30.3 – Examples of Eligible Supplemental Benefits

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The list below identifies items or services that may be offered as supplemental benefits, subject to CMS bid review **and** meeting the criteria identified in *section* 30.1. Definitions and limitations of the eligible benefits are provided below. This list below is intended to be illustrative, not exhaustive.

Acupuncture

The acupuncture provided *by MA plans* as a supplemental benefit must be provided by practitioners who are licensed or certified, as applicable, in the state in which they practice and are furnishing services within the scope of practice defined by their licensing or certifying state.

Alternative Therapies

MA plans may offer alternative therapies as supplemental benefits. These alternative therapies must be provided by practitioners who are licensed or certified, as applicable, in the state in which they practice and are furnishing services within the scope of practice defined by their licensing or certifying state. *MA plans* are to provide a description of therapies offered in the PBP Notes section.

Bathroom Safety Devices

MA plans may choose to offer, as a supplemental benefit, provision of specific non-Medicare-covered safety devices to prevent injuries in the bathroom. In addition to providing and installing appropriate safety devices, the benefit may include an in-home bathroom safety inspection conducted by a qualified health professional, in accordance with applicable state and Federal requirements, to identify the need for safety devices, as well as the applicability to the specific enrollee's bathroom (e.g., to determine whether a specific safety device can be installed into the bathroom).

The *MA* plan should describe the proposed benefit and, if an in-home assessment is offered, the qualifications of the health professional that will be performing those evaluations, in its submitted PBP.

Routine Chiropractic Services

MA plans may choose to offer routine chiropractic services as a supplemental benefit as long as the services are provided by a state-licensed chiropractor practicing in the state in which he/she is licensed and is furnishing services within the scope of practice defined by that state's licensure and practice guidelines. The routine services may include conservative management of neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches, and the provision of spinal and other therapeutic manipulation/adjustments.

X-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor may be covered by the *MA* plan as a supplemental benefit as long as the chiropractor is state-licensed and is practicing within the states' licensure and practice guidelines.

Counseling Services

Medicare Part B covers individual and group therapy services to diagnose and treat mental illness. The Part B coverage usually requires a physician referral for mental health care and is based on a mental health diagnosis.

Counseling services not covered by original Medicare may be offered as a supplemental benefit to all beneficiaries. These supplemental benefits may address general topics, such as: coping with life changes; conflict resolution; or grief counseling and be offered as individual or group sessions.

Fitness Benefit

Fitness benefits (e.g., fitness center membership, exercise and yoga classes) may be offered *by MA plans* as supplemental benefits designed to improve or maintain good health. The fitness benefit must, if applicable, include an orientation *for each enrollee* to the facility and the equipment. The benefit also may include development of a personalized exercise plan and a limited number of sessions with a certified trainer.

MA plans may not offer personal trainers or exercise coaches for in-home sessions.

MA plans should describe specifically what is included in the supplemental fitness benefit (e.g., access to fitness center or other facilities, support staff, general goals of the program) in the applicable PBP notes field.

Enhanced Disease Management (EDM)

Non-SNP *MA* plans may offer *Enhanced Disease Management* (EDM) as a supplemental benefit. *EDM must be targeted to groups of enrollees based on a diagnosis of, or risk for, a specific disease condition (e.g., diabetes, heart failure, cognitive impairment such as Alzheimer's and related dementias).* Services that CMS would expect to be included in a supplemental "EDM" benefit for coordinated care plans, and which would be expected to be approved as supplemental benefits, would include the following three activities:

- **Enrollees in the target group are assigned to qualified case managers with specialized knowledge about the disease(s) who contact the enrollee to provide additional case management and monitoring services.** We believe that this should be an essential aspect of an effective EDM program and it is important for *MA plans* to understand the difference between the assignment of case managers for all enrollees and the assignment of a case manager with specialized knowledge about a specific individual enrollee's disease(s). The case manager or other qualified health professional assigned to the enrollee should work to ensure that the enrollee makes and keeps appointments necessary to receive appropriate care from physicians and other health care providers including obtaining preventive services. That assigned case manager or other qualified health professional should facilitate the enrollee's participation in both standard disease management activities and supplemental EDM programs offered by the *MA* plan. The assigned case manager or other qualified health professional should ensure that all scheduled monitoring of the enrollee takes place and that information is analyzed and communicated to all members of the care team so that early signs of deterioration in the enrollee's condition are detected and action is taken to prevent further deterioration.

- **Educational activities being provided by certified or licensed professionals that are focused on the specific disease/condition.** Educational programs are designed to help enrollees develop knowledge and self-care skills and to foster the motivation and confidence necessary to use those skills to improve health. Examples of educational services that may qualify as a supplemental benefit include provision of information about the specific disease process(es), treatments and drug therapies, signs and symptoms to watch for, self-care strategies and techniques, dietary restrictions, and nutritional counseling.

- **Routine monitoring of measures, signs and symptoms, applicable to the specific disease(s)/condition(s) of the enrollee.** We expect the *MA plan* to collect and act upon *the* information *gathered from routing monitoring* in order to coordinate care in an appropriate and timely manner. Clinical staff with specialized knowledge of the enrollee's specific disease/condition should conduct this review *of the EDM program*.

<u>Health Education</u>

A health education program *may be offered* as a supplemental benefit *if it*:

- *Is* offered to all enrollees or targeted to groups of enrollees based on a diagnosis of, or risk for, a specific disease condition (e.g., diabetes, heart failure, cognitive impairment *such as Alzheimer's and related dementias*);

- *Provides* more than written material or a website and go beyond content alone to include interaction with a certified health educator or other qualified health professional.

The interactive sessions are expected to:

- Primarily provide health information;
- Encourage enrollees' adoption of healthy behaviors;
- Build skills to enhance enrollees' self-care capabilities;
- Align with the overall goal to improve participants' health; and
- May be provided in a number of modalities including, but not limited to:
    - Group sessions in which the educator provides information or skills instruction;
    - One-on-one instructional sessions; and
    - Interactive web- and/or telephone-based coaching to reinforce what an enrollee learned in a group or individual session.

Consistent with our description of health education activities and services above, MA plans may develop health education services to address health-related topics they identify as appropriate for their enrollee population and could include, as supplemental benefits, programs that support and encourage enrollees to adopt healthier lifestyles.

In-Home Safety Assessment

The In-Home Safety Assessment should be performed by an occupational therapist or other qualified health provider. Services included in such a benefit are provided only to enrollees who do not qualify for an in-home safety assessment under original Medicare's home health benefit and the *MA* plan must ensure the following conditions apply:

- The assessment's focus is on the beneficiary's risk for falls or injuries and identification of how falls may be prevented; and
- The bathroom safety devices that may be installed should be appropriate for the individual beneficiary's home, determined to be necessary by the occupational therapist or other qualified health provider furnishing the safety assessment in order to prevent injury, and be approved by the beneficiary.

The assessment may include identification and/or minor modification of some home hazards outside of the bathroom, in order to reduce risk of injury. Such modifications may include removal of rugs that are not attached to the floor and rearrangement of furniture to create clear pathways.

Meals

Meals may be offered as a supplemental benefit to address the following two types of circumstances:

- Immediately following surgery or an inpatient hospital stay, for a temporary duration, typically a four-week period, per enrollee per year, provided they are ordered by a physician or non-physician practitioner. As discussed in 42 CFR § 422.112(b)(3), after the temporary duration, the provider should refer the enrollee to community and social services for further meals, if needed, or

- For a chronic condition, including but not limited to cardiovascular disorders, COPD or diabetes, for a temporary period, typically two weeks, per enrollee per year provided they are ordered by a physician or non-physician practitioner; and are part of a supervised program designed to transition the enrollee to life style modifications.

Home delivery of meals may be offered as a supplemental benefit if the services are:

1) Needed due to an illness;

2) Consistent with established medical treatment of the illness; and

3) Offered for a short duration.

Social factors, by themselves, do not qualify an enrollee for meal services.

Note that all MA coordinated care plans are required to "coordinate MA benefits with community and social services generally available in the area served by the MA plan" (§422.112(b)(3)). Therefore, *MA* plans are to:

- Provide information and links to websites with nutritious diet planning information, such as ChooseMyPlate.Gov;

- Provide nutritional tips in their newsletters and/or on their websites; and

- Partner with social community services such as "Meals on Wheels."

However, the MA plan may not classify any of these community services as plan benefits. Additionally, an MA plan offering a meal benefit complying with the requirements described in this chapter may not advertise it as a "Meals on Wheels" benefit or use the term "Meals on Wheels" in the name of the benefit. It is important that prospective enrollees not confuse the *limited meal services offered as a supplemental benefit* with the broader services offered under the "Meals on Wheels" program. However, if an MA plan has entered into a contract with "Meals on Wheels" to furnish the approved meals benefit, it may inform its enrollees that the supplemental benefit (meal benefit) under the MA plan will be delivered by "Meals on Wheels."

Nutritional/Dietary Benefit

General nutritional education for all enrollees through classes and/or individual counseling may be provided as a supplemental benefit as long as the services are provided by practitioners who are practicing in the state in which s/he is licensed or certified, and are furnishing services within the scope of practice defined by their licensing or certifying state. (i.e., physician, nurse, registered dietician or nutritionist). The number of visits, time limitations, and whether the benefit is for classes and/or individual counseling must be defined in the PBP.

Over-the-Counter (OTC) Benefit

MA plans may offer OTC items as a supplemental benefit under Part C. OTC items include non-prescription drugs, also known as OTC drugs and health-related items. See *section* 40 below for details.

Personal Emergency Response System (PERS)

MA plans may provide enrollees with in-home Personal Emergency Response devices designed to notify appropriate personnel of an emergency (e.g., a fall), provided that they are primarily health related. A PERS may not include cellular telephones because such devices are not primarily health related (a definitive component of being a supplemental benefit).

Preventive Benefits Eligible as Supplemental Benefits

An example of a preventive benefit that is eligible as a supplemental benefit is providing additional sessions of smoking and tobacco cessation counseling. *MA plans* may offer additional sessions of face-to-face intermediate counseling and/or additional sessions of face-to-face intensive counseling per contract year and/or the *MA* plans may offer as a supplemental benefit interactive, on-line or telephone-based coaching and support programs to enhance enrollees' successful smoking and tobacco cessation.

Medical Nutrition Therapy (MNT)

MA plans may offer as a supplemental benefit additional hours of one-on-one MNT counseling provided by a registered dietician or other nutrition professional, to enrollees who are eligible for the Medicare Part B-covered MNT benefit; that is, those with diabetes, renal disease, or who have received a kidney transplant in the last three years. In addition, *MA* plans may offer as a supplemental benefit one-on-one MNT counseling provided by a registered dietician or other nutrition professional, to all, or a disease-defined group, of its enrollees. *As with all supplemental benefits, the MNT benefit's primary purpose must be to improve health outcomes.*

Physical Exam

Non-SNP MA plans may offer as a supplemental benefit a physical exam that provides services *beyond those services required to be provided in the Annual Wellness Visit. To be considered an Annual Physical Exam that qualifies as a supplemental benefit by CMS, the exam would be provided by a qualified physician or qualified non-physician practitioner, hereafter referred to as a practitioner. At a minimum, the exam would include a detailed medical/family history and the performance of a detailed head to toe assessment with hands-on examination of all the body systems. For example, the practitioner uses visual inspection, palpation, auscultation and 133 manual examination in his/her full examination to assess overall general health and detect abnormalities or signs that could indicate a disease process that should be addressed. We consider these components minimum elements and not an exhaustive list.*

Other aspects of the Annual Physical Exam may include, as appropriate, follow-up orders for referral to other practitioners, lab tests, clinical screenings, EKG, etc. The Annual Physical Exam also should emphasize prevention, i.e., the recommendations for preventive screenings, vaccination(s), and counseling about healthy behaviors. Practitioners should exercise clinical judgment when determining the additional components necessary for an Annual Physical Exam to meet the individual needs of the enrollee. MA plans do not need to fully describe in the PBP notes the non-Medicare covered activities and services included in the physical *exam if the benefit is consistent with our guidance.*

Point of Service (POS)

HMOs may offer a POS option as a mandatory or optional supplemental benefit pursuant to 42 CFR 422.105 and 422.111. This supplemental benefit may not be offered by any other *MA* plan type. The POS benefit provides coverage for some plan-covered services outside of the HMO's network. The HMO plan:

- May limit POS benefits to certain items and services, geographic area, or provider(s);
- May require that enrollees pay higher cost-sharing (e.g., deductibles) for POS services;
- May either require or waive prior authorization rules for obtaining POS services;
- May establish a plan maximum dollar amount it will pay for the POS benefit and/or a enrollee maximum out-of-pocket maximum for the POS benefit; if the plan chooses to establish a plan maximum dollar amount, it must inform the enrollee how much cost-sharing is required before the enrollee reaches this maximum amount and explain that the enrollee is liable for 100% of the cost of services after the enrollee has reached the plan maximum;
- Must fully disclose and clearly specify all limitations (e.g., benefits, geographic area, providers) and describe all POS benefits and cost-sharing;

- Must track enrollee and plan utilization and spending for POS services and provide this information to enrollees (i.e., in advance of meeting limitations and/or upon request by the enrollee); and

- Must be prepared to report enrollee utilization of contracting and non-contracting providers, at the plan level and in the form and manner prescribed by CMS.

Note: A PPO must cover all plan benefits furnished to its enrollees anywhere in the United States. Therefore, an MAO wishing to furnish specific plan-covered services outside its service area, but only in certain geographic locations, should offer an HMO plan with a POS option.

Post-discharge In-home Medication Reconciliation

An MA plan may offer a post-discharge medication reconciliation as a supplemental benefit. *For example, immediately* following discharge (e.g., within the first week) from a hospital or SNF inpatient stay, MA plans may offer, as a supplemental benefit, the services of a qualified health care provider *who*, in cooperation with the enrollee's physician, would review the enrollee's complete medication regimen that was in place prior to admission and compare and reconcile with the regimen prescribed for the enrollee at discharge to ensure new prescriptions are obtained and discontinued medications are discarded. This reconciliation of the enrollee's medications may be provided in the home and is designed to identify and eliminate medication side effects and interactions that could result in illness or injury.

Readmission **Prevention**

MA Plans may offer, as a supplemental benefit, non-Medicare covered services that are primarily for the purpose of preventing the enrollee's readmission to a hospital or other institution, *immediately following an enrollee's discharge from a hospital or skilled nursing facility (SNF) inpatient stay (e.g., within the first week).*

Services included in a supplemental readmission prevention benefit that CMS would expect to approve would:

- Not duplicate Medicare-covered benefits (e.g., home health which may provide some services to homebound beneficiaries);

- Be initiated immediately after an enrollee's discharge from an institutional setting (e.g., hospital, SNF); and

- Be provided for a limited and specified period of time not to exceed four weeks.

An MA plan may combine the benefits, *suggested as examples below*, as a complete "*Readmission* Prevention" benefit or offer the benefits separately. Examples include:

- In-Home Safety Assessment as described earlier in this section;

- Meals, as described earlier in this section; and

- Post discharge In-home Medication Reconciliation, as described earlier in this section;

Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)

MA plans may propose a supplemental benefit to allow a contracted provider to diagnose and treat some conditions via telephone, and/or real time interactive audio and video technologies. MA plans must ensure that this type of service will not be used as a substitute for an effective, ongoing doctor-patient relationship, but rather, will be supportive of that relationship and of efficient delivery of needed care. *MA plans* offering such a benefit should ensure that:

- Enrollees are not required to use remote access technologies, but may choose to use those services;

- Medical protocols are established and regularly updated based on relevant clinical guidelines and that prescribing and/or treatment recommendations are consistent with the state laws in the jurisdiction where the *MA plan* operates and are within the provider's scope of practice;

- The enrollee is made aware when using the technology that he or she is not required to use it and may contact his/her plan provider directly and request an in-person appointment;

- The information provided by, and to, the enrollee during the interactive process is directed to his/her PCP or other plan provider specified by the enrollee and will become part of the enrollee's medical record; and

- The *MA* plan will have a protocol for monitoring the use of the system by enrollees. The protocol should enable the *MA* plan to identify potential misuse *and instances where the system is supplanting* appropriate PCP visits. The protocol should be implemented at the beginning of the contract year the benefit is offered. The *MA plan* must provide CMS with this information upon request.

A PPO may not use remote access technologies services as described above to fulfill its requirement to provide out-of-network services. Email communication between an enrollee and his/her physician would not be acceptable as a supplemental benefit because that communication is part of the Part B physician services *MA plans* are required to provide.

MA plans must include in the *110.1* field a description of the remote access technologies services they propose to provide as a mandatory supplemental benefit. In addition, the remote access technology supplemental benefit may not replace the Medicare telehealth basic benefit described at 42 CFR § 414.65.

Repairs

Repairs of an item furnished as a supplemental benefit may be included as part of that supplemental benefit, as appropriate (e.g., eye glass and hearing aid repairs). However, as indicated in *section* 10.12, repairs of Medicare-covered DME are part of the Part B benefit and, consequently, may not be offered as supplemental benefits.

Telemonitoring Services

MA plans may *offer* a supplemental benefit that provides in-home equipment and telecommunication technology to monitor enrollees with specific health conditions (e.g., hypertension or heart failure). The benefit should be referred to as "Telemonitoring services" in the PBP and may not duplicate items or services provided under original Medicare (e.g., glucometers for diabetic beneficiaries). *MA plans* should include in the PBP notes field a description of the monitoring services they propose to provide as supplemental benefits. These benefits are distinct from telehealth benefits covered under original Medicare (see 42 CFR § 414.65). *Telemonitoring equipment may not include a cellular telephone because such devices are not primarily health related.* In addition, the supplemental benefit description should address the following issues:

- Telemonitoring services supplement, rather than replace, face-to-face physician visits;
- The enrollee should have an initial physician visit to diagnose or confirm the diagnosis of the specific condition prior to the use of the telemonitoring benefit;
- Except in rare circumstances, the data submitted should be collected/transmitted at least weekly, but may be sent daily or more frequently, as appropriate for the particular disease;
- The equipment provided to the enrollee should be disease-appropriate;
- The enrollee should be trained on how to use the equipment and transmit the data properly;
- Health care professionals should monitor and take action, as needed, based on the collected/transmitted data;
- The enrollee's physician should be included in the communication process; and
- All devices must comply with applicable state and federal requirements.

Transportation Services

An MA plan is *not obligated* to provide transportation *to obtain non-emergent, covered Part A and Part B services. However, such transportation may be offered as a supplemental benefit.*

The transportation offered must be used exclusively to accommodate the enrollee's health care needs: for example, the *MA* plan may offer a supplemental benefit that provides transportation to enrollees for physician office visits. The transportation must be arranged, or directly provided, by the *MA plan* and may not be used to transport enrollees for non-health-related purposes. The *MA* plan must describe the proposed benefit in the PBP.

Visitor/Travel Benefit

A Visitor/Travel (V/T) benefit may be offered as a supplemental benefit as a means to provide covered services outside of the service area of the MA plan. Under plan enrollment rules, MA plans that do not offer a V/T supplemental benefit must disenroll current enrollees who are temporarily absent from the *MA* plan's service area for more than six consecutive months. However, MA plans that offer a V/T benefit may retain enrollees who are covered by the benefit, but temporarily out of the service area (and still within the United States or its territories) for more than six, but less than 12 months (42 CFR § 422.74(d)(4)(iii)). See *chapter* 2 of the *MMCM*, "Medicare Advantage Enrollment and Disenrollment," located at http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp, for further details.

The specific requirements for the V/T benefit are as follows:

- The V/T benefit must furnish all plan-covered services in its designated V/T service area(s), including all Medicare Part A and Part B services and all mandatory and optional supplemental benefits, at in-network cost-sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112;

- The *MA plan* must define the geographic areas within the United States and its territories where the V/T benefit is available;

- The V/T benefit must be available to all plan enrollees covered by the benefit who are temporarily in the designated geographic areas where the V/T benefit is offered;

- V/T benefits may not be offered outside the United States and its territories; and

- Subject to compliance with Medicare access requirements and CMS review of bids, an *MA plan* may designate an area where it is not able to form a network of

direct-contracted providers as a covered V/T service area as long as the plan can ensure that its enrollees have access to all covered services.

Weight Management Programs

Weight management programs may be offered as a supplemental benefit *designed to promote healthy behaviors that help* an individual to lose weight and keep it off, but the program may not offer meals as part of the benefit. *As with all supplemental benefits, Weight Management Programs must be health driven and aim to improve health outcomes. For CMS to consider a Weight Management Program sufficiently health related, the benefit includes:*

- *A plan to keep the weight off over the long run:*
- *Guidance on how to develop healthier eating and physical activity habits; and*
- *Ongoing feedback, monitoring, and support.*

The weight management program *should provide structured lessons on a weekly basis that are tailored to the beneficiaries' personal goals. The program should support self-monitoring of eating and physical activity as well as offer regular feedback from a counselor on goals, progress, and results. The program may be offered online (fully or partly), but must also be entirely available to enrollees without access to online capabilities.*

Wigs for Hair Loss Related to Chemotherapy

An MA plan may offer as a supplemental benefit wigs for hair loss that is a result of chemotherapy. However, wigs may not be offered as a supplemental benefit for any other purpose.

Worldwide Emergency/Urgent Coverage

Worldwide Emergency*/Urgent* Coverage refers to coverage of services, either as a mandatory or optional supplemental benefit, outside the United States and its territories. Under this benefit, enrollees may obtain only services that would be classified as emergency and urgently needed services had they been covered inside the United States. MA plans that offer a Worldwide Emergency/Urgent Coverage benefit may retain enrollees who are covered by the benefit but temporarily outside of the United States or its territories for up to six months. *This coverage may also include ambulance services worldwide.*

As explained in *section* 10.5.2 above, a plan benefit design may not discriminate based on health status. In particular, the cost of a mandatory supplemental Worldwide Emergency/Urgent Coverage benefit should be nominal within the bid; otherwise, CMS may determine that the benefit discriminates against enrollees who are unable to travel due to health status.