional supplemental benefits will be qualitatively different than the supplemental health care benefits that MA plans may currently offer and may continue to offer to enrollees who are not chronically ill. Because the new benefits will not be limited to the primarily health related standard, it is possible for certain offerings to address issues beyond a specific medical condition, such as social supports. However, the basis for offering the new benefits will be based solely on an enrollees’ qualification as “chronically ill” and may not be based on conditions unrelated to medical conditions, such as living situation and income. In addition, this provision provides authority for the waiver of uniformity requirements “only with respect to supplemental benefits provided to a chronically ill enrollee.”

Beginning in 2020, MA plans may offer three forms of supplemental benefits: “standard” supplemental benefits offered to all enrollees; “targeted” supplemental benefits offered to qualifying enrollees by health status or disease state; and “chronic” supplemental benefits offered to the chronically ill. The first two (standard and targeted) will be allowable in 2019. Only “chronic” supplemental benefits will be evaluated under the new expansive definition in the Bipartisan Budget Act and be eligible for a waiver of the uniformity requirements. Standard and targeted supplemental benefits will be evaluated under the existing interpretation of whether the benefit is “primarily health related.”

It is possible that an enrollee qualifies for a “targeted” supplemental benefits as well as “chronic” supplemental benefits. In that circumstance, the MA plan must provide the targeted supplemental benefits as long as the enrollee establishes the required health status or disease state and the benefits are medically appropriate. However, the MA plan must only provide “chronic” supplemental benefits if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

Based on these differences, it will be important for MA plans to identify in their 2020 bids and in their Evidences of Coverage documents which supplemental benefits are offered as “standard”, “targeted”, or “chronic” benefits.

#### **IV. Value Based Insurance Design Model (from 2019 ANCL, MA rule and CMS Uniformity Flexibility Memo 4-27-2018)**

Separately, CMS continues to test value based insurance design (VBID) through the use of demonstration authority under Section 1115A of the Act (42 U.S.C. 1315a, added by Section 3021 of the Affordable Care Act), which includes some of the elements discussed in the Uniformity memo. The MA-VBID demonstration, currently administered by the Center for Medicare and Medicaid Innovation (CMMI) is testing whether the flexibility to offer clinically-nuanced VBID elements in MA plan benefit designs will lead to improved health outcomes and lower expenditures for MA enrollees.

There are features of the MA-VBID demonstration that are unique to the demonstration test, such as the ability to lower cost sharing or design interventions for Part D benefits. In addition, the MA-VBID demonstration has additional model requirements including an application prior to bid submission, geographic limitations for plan offerings in CY 2019, and requiring three years’ experience prior to participation in the demonstration. The reinterpretation of uniformity discussed in the CMS Uniformity memorandum is not subject to VBID demonstration requirements and plans must reflect benefit costs as described in MA bidding guidance issued annually by the Office of the Actuary.

In the MA rule preamble, CMS points out that the Bipartisan Budget Act of 2018 also requires a nationwide revision of VBID test model currently administered by the Center for Medicare and Medicaid Innovation (CMMI). It further expands the testing of the model under section 1115A (b) to all 50 states by 2020. CMS states that beginning in 2019, the VBID model will expand to an additional fifteen new states for a total of 25 states, allow Chronic Condition Special Needs Plans to participate, and allow participants to propose their own systems or methods for identifying eligible enrollees.

#### **V. Issues CMS Will Address in the Future (from MA rule)**

The SNP Alliance raised several issues to CMS in its comments to the proposed rule that CMS stated it would address in future guidance. One comment was a request that CMS include a statement that C–SNPs would automatically be permitted to adjust benefits and cost sharing based on the eligibility groupings that CMS has approved for each C–SNP. CMS responded by stating that it will update sub-regulatory guidance to clarify the impact of both this reinterpretation and the Bipartisan Budget Act on SNP policy

The SNP Alliance also asked CMS to clarify how the additional benefit flexibility for highly integrated dual eligible special needs plans (D–SNPs), as outlined in Chapter 16b of the Medicare Managed Care Manual, is affected by these new provisions. CMS stated that Chapter 16b and any corresponding guidance will be updated to clarify any impact this reinterpretation has on D–SNP policy. Finally, CMS noted our comment asking CMS to allow plans to provide certain supplemental benefits only to fully integrated D–SNP (FIDE SNP) enrollees who do not meet nursing home level of care requirements that would otherwise make them eligible for home and community-based services under an Elderly Waiver. CMS responded by stating that it will update sub-regulatory guidance to clarify the impact of both this reinterpretation and the Bipartisan Budget Act on D–SNP policy.

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