Challenges and Opportunities in Caring for High-Need, High-Cost Medicare Patients:

BPC Preliminary Findings and Policy Options

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BIPARTISAN POLICY CENTER

HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, BPC's Health Project seeks to develop bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The Health Project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

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GLOSSARY OF ACRONYMS

ACO: Accountable Care Organization

APM: Alternative Payment Model

CMF: Care Management Fee

CMMI: Center for Medicare and Medicaid Innovation

CMP: Civil Money Penalty

CMS: Centers for Medicare and Medicaid Services

CMS-HCC: CMS-Hierarchical Condition Categories

CPCP: Comprehensive Primary Care Payment

CPC Plus: Comprehensive Primary Care Plus

D-SNPs: Dual-Eligible Special Needs Plans

E&M: Evaluation & Management

FFS: Fee-for-Service

GRACE: Geriatric Resources for Assessment and Care for Elders

LTSS: Long-Term Services and Supports

MA: Medicare Advantage

MANNA: Metropolitan Area Neighborhood Nutrition Alliance

MLR: Medical Loss Ratio

MSSP: Medicare Shared Savings Program

PAC: Post-Acute Care

PACE: Programs for All-Inclusive Care for the Elderly

PBPM: Per Beneficiary Per Month

Executive Summary

As policymakers work to develop and implement program-wide health care delivery system reforms in Medicare, high-need, high-cost beneficiaries and individuals with multiple chronic conditions have been a population of particular focus. Academic and clinical research suggests that for high-need, high-cost patients—particularly frail and elderly individuals with complex conditions—the application of non-clinical interventions and other social supports, many of which are not covered under the traditional Medicare benefit, can improve health outcomes and reduce the need for expensive acute care services. The Centers for Medicare and Medicaid Services (CMS) has also recognized the importance of many of these services and supports.

In many instances, Medicare regulations and payment approaches can serve as barriers for health plans and providers that might otherwise seek to furnish and finance health-related non-clinical supports and services for high-need, high-cost Medicare-only individuals. Over the course of 2016, the Senate Finance Committee's Chronic Care Working Group—led by Committee Chairman Orrin Hatch (R-UT), Ranking Member Ron Wyden (D-OR), Senator Johnny Isakson (R-GA), and Senator Mark Warner (D-VA)—sought input from stakeholders on ways to alleviate barriers to care improvement for high-need Medicare beneficiaries with chronic conditions. Many of these barriers are addressed in this report.

In this report, the Bipartisan Policy Center provides a review of current regulatory, payment, and other perceived barriers for both health plans and for risk-bearing alternative payment model (APM) organizations seeking to provide health-related interventions and social supports—which are not covered under the traditional Medicare Part A or Part B benefit—for "Medicare-only"[a] individuals with multiple chronic conditions and functional or cognitive impairments.

Specific care models analyzed in this report include:

- Medicare Advantage (MA) plans
- MA Dual-Eligible Special Needs Plans (D-SNPs)
- Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)
- Next Generation (NextGen) ACOs
- Comprehensive Primary Care Plus (CPC Plus) Model Participants
- Programs for All-Inclusive Care for the Elderly (PACE) Organizations

BPC's regulatory research suggests that five principal policy issues could present limitations on the ability of MA plans, ACOs, and CPC Plus participants to furnish non-Medicare-covered health-related support interventions to Medicare-only individuals: (1) uniform benefit requirements for MA plans, (2) benefit-specific restrictions on MA plans' supplemental benefit offerings, (3) rules governing the calculation of Medical Loss Ratios (MLRs) for MA plans, (4) program integrity rules relating to beneficiary inducements and the Anti-Kickback Statute, and (5) uncertainty in the adequacy of Medicare financing.

For each of these barriers, BPC staff have suggested potential policy options, discussed in detail in the Next Steps section of this report. The appendix includes a table outlining barriers identified. BPC will issue final recommendations in April of 2017. BPC welcomes comments on these policy options and related policy questions.

[a] This report refers to Medicare beneficiaries who are not dually eligible for Medicaid as "Medicare-only" individuals.

Introduction

As policymakers work to develop and implement program-wide health care delivery system reforms in Medicare, high-need, high-cost beneficiaries and individuals with multiple chronic conditions have been a population of particular focus. In 2010, 37 percent of Medicare beneficiaries had four or more chronic conditions.[1] These beneficiaries accounted for 90 percent of Medicare hospital readmissions in 2010.[2] Medicare patients with four or more chronic conditions also comprised 74 percent of Medicare program spending in 2010. In addition to much higher levels of hospitalizations, emergency department visits, and hospital readmissions, Medicare beneficiaries with four or more chronic conditions also had disproportionately high utilization of post-acute care (PAC) services.[3] "Medicare-only"[b] individuals with six or more chronic conditions incurred $30,109 in Medicare costs on average in 2010,[4] or nearly three times the overall average Medicare per capita spending amount for 2010. Recent analyses also suggest that the presence of functional or cognitive impairment can be a strong predictor of a beneficiary's health care needs and Medicare costs.[5] These impairments can compound risks for high Medicare spending among beneficiaries with chronic conditions, as beneficiaries with functional impairment and one or more chronic conditions have Medicare expenses that are more than three times as high as Medicare beneficiaries who have chronic conditions, but do not have functional impairment.[6]

Academic and clinical research suggests that for high-need, high-cost patients—particularly frail and elderly individuals with complex conditions—the application of non-clinical interventions and other social supports to address social determinants of health can improve health outcomes and reduce the need for expensive acute care services.[7] Such interventions can include in-home meal delivery, supportive housing and home modifications, non-emergent medical transportation to medical appointments, targeted care management, and personal care services or other home- or community-based assistive services to address functional impairment.[8]

The Centers for Medicare and Medicaid Services (CMS) has also recognized the importance of many of these services and supports. Through the Accountable Health Communities model, the CMS Center for Medicare and Medicaid Innovation (CMMI) is testing the efficacy of supplying grant funding to providers and community organizations that will screen patients for social determinants of health-related needs and connect applicable in-need patients with community-based social support providers and organizations.[9] Providing this navigational support to help at-risk beneficiaries identify non-clinical support and service needs and connect with community support organizations is an important step in addressing the clinical disparities that stem from social determinants of health for the high-need, high-cost[c] Medicare-only population. However, CMMI explicitly prohibits the Accountable Health Communities model participants from using any grant funding under the program to finance the actual delivery of the needed supports and services.[10]

In many instances, Medicare regulations and payment approaches can serve as barriers for health plans and providers that might otherwise seek to furnish and finance health-related non-clinical supports and services for high-need, high-cost Medicare-only individuals. Over the course of 2016, the Senate Finance Committee's Chronic Care Working Group—led by Committee Chairman Orrin Hatch (R-UT), Ranking Member Ron Wyden (D-OR), Senator Johnny Isakson (R-GA), and Senator Mark Warner (D-VA)—sought input from stakeholders on ways to alleviate barriers to care improvement for high-need Medicare beneficiaries with chronic conditions. This important work resulted in the introduction of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016, which would help to break down the barriers faced by Medicare Advantage plans and other providers. Many of the barriers identified by the working group are discussed in more detail below.

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[b] This report refers to Medicare beneficiaries who are not dually eligible for Medicaid as "Medicare-only" individuals.

[c] For the purposes of this report, a "high-need, high-cost Medicare-only beneficiary" refers to a Medicare beneficiary who is not dually eligible for Medicaid and who has: (1) multiple chronic conditions, and (2) functional impairment in the performance of activities of daily living or instrumental activities of daily living, or a cognitive limitation.

In this report, the Bipartisan Policy Center provides a review of current regulatory, payment, and other perceived barriers for both health plans and for risk-bearing alternative payment model (APM) organizations seeking to provide health-related interventions and social supports—which are not covered under the traditional Medicare Part A or Part B benefit—for Medicare-only individuals with multiple chronic conditions and functional or cognitive impairments.

Applicable Payment and Care Models

This report focuses its analysis on payment models that require an assumption of financial risk on the part of the participating entity for the cost of Medicare-covered services for a beneficiary over the course of an entire year, rather than a limited-duration episode of care. The report focuses on these models because risk assumption by participants of these models creates unique incentives for the participants to appropriately furnish non-clinical supports and services not covered by Medicare Part A or Part B to high-need, high-cost Medicare beneficiaries in a manner that would reduce the risk of expensive hospitalizations and utilization of other acute care and PAC services.

Specific care models analyzed in this report include:

- Medicare Advantage (MA) plans
- MA Dual-Eligible Special Needs Plans (D-SNPs)
- Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)
- Next Generation (NextGen) ACOs
- Comprehensive Primary Care Plus (CPC Plus) Model Participants
- Programs for All-Inclusive Care for the Elderly (PACE) Organizations

Under the Medicare Access and CHIP Reauthorization Act of 2015, landmark changes to Medicare physician payment rules will encourage greater physician participation in, and the expansion of, risk-bearing APMs. This ongoing transition toward risk-based, value-driven provider payment models heightens the importance of ensuring better integration of non-Medicare-covered health-related supports and services into the new care delivery approaches.

Medicare Advantage

In 2016, the MA program provided health insurance coverage to roughly 18 million Medicare beneficiaries, or approximately 31 percent of the Medicare population.[11] Although D-SNPs are themselves MA plans, many D-SNPs are subject to different rules regarding the provision of non-Medicare-covered services and supports, and they are, by design, tailored to Medicare-Medicaid "dual-eligible" individuals rather than Medicare-only individuals. For these reasons, rules applicable to D-SNPs are discussed separately in the next subsection of this report.

Standard MA plans agree to accept capitated payments per-beneficiary for the total cost of Medicare Part A and Medicare Part B-covered services incurred by each enrolled beneficiary. Each year, as a part of annual contracting with CMS, MA plans submit bids that equate to each plan's expected per-enrollee cost of covering Part A and Part B benefits. Those bids are then measured against the county-level or regional "benchmark" that is derived from Medicare Fee-for-Service (FFS) per-beneficiary

spending.[d] To the extent that the county or regional benchmark exceeds the MA plan's bid, the plan will receive a portion of the difference as a "rebate" in addition to the bid amount, as a part of the per-beneficiary capitated payment. However, the MA plans are then required to use the rebate dollars to provide "supplemental benefits," such as reduced premiums or cost-sharing for Part A and Part B services, or coverage of additional benefits that are not covered under Part A or Part B.[e]

For supplemental benefits that are financed through rebate dollars, referred to as "mandatory supplemental benefits," the Medicare statute and regulations require that the supplemental benefits be uniformly available to all enrollees.[f] When an MA plan offers a supplemental benefit whose expected costs exceed the rebate amount, the plan may charge a uniform additional premium (beyond the standard Medicare Part B premium) across all plan enrollees. By contrast, an MA plan can also offer "optional supplemental benefits" that are financed solely by additional premiums paid by beneficiaries who wish to purchase the enhanced benefit coverage. These optional supplemental benefits only need to be provided to beneficiaries who elect to purchase the benefit through their payment of the additional premiums. Optional supplemental benefits cannot be financed through rebate dollars.

MA Dual-Eligible Special Needs Plans

As a special category of MA plans, D-SNPs were developed as a means of better coordinating Medicare and Medicaid benefits for dual-eligible beneficiaries.[12] Like other MA plans, for Medicare benefits, D-SNPs submit bids that are equivalent to their expected per-enrollee costs of providing Medicare Part A- and Medicare Part B-covered services. D-SNPs are also paid based on a capitation rate that is tied to the Medicare FFS "benchmark" per-beneficiary spending in their county or regional service areas. Like standard MA plans, D-SNPs must allocate any surplus—by which benchmark-based capitation payments exceed the bid amount—toward premium reductions, cost-sharing reductions, or supplemental service offerings. However, D-SNPs that meet a high standard of integration and specified performance on quality-based standards are permitted to offer supplemental benefits beyond those currently permitted for MA plans.[13] Program specifics on this supplemental benefit flexibility can be found below, in the "Medicare Advantage-Specific Issues" section of this report, as well as in the Appendix.

D-SNPs are required to help coordinate enrollees' Medicaid-covered services, and may (but are not currently uniformly required to) have contracts with a State Medicaid Agency to accept capitation payments for the coverage of the enrollee's Medicaid benefits.[14]

Additional details regarding the D-SNP model of care and other elements of the D-SNP program can be found in BPC's September 2016 report, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*.

Accountable Care Organizations

First launched as a Medicare payment model in 2011, ACOs are provider-led or organized entities that agree to coordinate services across the continuum of care for Medicare FFS beneficiaries that are "attributed" to the ACO. A beneficiary's

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[d] Certain plans that achieve threshold performance on quality metrics under the MA Star Ratings System also receive additional quality bonuses that are incorporated into the benchmark rate.

[e] By contrast, if the MA plan's bid exceeds the applicable per-beneficiary benchmark for the service area, the MA plan must charge the enrolled beneficiaries an additional premium amount (beyond the otherwise applicable Part B premium) to cover the excess cost.

[f] Note: In some instances, MA plans may provide limits on the conditions or circumstances that trigger the coverage of the mandatory supplemental benefit. For instance, MA plans may require a diagnosis of specific targeted chronic condition, such as diabetes, before a beneficiary qualifies for coverage of enhanced disease management as a mandatory, rebate-financed, supplemental benefit.

attribution to the ACO is based upon the beneficiary's utilization of primary care services from applicable ACO providers.[g] ACOs are then paid based upon whether actual combined Part A and Part B spending per attributed beneficiary exceeds the ACO's risk-adjusted per-beneficiary spending benchmark. These spending benchmarks are based on historical beneficiary-specific costs of care. When an ACO holds per-beneficiary spending below the benchmark, the ACO shares with CMS in the resulting savings. For certain "tracks" of ACO models, instances in which the ACO fails to hold per-beneficiary spending below the benchmark can result in the ACO sharing with CMS in the "losses" and being required to pay back a portion of the excess costs to CMS.

As of 2015, 7.7 million Medicare beneficiaries, or roughly 21 percent of Medicare FFS beneficiaries and 14 percent of the overall Medicare population, were attributed to and receiving care from an ACO.[15]

As the most widespread ACO model and one of the most prominent Medicare APMs in operation, the MSSP provides three different payment "tracks" through which ACOs can participate. Track One provides an ACO with the opportunity to share in savings when actual costs are held below the benchmark, while not subjecting the ACO to "downside risk" for repayment of expenses when the actual costs exceed the benchmark.[16] By contrast, Track Two requires that the ACO assume downside risk for repaying a portion of excess expenses when actual costs exceed the pre-set benchmark, but it offers the ACO a greater share of the savings amounts (compared with Track One) when costs are held below the benchmark. Finally, Track Three requires that the ACO assume a greater level of downside risk than Track Two ACOs, but it also offers the MSSP's highest sharing rates for shared savings.[17]

The separate NextGen ACO model that is being tested at CMMI provides for even greater shares of savings than anything available in the MSSP, with corresponding higher requirements for ACO assumption of risk for losses, while also establishing options for capitation arrangements.[18] Consistent with BPC recommendations from 2015, CMS allows NextGen ACO model participants to develop specific rewards for beneficiaries who seek care from the ACO's providers, and authorizes the development of preferred provider networks for providers that contractually partner with (but do not participate in) the ACO.

Comprehensive Primary Care Plus

Launched in 2016, the CPC Plus model provides participating primary care practices with a series of monthly per-beneficiary payments that are made either in lieu of, or in addition to, FFS payments for primary care services.[19] These payments are designed to help primary care practices finance care coordination for aligned beneficiaries, which could ideally result in reductions in overall utilization of services reimbursed under FFS payment approaches. The monthly payments include a Care Management Fee (CMF) that is provided on a per-beneficiary basis to help pay for the costs of care coordination activities. Practices also receive a Performance-Based Incentive Payment that is paid in advance on a per-beneficiary basis each month to all CPC Plus participants, but it is only retained by participants that achieve clinical quality and utilization efficiency benchmarks. By contrast, at the end of the performance year, CMS recoups the incentive payment from practices that fail to meet the quality and utilization standards.

Finally, CPC Plus participants that elect to participate in "Track Two"[h] of the model also receive a Comprehensive Primary

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[g] Note: In some instances, Medicare beneficiaries are able to voluntarily attest to being attributed to a particular ACO in advance, irrespective of their actual utilization of primary care services from ACO providers.

[h] Note: In contrast to Track Two, Track One participants in the CPC Plus model only receive the CMF and Performance-Based Incentive Payments, but they do not agree to bear financial risk through the reduction of otherwise applicable Medicare FFS payment rates for E&M services. These Track One participants do not receive monthly CPCP amounts.

Care Payment (CPCP) on a per-beneficiary per-month (PBPM) basis. The CPCP is designed to equate to a set percentage of the primary care practice's historical PBPM revenue for evaluation and management (E&M) services under FFS, while FFS payments going forward are reduced by the same percentage.[20] For example, a primary care practice could receive a CPCP equal to 40 percent of its historical monthly FFS revenue for E&M services and then have Medicare FFS payments for E&M services reduced to equal 60 percent of the otherwise applicable payment rates.

The CPC Plus model is being tested in 14 states over the course of a five-year period, beginning in 2017.

Programs for All-Inclusive Care for the Elderly

As a longstanding and permanently authorized Medicare and Medicaid payment model, PACE organizations provide comprehensive care and services for enrolled beneficiaries who are at least 55 years old, are certified as eligible for a nursing home level of care due to functional impairments, and are capable of living safely in the community.[21]

In many ways, the PACE model could be considered one of the first APMs, given its focus on community-based providers coordinating care for (and accepting financial risk for the costs of) complex Medicare and Medicaid beneficiaries. The PACE model of care incorporates adult health centers with an interdisciplinary team that includes a primary care physician, nurses, social workers, physical and occupational therapists, home care coordinators, personal care attendants, drivers, activity coordinators, and a PACE center manager.[22] Although Medicare/Medicaid "dual-eligible" individuals constitute a significant portion of enrollees in PACE, the PACE organizations can enroll frail Medicare-only individuals, to the extent that the Medicare-only beneficiaries can self-fund (through out-of-pocket financing) the Medicaid-covered services provided through the PACE model.

PACE organizations receive separate risk-adjusted capitation payments from the Medicare program, for Medicare-covered services, and from the Medicaid program, for Medicaid-covered services. For Medicare-only individuals, the beneficiary is required to pay the Medicaid capitation amount out-of-pocket.[23] PACE organizations are at full financial risk for the costs of care exceeding the capitation amounts. However, the PACE organizations also have the flexibility to provide any services or items that the interdisciplinary care team determines are necessary for improving and maintaining the beneficiary's health,[24] regardless of whether the services or items are covered benefits under Medicare or Medicaid.

As of December 2016, 37,500 individuals are served by the 122 PACE organizations currently operating across 32 states.[25]

Value of Health-Related Supports and Services

Recent research indicates that integration of non-clinical supports and services with traditional acute care and medical services can have an important impact on improving quality, optimizing efficiency, and reducing utilization of health care services.

For instance, investment in meal delivery for individuals with chronic conditions has been shown to result in lower hospitalization rates and reduced need for expensive facility-based PAC services. In a pilot study funded and performed by a Philadelphia-based nonprofit organization, the Metropolitan Area Neighborhood Nutrition Alliance (MANNA), researchers found that providing 21 home-delivered meals per week to selected individuals with severe chronic conditions resulted in 50 percent lower hospitalization rates and a 20 percent higher rate of hospital discharge to the home (rather than to a PAC facility) over the course of the year, compared with a risk-standardized control group with the same conditions.[26] Average monthly health care costs for patients receiving meal delivery under the MANNA pilot fell by 27 percent during the intervention period.[27] The provision of home-delivered nutritious meals for frail elderly patients also has a strong correlation with reduced utilization of expensive nursing facility services.[28] Integrated hospital systems, such as Steward Health Care in Massachusetts, have also begun to use targeted in-home meal delivery following hospital discharge—for certain high-risk patients with chronic conditions—as a tool for helping to reduce hospital readmissions.[29]

The lack of access to transportation to medical appointments can also present challenges to continuity of care, access to care, and quality outcomes, particularly for frail patients with chronic conditions. According to a 2012 study, roughly 25 percent of patients reported missing a medical appointment due to lack of access to transportation.[30] Other research demonstrated that coverage of non-emergent transportation services can yield as much as an 11-to-1 return on investment, accrued through savings from reductions in short-stay hospitalizations that can be prevented through medical transportation trips.[31]

Similarly, comprehensive care management for individuals with complex care needs can play a role in reducing avoidable hospitalizations and utilization of other high-cost Medicare-covered services. In the Geriatric Resources for Assessment and Care for Elders (GRACE) model established in Indiana, low-income elderly patients living in the community were provided with home-based care management by a nurse practitioner or social worker in concert with a geriatric interdisciplinary team. During the two-year assessment period, high-risk patients receiving care through the GRACE model were found to have lower emergency department visit rates and fewer hospital admissions, relative to a control group that received traditional primary care services without the home-based care management support.[32]

Barriers to the Integration of Health-Related Non-Clinical Supports and Services

BPC's regulatory research suggests that five principal policy issues could present limitations on the ability of MA plans, ACOs, and CPC Plus participants to furnish non-Medicare-covered health-related support interventions to Medicare-only individuals: (1) uniform benefit requirements for MA plans, (2) benefit-specific restrictions on MA plans' supplemental benefit offerings, (3) rules governing the calculation of Medical Loss Ratios (MLRs) for MA plans, (4) program integrity rules relating to beneficiary inducements and the Anti-Kickback Statute, and (5) uncertainty in the adequacy of Medicare financing.

To varying degrees, some delivery models contain authorities to provide non-clinical supports and services to address specific situations. However, this results in a patchwork system that varies across delivery models.

Tables One and Two in the appendix provide additional technical details on the barriers identified in this report, as well as a comparison of barriers across different models.

Medicare Advantage-Specific Issues

Current statutory provisions and regulations require that an MA organization offering an MA plan must offer it: (1) to all Medicare beneficiaries residing in the service area of the MA plan; and (2) at a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area or segment of service area.[33] Although designed to ensure equity across enrollees, the "uniform benefit" requirement can, in many cases, limit the ability of an MA plan to target specific supplemental benefits (paid for through rebate dollars) to subgroups of beneficiaries.

There are some cases where eligibility for MA supplemental benefits can be contingent upon diagnoses for certain conditions or other specific clinical circumstances. However, the uniform benefit requirement would likely need to be waived in order for MA plans to limit their provision of non-clinical health-related social supports to targeted subsets of enrollees with multiple chronic conditions and functional impairment. The Medicare Payment Advisory Commission, the Senate Finance Committee Chronic Care Working Group, and others have recommended reforming the uniform benefit requirement to provide more flexibility for MA plans to target supplemental services and supports toward high-need beneficiaries and enrollees with chronic conditions.[34]

CMMI is also in the process of testing a Value-Based Insurance Design demonstration model that allows participating MA plans in select states to receive a waiver of the uniform benefit and cost-sharing rules and target supplemental service offerings and cost-sharing reductions to specific enrolled populations with certain chronic conditions.[35]

Differences between an MA plan's bid and the county or regional per-beneficiary spending benchmark may not be wide enough to finance certain types of non-covered supplemental services through rebate dollars (and in some cases, supplemental premiums), unless an allowance is made for MA plans to provide the benefits only to a select subgroup of qualifying enrollees. In 2016, rebates (provided to plans bidding below the benchmark) averaged $81 per member per month,[36] or $972 per enrolled beneficiary per year. In the current arrangement, with uniform benefit rules in place, there are also inherent incentives for plans to allocate those rebate dollars toward reductions in Medicare premiums or cost-sharing (rather than coverage of supplemental items and services), in order to help attract a broader range of beneficiaries and help grow enrollment.

These uniform benefit requirements could otherwise present a problem for D-SNPs seeking to tailor MA supplemental benefits to specific populations within a D-SNP enrollee pool. However, many of the non-Medicare-covered interventions identified in this report can be covered under the Medicaid benefit for a dual-eligible individual. For D-SNPs that have contracts with a state for

Medicaid benefits, many of these services and items could also be provided directly by the D-SNP in a targeted manner, and be financed under the Medicaid capitation rate.

Barriers Addressed in the CHRONIC Care Act of 2016

The Senate Finance Committee's Chronic Care Working Group included the following provisions in the CHRONIC Care Act to address barriers to the targeting of supplemental benefits and the integration of non-clinical supports and services in the MA care model:

- **Uniform Benefit Issues:** The legislation would provide CMS with the authority to waive the uniform benefit requirement to allow for MA plans to target supplemental benefits only to "chronically ill enrollees" who:

  (1) Have one or more comorbid and medically complex chronic condition that is life threatening or significantly limits the overall health or function of the enrollee;

  (2) Have a high risk of hospitalization or other adverse health outcomes; and

  (3) Require intensive care coordination.

- **"Primarily Health-Related" Supplemental Benefits:** Beginning in 2019 and throughout all subsequent years, the legislation would allow MA plans to provide chronically ill enrollees with supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee, and need not be limited to being primarily health-related benefits.

In addition to the uniform benefit constraints, in order to be offered as a supplemental benefit under the MA plan's benefit package, the items or services must be approved by CMS. Current CMS subregulatory guidance and manual policies require that supplemental benefits must be "primarily health related." These guidance and manual policies also establish implicit and explicit limitations on the inclusion of certain items and services as supplemental benefits.[37] Services and items restricted under these guidance policies include many components of long-term services and supports (LTSS) and several social support services that have been identified in academic literature as key to addressing social determinants of health, such as in-home meal delivery, home modifications, and case management services.

As noted above, for D-SNPs that meet certain requirements,[i] CMS provides flexibility for the plans to provide supplemental benefits that would not be allowed for other MA plans under current CMS guidance and subregulatory policies. Among other things, this supplemental benefit flexibility allows for applicable D-SNPs to provide non-skilled personal care attendant services, extended duration in-home meal delivery, respite care services for caregivers of enrollees, home modifications beyond shower safety equipment, and adult day care services.

Finally, the rules governing the calculation of an MA plan's MLR, for the purposes of the minimum MLR requirement, can discourage the provision of non-reimbursed services and supports furnished to MA enrollees on an in-kind basis. MA plans are

[i] In order to be eligible for this flexibility, the D-SNP must: (1) have a contract with a state for the provision of primary, acute, and long-term care benefits; (2) coordinate delivery of Medicare- and Medicaid-covered services; (3) attain at least three stars in the MA Star Ratings System for the most recent year; and (4) not have a score of two negative points or more on the most recent Part C and Part D performance reviews.

currently required to allocate at least 85 percent of their premium revenue[j] toward payment of claims for clinical health services and prescription drugs for enrolled beneficiaries and toward financing of certain quality improvement activities or Part B premium rebates. If the MA plan fails to meet this 85 percent minimum MLR threshold, the plan is required to remit the difference between its actual MLR and the 85 percent minimum to CMS.[38]

For costs of services to be counted toward an MA plan's MLR, the costs must either be "incurred claims costs" or costs attributable to a service or plan effort that is deemed to be a "quality improvement activity." To be counted as an incurred claims cost, the intervention would either need to be a benefit covered under the Medicare Part A or Part B benefit, or a supplemental benefit approved by CMS.[39]

It is unclear whether "free" non-clinical services not covered under MA supplemental benefits (and provided in-kind to beneficiaries) could be included as quality improvement activities. The regulatory definition of quality improvement activities provides for an exclusion of "activities which were paid for with grant money or other funding separate from premium revenue."[40] Therefore, if the service cannot be counted as a quality improvement activity and cannot be included as a supplemental benefit due to the CMS rules discussed above, then the cost of the service cannot be counted toward the MLR. This MLR-related barrier appears to be equally applicable to standard MA plans and D-SNPs.

Program Integrity Issues for Provider-Based Models

Medicare statutory provisions guarding against "beneficiary inducements," as well as restrictions contained in the Anti-Kickback Statute, could have the effect of limiting the ability of provider-based care model participants to furnish non-Medicare-covered services and supports to Medicare beneficiaries on an in-kind basis.

The beneficiary inducement restrictions prohibit any person or entity from offering or transferring remuneration to an individual eligible for Medicare or Medicaid benefits, to the extent that the entity knows or should know that the remuneration is likely to influence the individual to order or receive Medicare- or Medicaid-covered items or services from a particular provider or supplier.[41] The term "remuneration" includes transfers of items or services for free or for other than fair market value.[42] Violators of the beneficiary inducements prohibition are subject to Civil Money Penalties (CMPs) of up to $10,000 for each instance of violation.

The Anti-Kickback Statute established a prohibition on the knowing and willful exchange of remuneration in an effort to induce a person to refer a patient to a provider, practitioner, or supplier for an item or service covered under a federal health program.[43] The Anti-Kickback Statute also prohibits the knowing and willful exchange of remuneration for the purpose of inducing a person to purchase services or items that are reimbursed under a federal health program. Unlike the beneficiary inducement prohibition discussed above, the Anti-Kickback Statute requires a showing of an intent to induce a referral or purchase of services as a result of the remuneration.[44]

In the case of both statutory restrictions, but particularly the beneficiary inducement prohibition, the furnishing of free or in-kind services and supports by an ACO or a CPC Plus-participating practice could be viewed as a remuneration that is likely to result in the beneficiary seeking more Medicare-covered services from the ACO or CPC Plus providers. CMS and the Department of Health and Human Services-Office of the Inspector General understood the potential beneficiary inducement and Anti-Kickback Statute concerns for ACOs, and established waivers from both restrictions for MSSP ACOs[45] and NextGen ACO model participants.[46] Both waivers require that the in-kind patient incentives that the ACOs provide must be reasonably related

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[j] A variety of expenses can be deducted in the MLR calculation to reduce the final dollar value of the "premium revenue denominator," including federal and state taxes, licensing and regulatory fees, and community benefit expenses.

to a beneficiary's medical care, and either (1) advance one or more clinical goals, or (2) be preventive care items or services. The NextGen ACO guidance also limits the beneficiary inducement and Anti-Kickback Statute waiver to in-kind patient incentives that the participants explicitly identify in participation agreements with CMS. Given the fact that many non-clinical supports and services are likely to assist in achieving a clinical goal of chronic condition management for high-need, high-cost patients, the waivers have the potential to provide some relief for ACOs that seek to furnish such supports and services on an in-kind basis to attributed beneficiaries.

Unlike the ACO programs, the CPC Plus model is not afforded Patient Incentive Waivers from the beneficiary inducement restrictions and the Anti-Kickback Statute.[47] The lack of such waivers raises the possibility of liability for CMPs under the beneficiary inducement rules, as well as the potential for criminal liability under the Anti-Kickback Statute. This liability could serve as a deterrent for CPC Plus primary care practices that would otherwise look to furnish in-kind supports and services with the goal of reducing unnecessary acute care spending, hospitalizations, or emergency department visits.

Financing Issues

Notwithstanding the potential for acute care savings that could result from the integration of non-clinical interventions, the availability of financing can be an issue in the delivery of these supports and services. Across all models, the level of current Medicare financing could inhibit the ability of the above-mentioned entities to provide some of the more expensive health-related support services, such as LTSS and extended-duration home-delivered meals. These services could not be provided for an extended period without additional financing streams beyond the existing Medicare payment and beneficiary premium. For other interventions that are either cost-effective substitutions or relatively low net cost services, existing benchmarks and potential shared savings (for ACOs) or rebate dollars (for MA plans) could prove to provide sufficient resources to finance the interventions.

For most supports and services, a change in the uniform benefit requirement could result in the MA plans having sufficient financing abilities (within rebate dollars and supplemental premiums applied across all beneficiaries) to cover costs of providing the supports and services. However, for LTSS and other intensive non-clinical interventions, financing the supplemental benefit through MA rebate dollars (plus additional enrollee premiums) may not be feasible—given the modest differences between bids and benchmarks. Offering coverage of these services and supports as optional supplemental benefits, financed solely through enrollee premiums from beneficiaries who choose to pay for the benefit, could present risk-selection concerns. In addition, the MA risk adjustment model—known as the CMS-Hierarchical Condition Categories (CMS-HCC) model—has been shown to under-predict the actual medical expenses of the highest-cost Medicare beneficiaries by as much as 29 percent, while over-predicting actual medical expenses for the lowest-cost Medicare beneficiaries by as much as 62 percent.[48] While CMS has worked to address these issues with the risk model, [49] the potential for significant under-prediction (and underpayment in risk adjustment) for the highest-cost enrollees can serve as a disincentive for MA plans to offer, as supplemental benefits, the types of social supports and services that could attract high-need, high-cost Medicare-only individuals to their plans.

For risk-bearing ACOs, the shared savings (accrued through holding actual per-beneficiary spending below the benchmark) for an individual beneficiary may not cover the cost of providing some of the more expensive supports to the beneficiary on an in-kind basis. Research suggests that self-financing through shared savings is less likely to be a barrier for other less costly services, such as non-emergent medical transportation.[50] A recent survey of ACOs revealed that 63 percent reported that their organization had only a "minor focus" on providing social services for attributed beneficiaries, although 95 percent of those ACOs indicated that it was "somewhat important" or "very important" that the ACO take the lead on addressing the social service needs of the populations that they serve.[51] Of the ACOs that were surveyed, 89 percent indicated that lack of funding was a major barrier to addressing patients' social needs. In addition, the MSSP does not currently have voluntary enrollment mechanisms, akin to the

Medicare Networks model proposed by BPC in 2013, that would increase an ACO's certainty regarding their attributed population and the engagement of that population. This lack of certainty for ACOs, and the potential for an ACO's attributed population to shift dramatically year to year, can serve as a disincentive to making long-term investments in social supports and services for attributed beneficiaries. In addition, the same issues raised above regarding risk adjustment for MA plans would also apply for ACOs, since the ACO benchmarks are risk-adjusted based on the same CMS-HCC model.

It remains unclear whether the monthly per-beneficiary payments received by CPC Plus participants (particularly those in Track Two of the CPC Plus model) would provide a viable funding stream to finance non-Medicare-covered supports and services for certain high-need, high-cost Medicare-only individuals. However, based on the CMS-published average PBPM amounts for the CMFs and Performance-Based Incentive Payments, it appears that the monthly fees may not be sufficient to finance some of the more expensive interventions. Moreover, CMFs are designed to help support investments in care coordination activities, rather than financing additional social services and supports.

Finally, it is unclear whether the larger combined capitation amounts provided to PACE organizations allows them the financial ability to offer a full-range of needed supports and services to Medicare-only individuals. While Medicaid benefits incorporated into the PACE model include many non-clinical health-related supports, it is also uncertain the extent to which Medicare-only individuals of different income levels could afford to pay the Medicaid capitation amounts out-of-pocket.

Next Steps

Following the release of this preliminary report, BPC will seek input on additional barriers that MA plans, ACOs, and CPC Plus participants may face, beyond those identified in this report. In conjunction with outreach to stakeholders, BPC will explore policy options for reducing regulatory barriers and addressing financing issues for the provision of non-clinical supports and services for high-need, high-cost Medicare-only individuals.

Outlined below are potential policy options that could be considered, as well as outstanding questions for those policy options, for which BPC will seek feedback from stakeholders before developing any final recommendations. Any such recommendations will be included in a final report that will be released in the spring of 2017.

Addressing Medicare Advantage Plan Design Barriers

Identified Barrier #1: The MA uniform benefit requirement can, in some instances, act as an impediment that prevents MA plans from being able to target non-Medicare-covered services and supports to high-need, high-cost patients. The requirement to offer supplemental benefits uniformly to all beneficiaries—and not just high-need, high-cost individuals for whom the intervention is proven to be effective—can result in the service being too costly to be financed through MA rebate dollars.

Policy Option #1: Congress should direct CMS to waive the MA uniform benefit requirement and allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees who: (1) are not dually eligible for Medicaid; (2) have multiple chronic conditions; and (3) either have functional or cognitive impairment. Supports and services covered under this policy option must be reasonably related to optimizing health or functional status, and they must be part of a person-centered care plan. CMS should take steps to ensure that the offer of these targeted services cannot be used for marketing purposes by MA plans.

These non-Medicare-covered health-related supports and services can be included as mandatory supplemental benefits, financed through existing MA rebates.

Identified Barrier #2: Current CMS guidance and subregulatory rules require that supplemental benefits must be primarily health-related. These supplemental benefit rules also establish limits and prohibitions on the inclusion of specific social services and supports as supplemental benefits, including: a limitation on circumstances in which in-home meal delivery services can be offered and the duration through which meal delivery can be provided; a limitation on home modification services to bathroom safety-related modifications only; and a prohibition on the inclusion of case management services as a supplemental benefit.

Policy Option #2: CMS should waive the current requirement that supplemental benefits be primarily health-related and waive existing regulatory limitations on the provision of in-home meal delivery services, case management services, and home modifications as supplemental benefits, so long as the benefits are targeted to non-dual-eligible enrollees with multiple chronic conditions and functional or cognitive impairment and the benefits are part of a person-centered care plan.

Identified Barrier #3: When MA plans cannot include non-Medicare-covered social supports and services as supplemental benefits, and instead attempt to furnish those services to enrollees on an in-kind basis, in many instances, it appears unlikely that the plan will be able to count the costs of those free or in-kind services as either incurred claims costs or quality improvement activity costs, which count toward the plan's MLR.

Policy Option #3: CMS should modify the definition of incurred claims costs in MLR regulations to include the costs of health-related supports and services provided on an in-kind basis to non-dual-eligible enrollees with multiple chronic conditions and functional or cognitive impairment, as a part of a person-centered care plan. For audit and verification purposes, MA plans should be required to keep records of payment of claims or other invoices for such services whose costs are included in the incurred claims costs calculation.

Questions for Follow-Up: How would the changes to the uniform benefit requirement, the supplemental benefit rules, and the MLR calculation rules impact MA benchmarks, federal spending, and beneficiary premiums?

Would the change to the uniform benefit requirement (and ability to target interventions and supports toward high-need, high-cost beneficiaries) provide MA plans with the flexibility needed to finance proven interventions through existing MA rebate dollars, as supplemental benefits?

Should uniform benefit flexibility be limited to services and supports for which there is a robust evidence base for success of the intervention? Or should plans have the flexibility to cover any health-related support or service within a person-centered care plan for the applicable high-need, high-cost beneficiary?

Addressing Program Integrity-Related Barriers for Provider-Based Models

Identified Barrier #1: The Patient Incentive Waivers provided to MSSP ACOs and NextGen ACOs waive the prohibition against beneficiary inducements and the Anti-Kickback Statute to allow for the in-kind furnishing of non-Medicare-covered services that are reasonably related to achieving clinical goals, including the clinical goal of chronic condition management. However, in some instances additional clarity could help ACO providers determine whether non-clinical health-related supports and social services can be provided under the waiver.

Policy Option #1: CMS should clarify that the Patient Incentive Waiver under the MSSP ACO and NextGen ACO programs will allow for the free or in-kind provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed non-dual-eligible beneficiaries with multiple chronic conditions and functional or cognitive impairment.

Such services should include, but are not limited to, in-home meal delivery, home modifications, and home- or community-based assistive services to address functional impairment.

Identified Barrier #2: Unlike the ACO programs, the CPC Plus Initiative does not provide a Patient Incentive Waiver. As a result, primary care practices would be barred, under the beneficiary inducement prohibition and the Anti-Kickback Statute, from providing non-Medicare-covered health-related supports and services on an in-kind basis.

Policy Option #2: CMS should provide a Patient Incentive Waiver, similar to the waiver applicable for MSSP ACOs and NextGen ACOs, for participants of Track Two of the CPC Plus Initiative. The in-kind furnishing of supports and services under this waiver must be limited to services that are a part of a person-centered care plan.

Question for Follow-Up: If a Patient Incentive Waiver were provided for CPC Plus Initiative Track Two participants, would primary care practices have the necessary infrastructure and contracting capabilities in place to furnish non-Medicare-covered interventions on an in-kind basis?

Addressing Financing-Related Barriers in MA and Provider-Based Models

Identified Barrier #1: Although a waiver of the MA uniform benefit requirement and clarity regarding program integrity waivers for ACOs could create the necessary flexibility that could allow MA plans and ACOs to finance and furnish non-Medicare-covered supports and services, in some instances the needed intervention may still be too costly to finance solely through shared savings (for ACOs) or rebate dollars (for MA plans). For such interventions, additional benchmark financing could be necessary.

Policy Option #1: To the extent that Congress wants to provide additional funds to finance services that would otherwise not be financed, Congress should direct CMS to adjust the applicable spending benchmarks for MA plans, Track Two and Track Three MSSP ACOs, and NextGen ACOs to help finance the delivery of non-Medicare-covered health-related supports and services for Medicare beneficiaries who are not dually eligible for Medicaid, have multiple chronic conditions, and have functional or cognitive impairment. Congress should require CMS to provide a specific estimate of the dollar value of the benchmark increase for each MA plan or ACO, based on historical beneficiary enrollment and attribution.

In conjunction with a limited waiver of uniform benefit requirements, MA plans would be required to allocate the additional dollars attributable to the benchmark adjustment toward non-Medicare-covered health-related supports and services that optimize health or functional status for Medicare beneficiaries who are not dually eligible for Medicaid, have multiple chronic conditions, and have functional or cognitive impairment.

ACOs should be required to certify that the organization has allocated funding toward the delivery of non-Medicare-covered health-related supports and services in an amount equal to the projected increase in the ACO's benchmark that would result from the benchmark adjustment.

Both MA plans and ACOs should be required to certify that the supports and services financed through the benchmark adjustment are limited to supports and services that are part of a person-centered care plan.

Identified Barrier #2: The CMS-HCC risk adjustment model has been shown to under-predict the actual medical expenses of the highest-cost beneficiaries, while over-predicting the actual medical expenses of the lowest-cost beneficiaries, despite significant resources allocated toward documenting and verifying beneficiaries' diagnoses that form the basis of the model. This potential misalignment within the risk adjustment model could discourage MA plans (and to a certain extent ACOs) from offering non-Medicare-covered supplemental supports and services that are likely to attract high-need, high-cost beneficiaries for which there is a risk of underpayment in risk adjustment due to under-prediction of costs by the risk model. This concern could be magnified in a situation in which MA plans and ACOs are offering person-centered care models with supplemental social supports and services incorporated into the benefit design. There is some evidence that risk adjustment modifications based on functional impairment, such as those similar to the frailty adjuster in the PACE model, while not perfect, could address under-prediction concerns in the CMS-HCC model. [52]

Policy Option #2: In conjunction with action on the Policy Option to waive uniform benefit requirements, Congress should direct CMS to examine potential modifications to the CMS-HCC risk adjustment model to ensure more accurate predictions of medical expenses for the highest- and lowest-cost Medicare beneficiaries. Such a modification could incorporate a measure of functional or cognitive impairment. Under this scenario, CMS could enhance existing survey platforms used to measure functional and cognitive impairment and/or develop a functional status assessment tool that would be implemented and used

across MA and Medicare FFS to evaluate and document functional or cognitive impairment of the Medicare beneficiary. If this approach proves feasible—and data gathered by CMS support the use of a functional or cognitive impairment adjustment in the risk model—the otherwise applicable risk scores could be adjusted upward for beneficiaries who are certified as having functional or cognitive impairments, and adjusted downward for beneficiaries who do not have functional or cognitive impairments.

Identified Barrier #3: If the benchmark adjustments discussed in Policy Option #1 prove to be infeasible for budgetary or other reasons, additional quality measurement and payment policy incentives could be designed within the existing benchmarks to help foster MA plan and ACO investment in the provision of non-Medicare-covered health-related supports and services. Due to the fact that MA plan payments and ACO shared savings percentages are increased for high performers on the overall quality measurement programs, the addition of quality measures relating to incorporation of health-related supports and services could establish added financial incentives for MA plans and ACOs to pursue the offering of such supports and services.

Policy Option #3: In conjunction with action on the Policy Option to waive uniform benefit requirements, Congress should direct CMS to develop MA Star Ratings Program measures and ACO Quality Measurement metrics that evaluate the incorporation of non-Medicare-covered health-related social supports and services (that can be reasonably financed within existing MA rebates and ACO shared savings amounts) into the MA and ACO care model. MA plans and ACOs with greater levels of social support and service integration should be rewarded with higher scores on these quality measures, while MA plans and ACOs with less comprehensive integration of these services should receive lower scores.

Identified Barrier #4: The MSSP does not currently incorporate a voluntary enrollment option through which beneficiaries can be attributed by choice to an ACO. This lack of advance certainty regarding their attributed beneficiary populations (and the inherent lack of true engagement from those populations as a result of the passive attribution model) can result in significant shifts in an ACO's attributed population from one year to the next. ACOs that do not have confidence in the consistent attribution of their attributed beneficiary pools have significant disincentives against investing in non-clinical supports and social services that yield benefits in the long-term, rather than the near-term.

Policy Option #4: Consistent with past BPC recommendations, CMS should establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses as ACO participants transition to greater risk-sharing.

Questions for Follow-Up: If BPC were to pursue a benchmark adjustment discussed in Policy Option #1, what dollar value or percentage of the benchmark should form the basis for the adjustment amount?

How would applying a benchmark adjustment under Option #1 impact federal spending, beneficiary premiums, and quality of care?

If BPC were to instead pursue the quality measure incentive approach under Option #3, would those new quality measures provide sufficient incentives for MA plans and ACOs to invest in innovative care models that incorporate the provision of non-Medicare-covered health-related supports and services?

Appendix

TABLE 1: COMPARISON OF CARE INNOVATION AND INTEGRATION BARRIERS ACROSS DIFFERENT MODELS

	MA Supplemental Benefit Rules	MA Uniform Benefit Requirements	Medical Loss Ratio Application	Program Integrity Rules (Anti-Kickback & Beneficiary Inducement)	Marketing Restrictions on Communications with Beneficiaries	Financial and Non-Payment Barriers
Medicare Advantage	Explicit limits/ restrictions on meal delivery, case management, and home modifications (see specific restrictions in Table 2 below). No restrictions on transportation to medical appointments.	An organization offering an MA plan must offer it: (1) to all Medicare beneficiaries residing in the service area of the MA plan; (2) at a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area or segment of service area. The uniform benefit requirement can, in many cases, limit the ability of an MA plan to target specific supplemental benefits (paid for through rebate dollars) to subgroups of beneficiaries. The uniform benefit requirement would likely need to be waived in order for MA plans to limit their provision of non-clinical health-related social supports to targeted subsets of enrollees with multiple chronic conditions and functional impairment.	Unclear whether "free" non-clinical services not covered under supplemental benefits could be included as quality improvement activities, due to exclusion of "activities which were paid for with grant money or other funding separate from premium revenue."[k] For services that cannot be counted as a quality improvement, the intervention would need to be a CMS-approved supplemental benefit in order to be considered an incurred claim cost[l] and count toward MLR.	N/A	N/A	For most supports and services, a change in the uniform benefit requirement could result in the MA plans having sufficient financing abilities (within rebate dollars and supplemental premiums applied across all beneficiaries) to cover costs of providing the supports and services.

[k] 42 C.F.R. § 422.2430(b)(3).

[l] 42 C.F.R. § 422.2401; See also: 42 C.F.R. § 422.2420(a)(2), 42 C.F.R. § 422.2420(b)(2), and 42 C.F.R. § 422.100(c).

	MA Supplemental Benefit Rules	MA Uniform Benefit Requirements	Medical Loss Ratio Application	Program Integrity Rules (Anti-Kickback & Beneficiary Inducement)	Marketing Restrictions on Communications with Beneficiaries	Financial and Non-Payment Barriers
Medicare Advantage Dual-Eligible Special Needs Plans	For D-SNPs that meet certain requirements, CMS provides flexibility for the plans to provide supplemental benefits that would not be allowed for other MA plans. Specifically, applicable D-SNPs are allowed to provide non-skilled personal care attendant services, extended-duration in-home meal delivery (beyond the two-week or four-week periods allowed for other MA plans), respite care services for caregivers of enrollees, home modifications beyond shower safety equipment, and adult day care services. In order to be eligible for this flexibility, the D-SNP must: (1) have a contract with a state for the provision of primary, acute, and long-term care benefits; (2) coordinate delivery of Medicare- and Medicaid-covered services; (3) attain at least three stars in the MA Star Ratings System for the most recent year; and (4) not have a score of two negative points or more on the most recent Part C and Part D performance review.	Uniform benefits requirements could present a problem for D-SNPs seeking to tailor MA supplemental benefits to specific populations, although for D-SNPs that have contracts with a state for Medicaid benefits, many of these supplemental services could be provided in a targeted manner under the Medicaid capitation rate.	Services that are not provided as covered Medicare or Medicaid benefits, or approved supplemental benefits, would be unlikely to qualify as expenses that could be counted toward the MLR, for reasons discussed above.	N/A	N/A	N/A

	MA Supplemental Benefit Rules	MA Uniform Benefit Requirements	Medical Loss Ratio Application	Program Integrity Rules (Anti-Kickback & Beneficiary Inducement)	Marketing Restrictions on Communications with Beneficiaries	Financial and Non-Payment Barriers
MSSP ACOs	N/A	N/A	N/A	MSSP ACOs Receive Anti-Kickback Statute Waiver & Patient Incentive Waiver. The waiver provides that MSSP ACOs that apply for and receive the waiver are allowed to provide items or services to beneficiaries for free or at below market value if the items or services are provided in-kind, are reasonably related to the beneficiary's medical care, and either: (1) are preventive, or (2) advance at least one of the following clinical goals: (a) adherence to a treatment regime; (b) adherence to a drug regime; (c) adherence to a follow-up care plan; or (d) management of a chronic disease or condition.	Unlikely to present a significant barrier, as communications from the ACO-participating providers to beneficiaries regarding the availability of non-Medicare-covered services provided on an in-kind basis as a supplemental benefit would likely fall under an exception to the ACO regulations' definition of "marketing materials and activities." However, additional clarity could be useful for providers.	ACO self-financing of non-Part A/B-covered services via shared savings amounts is not likely to be feasible for some of the more expensive interventions (e.g. extended duration meal delivery or most LTSS). Self-financing is less likely to be a barrier for other services, such as transportation and some home modifications.
NextGen ACOs	N/A	N/A	N/A	NextGen ACOs Receive Patient Engagement Incentives Waiver. CMS and the Department of Health and Human Services-Office of the Inspector General waive the Beneficiary Inducement CMP and Anti-Kickback Statute to allow NextGen ACOs to provide in-kind items/services that are identified in advance in the participation agreement, are reasonably related to the beneficiary's medical care, and that either: (1) are preventive, or (2) advance at least one of the following clinical goals: (a) adherence to a treatment regime; (b) adherence to a drug regime; (c) adherence to a follow-up care plan; or (d) management of a chronic disease/condition.	Unlikely to present a significant barrier. Marketing and beneficiary communication limitations are not included in the NextGen ACO Request for Applications.	Higher sharing rates and sharing caps (compared with MSSP)—and PBPM capitation payment options—provide a larger potential pool of savings dollars to be invested in non-covered interventions, but self-financing via savings would still be an issue for more expensive interventions.

	MA Supplemental Benefit Rules	MA Uniform Benefit Requirements	Medical Loss Ratio Application	Program Integrity Rules (Anti-Kickback & Beneficiary Inducement)	Marketing Restrictions on Communications with Beneficiaries	Financial and Non-Payment Barriers
Comprehensive Primary Care Plus Model	N/A	N/A	N/A	CPC Plus model participants are **NOT** provided with waivers. Anti-Kickback Statute and Beneficiary Inducement rules could be significant barrier. Note: CPC Plus practices will be expected to provide a systematic assessment of patients' psychosocial needs and an inventory of resources and supports to meet those needs. Practices will also be encouraged to provide referrals to identified community/social services as needed. However, the lack of Anti-Kickback Statute and Beneficiary Inducement CMP waivers could prevent the CPC Plus participant from actually *financing* the community/social services.	Limitations on communications to beneficiaries not included in CPC Plus Request for Applications.	CMFs range from $15 to $28 PBPM ($100 PBPM for certain high-risk beneficiaries, based on risk scores), which could limit the types of non-covered services that could be financed through CMFs. There appears to be only limited potential for self-financing of non-covered interventions from Track Two participants that also receive CPCP, partially in lieu of Medicare FFS payments for evaluation and management services. Having CPCP payments being tied to primary care evaluation and management spending, rather than global spending, also limits investment incentives.
PACE	N/A	N/A	PACE Organizations are exempt from the MLR.	The provision of services covered by PACE organizations under the interdisciplinary team's care plan, which go beyond Medicare Part A/B services, would not be considered "remuneration" for purposes of beneficiary inducement rules because they are required to be covered under statute, in accordance with the PACE protocol.	N/A	It is unclear whether Medicare-only beneficiaries of different income levels could afford to pay out-of-pocket for the Medicaid capitation amounts attributable to PACE organization-provided Medicaid-covered services.

TABLE 2: INTERVENTION-SPECIFIC BARRIERS FOR MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS

	Non-Emergent Transportation	In-Home Meal Delivery	Home Modifications	Case Management	LTSS
Medicare Advantage	**BARRIERS:** None. MA plans allowed to offer transportation to medical appointments (but not for non-medical purposes) to enrollees as a supplemental benefit.	**BARRIERS:** Durational limitations. MA supplemental benefit for meal delivery must be limited to: (1) immediately following surgery or an inpatient hospital stay, for a temporary duration (as ordered by a physician or non-physician practitioner); or (2) for a chronic condition for a temporary period (typically two weeks) to help transition the enrollee to a lifestyle modification. Social factors, by themselves, do not qualify an enrollee for meal services.	**BARRIERS:** Explicit supplemental coverage allowance limited to bathroom safety modifications. MA program manual provisions clarify that installation of bathroom safety devices in the enrollee's home and "minor modifications" such as rug removal or furniture rearranging can be included as a part of a supplemental benefit for in-home safety assessments. The manual provisions and applicable regulations do not provide details on the status of other home modifications.	**BARRIERS:** Explicit prohibition within supplemental benefits. MA program manual provisions provide that case management and care coordination services may not be included as supplemental benefits because these activities are "required for all coordinated care plans." These requirements for coordinated care plans generally provide that MA organizations must establish a service coordination plan, which integrates services through arrangements with community and social service programs. These arrangements can be with contracted providers or non-contracted providers in the area served by the MA organization, including nursing home and community-based services.	**BARRIERS:** Financial Even limited LTSS benefits are likely to be too expensive to finance solely through rebate dollars. Unlikely that actuaries would certify reductions in MA bid amounts to account for acute care savings driven by an LTSS supplemental benefit.

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Notes

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