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Centers for Medicare & Medicaid Services
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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 27, 2018

TO: Medicare Advantage Organizations and Section 1876 Cost Contract Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Reinterpretation of "Primarily Health Related" for Supplemental Benefits

In the contract year (CY) 2019 Call Letter, issued on April 2, 2018, CMS announced that we reinterpreted the scope of the "primarily health related" supplemental benefit definition. The purpose of this memorandum is to provide Medicare Advantage (MA) organizations and Section 1876 cost plans with guidance for preparing their CY 2019 plan bids. This guidance will be incorporated into the Medicare Managed Care Manual, Chapter 4.

Historically, CMS has defined a mandatory or optional supplemental health care benefit in Chapter 4 of the Medicare Managed Care Manual as an item or service (1) not covered by Original Medicare, (2) that is *primarily health related*, and (3) for which the plan must incur a non-zero direct medical cost. An item or service that meets all three conditions may be proposed as a supplemental benefit in a plan's plan benefit package (PBP). The final determination of benefit status is made by CMS during the annual benefit package review.

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. We expect organizations will establish reasonable safeguards to ensure enrollees are appropriately directed to care. CMS anticipates organizations will use this expanded definition to address health care needs and make adjustments to their annual supplemental benefit offerings based on the expected needs of their plan population. For example, organizations may decide to offer 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).

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. If a request concerning coverage of a discrete 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 coverage decision is subject to the Subpart M appeals process.

Furthermore, organizations are responsible for clearly identifying what will and will not be covered in the plan's Evidence of Coverage (EOC). Any limitations on coverage should be clearly noted in the 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.

The list below details allowable supplemental benefits resulting from CMS's reinterpretation of the definition of "primarily health related" and summarizes where these new benefits should be entered and briefly described in the PBP. This list is not exhaustive.

- **Adult Day Care Services (PBP B13d, e, or f):** Services provided outside the home such as assistance with ADLs/IADLs, education to support performance of ADLs/IADLs, physical maintenance/rehabilitation activities, and social work services targeted to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. Recreational or social activities or meals that are ancillary to primarily health related services and items may also be provided but the primary purpose of adult day care services must be health related and provided by staff whose qualifications and/or supervision meet state licensing requirements. Transportation to and from the adult day care facility may be provided and should be included in PBP B10b.

- **Home-Based Palliative Care (PBP B13d, e, or f):** Home-based palliative care services to diminish symptoms of terminally ill members with a life expectancy of greater than six months not covered by Medicare (e.g., palliative nursing and social work services in the home not covered by Medicare Part A). Medicare covers hospice care if a doctor and/or the hospice medical director certify the patient is terminally ill and has six months or less to live.

- **In-Home Support Services (PBP B13d, e, or f):** In-home support services to assist individuals with disabilities and/or medical conditions in performing ADLs and IADLs within the home to compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. Services must be provided by individuals licensed by the state to provide personal care services, or in a manner that is otherwise consistent with state requirements.

- **Support for Caregivers of Enrollees (PBP B13d, e, or f):** Respite care provided through a personal care attendant or the provision of short-term institutional-based care, as appropriate, to ameliorate the enrollees' injuries or health conditions, or reduce the enrollees' avoidable emergency and healthcare utilization. Respite care should be for short periods of time (e.g., a

few hours each week, a two week period, a four week period) and may include services such as counseling and training courses for caregivers of enrollees.

- **Medically-Approved Non-Opioid Pain Management(PBP B13d, e, or f):** Medically-approved non-opioid pain treatment alternatives, including therapeutic massage furnished by a state licensed massage therapist. "Massage" should not be singled out as a particular aspect of other coverage (e.g., chiropractic care or occupational therapy) and must be ordered by a physician or medical professional in order to be considered primarily health related and not primarily for the comfort or relaxation of the enrollee. The non-opioid pain management item or service must treat or ameliorate the impact of an injury or illness (e.g., pain, stiffness, loss of range of motion).

- **Stand-alone Memory Fitness Benefit (PBP B13d, e, or f):** Memory fitness benefit may be incorporated as a component of a health education benefit and/or offered as a standalone benefit. The benefits and activities must be primarily for the prevention, treatment, or amelioration of the functional/psychological impact of injuries or health conditions.

- **"Home & Bathroom Safety Devices & Modifications" (PBP B14c):** Non-Medicare-covered safety devices to prevent injuries in the home and/or bathroom. Plans may also offer installation. The benefit may include a home and/or bathroom safety inspection conducted by a qualified health professional, in accordance with applicable state and Federal requirements, to identify the need for safety devices and/or modifications, as well as the applicability of the device or modification to the specific enrollee's needs and home.

  Examples of safety devices and modifications include: shower stools, hand-held showers, bathroom and stair rails, grab bars, raised toilet seats, temporary/portable mobility ramps, night lights, and stair treads. The plan must briefly describe the proposed benefit and enrollee criteria for receiving these additional benefits (e.g., enrollee at risk of falls) in the PBP.

  Home modifications must not include items or services that are capital or structural improvements to the home of the enrollee (e.g., easy use door knobs and faucets, permanent ramps, and widening hallways or doorways). In addition, items such as smoke detectors and fire alarms are not permitted.

- **Transportation (PBP B10b):** Transportation to obtain non-emergent, covered Part A, Part B, Part D, and supplemental benefit items and services to accommodate the enrollee's health care needs. For example, transportation for physician office visits. Transportation must be arranged, or directly provided, by the plan and may not be used to transport enrollees for purposes that are not health related. The plans also may include a health aide to assist the enrollee to and from the destination. Transportation is limited to the provision of medical services and may not be for items and services such as groceries or banking.

- **Over-the-Counter (OTC) Benefits (PBP B13b):** Health-related items and medications that are available without a prescription, and are not covered by Medicare Part A, Part B, or Part D. In addition to the items included in Chapter 4 of the Medicare Managed Care

Manual, we are clarifying that assistive devices, such as pill cutters, pill crushers, pill bottle openers, and personal electronic activity trackers are permitted. Activity trackers may be offered as a standalone benefit or as part of a fitness benefit.

We note that all benefits, with the exception of in-home food delivery for certain dual eligible special needs plans (D-SNPs) under our 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.

We also note that the Bipartisan Budget Act of 2018 (Public Law No. 115-123) further expanded supplemental benefits for chronically ill enrollees only beginning CY 2020. CMS will provide guidance concerning these additional benefits prior to the CY 2020 bid deadline.

CMS believes the new benefit flexibilities discussed above will help organizations better manage health care services for enrollees. If you have any policy related questions about the information outlined in this memorandum, please submit your question to https://dpap.lmi.org/dpapmailbox/. If you have any operational and/or PBP related questions about the information outlined in this memorandum, please submit your question to https://mabenefitsmailbox.lmi.org/.