



Providing Non-Medical Supplemental Benefits in Medicare Advantage:

A Roadmap for Plans and Providers

Non-medical supplemental benefits may be new, but they are here to stay. Never before have Medicare Advantage (MA) plans had the flexibility to offer targeted, innovative benefits for services that typically exist far outside the traditional healthcare sphere. Likewise, never before have non-traditional providers had the opportunity to engage in such a meaningful way with MA plans. These benefits represent a significant turning point in Medicare policy, but realizing their potential will take a new level of collaboration among insurers, providers, government, and consumers. This paper provides a roadmap for health plans and providers to take the next big step in delivering non-medical benefits to meet member needs.

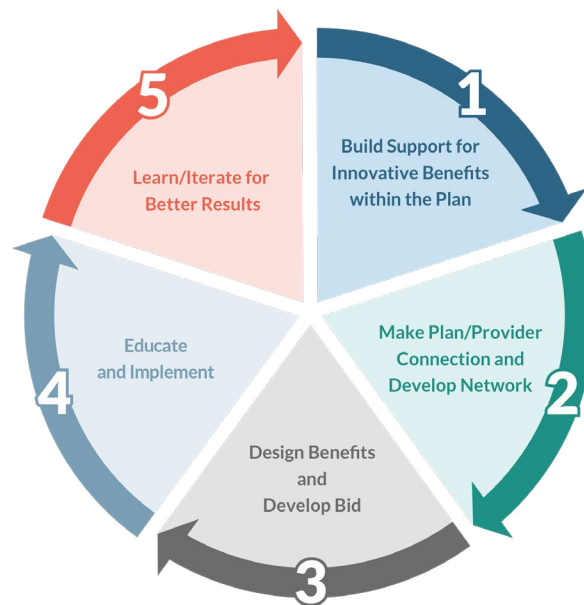


Executive Summary

We interviewed over 20 plans, providers, and advocacy organizations on their experiences with new, non-medical benefits. Our interviews focused on challenges plans and providers have faced, successful approaches they are using, and lessons learned. The qualitative data from these interviews form the basis of the following tool, which provides guidance and valuable insights for each step in a plan’s process – from building internal consensus to implementation and fulfillment. It identifies common challenges and provides tactical options for addressing them. Our hope is that this Roadmap further accelerates adoption of new benefits by clarifying the value of non-medical benefit offerings and answering some of the hard business questions that inevitably arise around change.

Combining early learnings from plans and providers at the forefront of these new benefits, we organized findings and insights into five concrete, actionable activities.

Supplemental Benefit Development



- **Building Internal Support and Consensus.** Considerable energy and resources are required to align internal plan leaders around offering new benefits.
 - ▶ Top Barrier: Organizational culture and competing priorities can inhibit plan take-up of new benefits because of a perception of too much risk and uncertainty.
 - ▶ Solution: Internal champions research the benefits members want, provide as much evidence as possible, and propose pilots.

- **Building the Provider-Plan Relationship.** MA plans must build relationships, execute contracts, and build networks with entirely new provider types.
 - ▶ Top Barrier: Plans often do not have experience with identifying, selecting, and contracting with non-traditional benefit providers that have little to no experience working with MA plans – for example, who have never reviewed a plan contract.
 - ▶ Solution: This is an area where plans have found it especially helpful to work with organizations that specialize in building networks with non-medical organizations, including providers themselves and community-based organizations that have aggregated peers and invested in technology to support networking.

- **Designing, Targeting, and Pricing Benefits.** The parameters of supplemental benefits and cost-sharing must be designed and priced by the benefit teams and actuaries.
 - ▶ Top Barrier: This is especially challenging in the absence of a utilization or spending history, and limited evidence in the literature about cost-effectiveness and expected take-up.
 - ▶ Solution: MA plans moving ahead with these benefits say that the offering requires a leap of faith, to some extent, but that it can be done in small increments and tested.

- **Educating Members and Staff and Implementing Benefits.** Plans must dedicate resources to educating providers, care managers, members, and other stakeholders on the new benefits.
 - ▶ Top Barrier: Members may be unaware of benefits and unsure how to access them.
 - ▶ Solution: MA plans use care managers to identify and outreach to eligible members, and provide multiple clear, simple communications to educate staff, brokers and other enrollment assisters, providers, and individual members on what the benefits are, who qualifies, and how to access them.

- **Learning and Improving Benefits Over Time.** Plans should provide more effective benefits over time as they identify services that are highest value.
 - ▶ Top Barrier: The competitive environment in MA makes information sharing and collective learning difficult.
 - ▶ Solution: Medicare Advantage Organizations (MAOs) should collect both qualitative and quantitative information and assess impact to inform where effective benefits can be expanded to new plans. Neutral and trusted third parties can play an important role in sharing learnings.

The information in this Roadmap is organized into three sections:

- ▶ **Supplemental Benefits in Medicare Advantage: The Big Picture**
Provides context on the growth of supplemental benefits in MA and background on supplemental benefit authorities
- ▶ **The Competitive Landscape for New, Non-Medical Benefits**
Provides a snapshot overview of plans offering new supplemental benefits in Medicare and examples of benefits
- ▶ **The Emerging Roadmap for Plans and Providers**
Provides actionable steps to overcome roadblocks and deliver new benefits to Medicare beneficiaries

Please see the accompanying Policy Brief in the “For Policymakers” section of *this page* for recommendations for CMS and Congress.



Supplemental Benefits in Medicare Advantage: The Big Picture

Medicare Advantage Today

As more of the Baby Boomer Generation ages into Medicare, MA plans continue to seek innovative ways to serve beneficiaries and further enrollment in the expanding program. MA enrollment continues to grow year over year, currently sitting at over 40% of total Medicare enrollment.¹ MA's growth is likely due, in part, to its ability to meet the needs of older adults who cannot otherwise afford supplemental insurance or who don't have access to employer-sponsored health insurance options. Research confirms that the MA program is more likely to serve low-income beneficiaries compared to Traditional Fee-for-Service Medicare.² Matching the popularity of MA as a whole, the total number of MA plans has also grown. The Centers for Medicare and Medicaid Services (CMS) reports that, for 2020, each county had an average of 39 plans per county, now increasing to an average of 47 plans per county in 2021.³ Despite the rise of MA, however, disparities also remain, such as the low penetration of MA in rural states and counties.

New Supplemental Benefits

As the MA market has grown increasingly competitive over time, one way that plans have differentiated themselves from competitors is by offering new and innovative supplemental benefits to better meet the needs of their members. While MA plans continue to offer popular supplemental benefits like dental, vision, hearing, or fitness benefits, many have also begun exploring new, non-medical supplemental benefits.

¹ The Centers for Medicare and Medicaid Services Enrollment Data. (October 2020). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/MA-State-County-Penetration>.

² Better Medicare Alliance. (2020). <https://www.bettermedicarealliance.org/publication/data-brief-medicare-advantage-provides-strong-financial-value-to-beneficiaries-as-compared-to-all-other-coverage-options/>.

³ The Centers for Medicare and Medicaid Services Press Release. (September 2020). <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-historically-low-medicare-advantage-premiums-and-new-payment-model>.

These new supplemental benefits were recently introduced by CMS and Congress. These new benefits are available largely through two authorities: the first authority was introduced in 2018 by CMS and expanded the definition of what was considered “primarily health-related” to include services that diagnose, prevent, or treat an illness or injury; compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization. This authority allowed plans to offer a broader set of supplemental benefits, starting in Plan Year 2019, as “primarily health-related,” including services like In-Home Support Services and Caregiver Supports.

The second authority was introduced by Congress in the *CHRONIC Care Act*, authorized in the Bipartisan Budget Act of 2018, and created a new set of benefits specifically for chronically ill Medicare beneficiaries, called Special Supplemental Benefits for the Chronically Ill, or SSBCI. First available in Plan Year 2020, these benefits are different from primarily health-related supplemental benefits in that they are not required to be health-related, and thus are able to include services like Pest Control and Social Needs Benefits. Like primarily health-related supplemental benefits, SSBCI receive funding primarily from MA plan “rebates,” which average \$122 per member per month in 2020. As such, these new, non-medical services must compete for the same rebate dollars as other popular benefits, like dental and hearing, and as cost-sharing reductions. On average, plans spend about \$22 of total per member per month rebate dollars on Part A and B supplemental benefits.”⁴

In addition to the two authorities discussed above, CMS has provided two additional flexibilities: uniform flexibility and the Value-Based Insurance Design (VBID) Model demonstration. Uniform flexibility was introduced and finalized in the same final rule that expanded the definition of “primarily health-related” in 2018. This new flexibility allows plans to provide services (including both benefits or reduced cost-sharing) in a way that is “tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly.”⁵ VBID is a Center for Medicare and Medicaid Innovation (CMMI) model that began in 2017 to test innovations in Medicare Advantage. Plans participating in VBID can provide supplemental benefits based on chronic conditions and/or socioeconomic characteristics and can provide rewards to incentivize the use of drug benefits, among other flexibilities.⁶

⁴ MedPAC. (March 2020). “Report to the Congress: Medicare Payment Policy” http://www.medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0.

⁵ The Centers for Medicare and Medicaid Services 2019 Final Rule. (April 2018). <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>.

⁶ The Centers for Medicare and Medicaid Services. (2020). <https://innovation.cms.gov/files/x/vbid-rfa2021.pdf>.

The Medicare program is over 50-years-old and is designed and frequently updated by Congress. Many of its requirements are complex; supplemental benefits are no exception.

Requirements for Expanded Primarily Health-Related Benefits:

Previously, benefits were considered primarily-health related “if [the] primary purpose of the item or service is to prevent, cure, or diminish an illness or injury.”

CMS expanded the definition in 2018 to include a three-part test:

- “Must diagnose, prevent, or treat an illness or injury, compensate for physical impairments,
- Act to ameliorate the functional/psychological impact of injuries or health conditions,
- Or reduce avoidable emergency and healthcare utilization.”

Benefits provided under this broader interpretation must be medically appropriate and **recommended** by a licensed provider as part of a care plan if not directly provided by one and do not include items or services solely to induce enrollment.

Other Considerations for These Benefits:

These benefits must be offered uniformly, meaning similarly-situated individuals receive the same services.

Benefits under this broader interpretation cannot be solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.

Examples of These Benefits:

- Adult Day Care Services (Adult Day Health Services)
- Home-Based Palliative Care
- In-Home Support Services
- Support for Caregivers of Enrollees
- Therapeutic Massage

Sources: CMS Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>; April 2018 CMS Guidance: <https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf>.

Requirements for Special Supplemental Benefits for the Chronically III (SSBCI):

SSBCI must “Have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.”

A chronically ill enrollee is defined as an enrollee who:

- “Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
- Has a high risk of hospitalization or other adverse health outcomes; and
- Requires intensive care coordination.”

Other Considerations for These Benefits:

Statute also gives plans the authority to waive uniformity requirements for these benefits, meaning that they can be targeted to each beneficiary’s individualized need.

Examples of These Benefits:

- Food and Produce
- Meals (beyond limited basis)
- Pest Control
- Transportation for Non-Medical Needs
- Indoor Air Quality Equipment and Services
- Social Needs Benefit
- Services Supporting Self-Direction

Sources: Bipartisan Budget Act of 2018: <https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>; April 2019 CMS Guidance: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_III_HPMS_042419.pdf.

A Turning Point

For the first time in the Medicare program, insurers have the flexibility to pay for benefits that provide more holistic, person-centered care for their beneficiaries, including the ability to address both long-term services and supports (LTSS) and social determinant of health (SDOH) needs. Numerous studies have documented that addressing these needs can generate better health outcomes and cost-savings through reduced healthcare utilization.^{7,8} At its core, and aligning with the spirit of the *CHRONIC Care Act*,⁹ these benefits reflect common-sense changes to maintain or improve Medicare beneficiaries' health and well-being. Accordingly, it is imperative that insurers retain the flexibility to provide these kinds of services and are supported in their efforts to do so.

Recognizing that these flexibilities demonstrate an unprecedented opportunity to take small steps towards new solutions in the Medicare program, ATI Advisory and the Long-Term Quality Alliance (LTQA), supported by a grant from The SCAN Foundation, convened a diverse working group of national experts on Medicare Advantage and long-term services and supports, addressed as the SSBCI Leadership Circle. With the group's consensus, ATI Advisory and LTQA released "*Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill*" to inform how these new supplemental benefits should be designed and implemented over time.

What Are LTSS?

"Care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves."

Examples: eating, bathing, dressing, mobility, cooking, and driving

Source: Centers for Medicare and Medicaid Services (CMS)

What Are SDOH?

"...circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economic, social policies, and politics."

Examples: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context

Source: World Health Organization; Healthy People 2030

⁷ Zachary Pruitt, Nnadozie Emechebe, Troy Quast, Pamme Taylor, and Kristopher Bryant. Population Health Management. Dec 2018.469-476. <http://doi.org/10.1089/pop.2017.0199>.

⁸ AARP Public Policy Institute. "State Studies Find Home and Community-Based Services to be Cost-Effective" https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf.

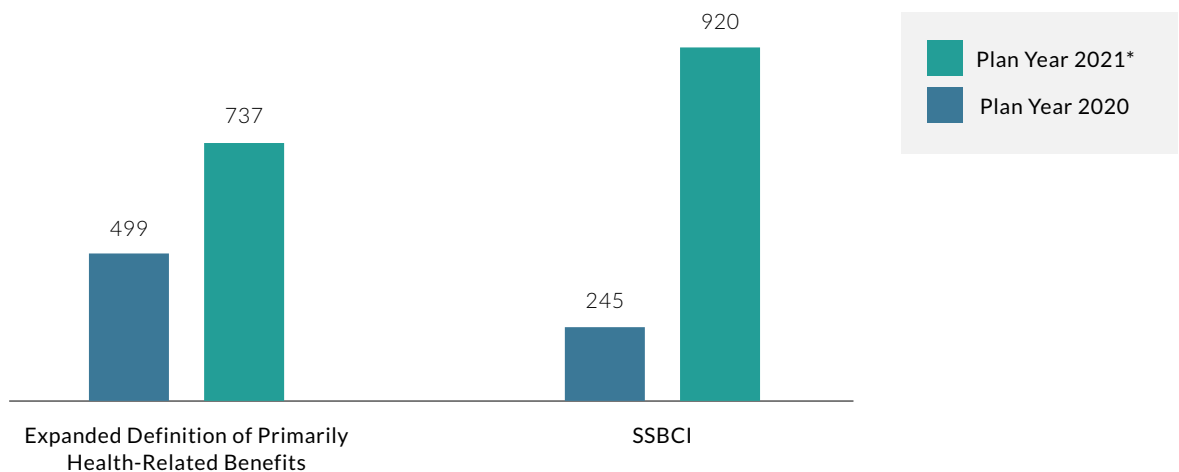
⁹ The *CHRONIC Care Act* was a collaborative, bipartisan piece of legislation produced between policymakers and the industry to increase flexibility to improve management of chronic disease and, ultimately, meet individual needs. Learn more on the *CHRONIC Care Act* from the Senate Finance Committee's press release: <https://bit.ly/3kzOtp7>.



The Competitive Landscape for New, Non-Medical Benefits

First available in 2019 and 2020 respectively, expanded primarily health-related benefits and SSBCI continue to be offered by more plans over time. As Plan Year 2021 approaches, these benefits continue to expand, in many instances through MAOs with 2020 experiences offering these benefits across more of their plans. However, in Plan Year 2021 alone, the number of MAOs offering an expanded primarily health-related benefit has increased from 36 to 58 organizations.

Plans Offering New, Non-Medical Benefits In Plan Year 2020 and Plan Year 2021

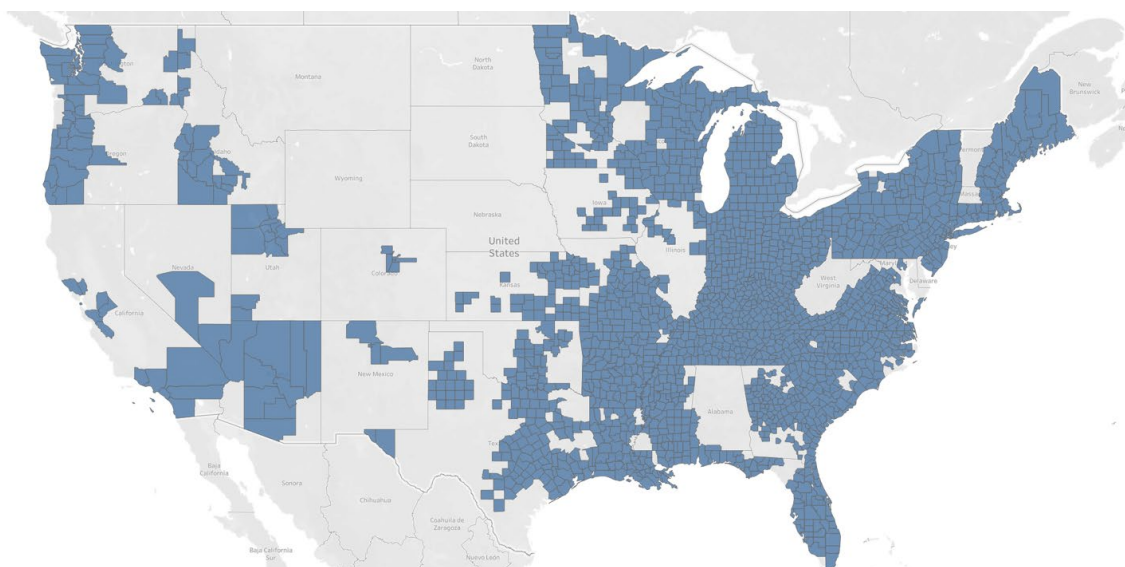


***Note:** Plan Year 2021 SSBCI numbers taken from CMS press release, which uses language “about X plans” so numbers are approximate.
Source(s): ATI Advisory analysis of CMS PBP files. CMS Press Release released September 24, 2020: <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-historically-low-medicare-advantage-premiums-and-new-payment-model>.

Expanded Primarily Health-Related Benefits

In Plan Year 2019, the first year expanded primarily health-related benefits were available, few plans chose to offer these benefits. Only 102 plans offered expanded primarily health-related benefits, excluding Dual-Eligible Special Needs Plans (D-SNPs).¹⁰ Much of this low uptake was due to the late release of CMS' Medicare Advantage final rule, compressing plans' abilities to alter or submit their bids.¹¹ By Plan Year 2020, however, these benefits expanded considerably to 499 plans. In 2021, 737 plans will be offering these benefits in 41 states and Puerto Rico, across more than 1,900 counties (see map below).^{12,13}

Map of Counties with a Plan Offering an Expanded Primarily Health-Related Benefit in 2021



Note: This map does not include Hawaii, Alaska, or other U.S. territories (like Puerto Rico) where plans may be offered.
Source: ATI Advisory analysis of CMS PBP files.

¹⁰ Better Medicare Alliance, analysis by Milliman. (2020). https://www.bettermedicarealliance.org/wp-content/uploads/2020/04/MA-Supplemental-Benefits-Milliman-Brief_20200327.pdf. **Note:** Milliman analysis excluded EGWPs, Cost plans, MSA plans, MMPs, and D-SNPs.

¹¹ Long-Term Quality Alliance. (2018). <http://www.ltqa.org/wp-content/themes/LtqaMain/custom/images/LTQA-Report-on-MA-Flexible-Supplemental-Benefits-FINAL-11-9-18.pdf>.

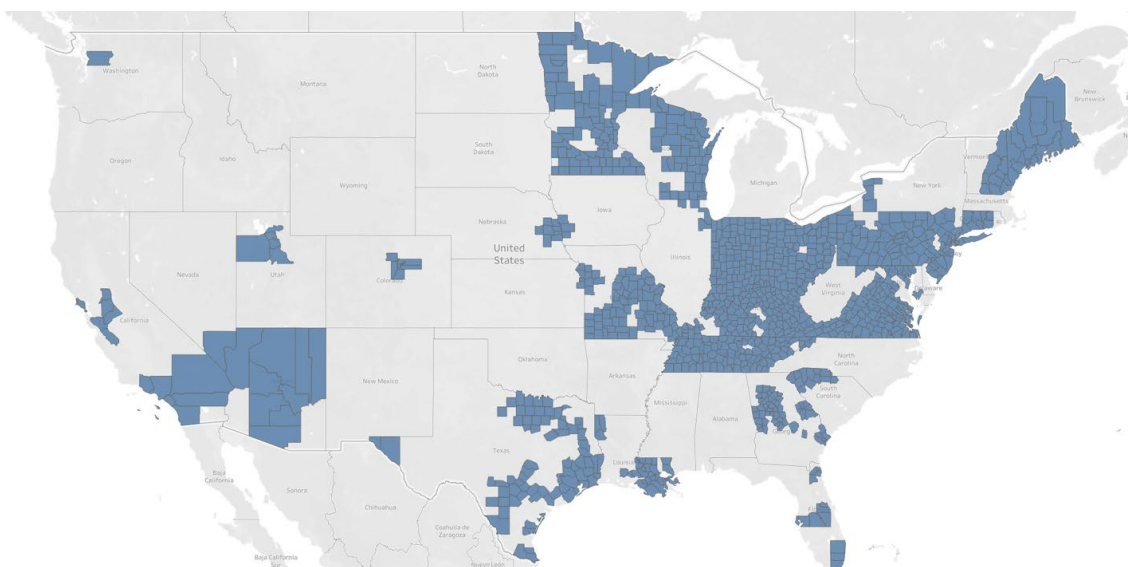
¹² For this report, expanded primarily health-related benefits include Therapeutic Massage, Adult Day Health Services, Home-Based Palliative Care, In-Home Support Services, and Home-Based Palliative Care. Analysis captures benefits filed under specific variables in the PBP files and do not capture benefits filed under "Other" categories.

¹³ **Note:** 2019 analysis showing 102 plans excluded D-SNPs. Comparable numbers, excluding D-SNPs, are 361 plans for 2020 and 584 plans for 2021.

SSBCI

SSBCI uptake also grew considerably for Plan Year 2021, the second year that plans can offer these benefits. In 2020, SSBCI were offered by 245 plans, with Pest Control, Food and Produce, and Transportation to Non-Medical Locations as the most popular SSBCI offered by plans (see map below for which counties had SSBCI available in 2020). CMS has announced that over 920 plans will be offering SSBCI in 2021, an almost four-fold increase year-over-year. CMS has not yet released additional details. ATI Advisory will publish a data brief on Plan Year 2021 SSBCI once the data become available in early 2021.

Map of Counties with a Plan Offering SSBCI in 2020



Note: This map does not include Hawaii, Alaska, or other U.S. territories (like Puerto Rico) where plans may be offered.
Source: ATI Advisory analysis of CMS PBP files.

In Plan Year 2020, 11 percent of Medicare Advantage plans offered either an expanded primarily health-related benefit or SSBCI. In comparison, however, more popular benefits were more widely available across plans: dental in 69%, vision in 76%, hearing in 71%, and medical transportation in 34% of plans. Entering Plan Year 2021, however, these new, non-medical benefits have a much larger footprint (see Table 1 below).¹⁴

¹⁴ ATI Advisory analysis of plans offering dental, vision, and hearing benefits excludes PDPs, Part B-only plans, and PACE. These methods are used consistently throughout the report. Analysis includes employer plans, accounting for possible differences between other reports' analyses.

Table 1: Number of Plans Offering Non-Medical Supplemental Benefits

	Benefit	Number of Plans Offering in 2020: ¹⁵	Number of Plans Offering in 2021:
New Primarily Health-Related Supplemental Benefits	In-Home Support Services	223	429
	Adult Day Health Services	84	127
	Home-Based Palliative Care	61	134
	Support for Caregivers of Enrollees	125	95
	Therapeutic Massage	230	176
	TOTAL (offering at least 1 new primarily health-related supplemental benefit):	499	737
Special Supplemental Benefits for the Chronically Ill	Food and Produce	101	Data on 2021 SSBCI will be available in Q1 2021
	Meals (beyond limited basis)	71	
	Pest Control	118	
	Transportation for Non-Medical Needs	88	
	Indoor Air Quality Equipment and Services	52	
	Social Needs Benefit	34	
	Complementary Therapies	1	
	Services Supporting Self-Direction	20	
	Structural Home Modifications	44	
	General Supports for Living	67	
	Other: Service Dog Supports	51	
TOTAL (offering at least 1 SSBCI):	245		

Source: ATI Advisory analysis of CMS PBP files.

¹⁵ For all ATI Advisory analyses, a ‘plan’ is defined as the combination of a Contract Number, Plan ID, and Segment ID. Analyses capture benefits that are filed under specific variables for the benefits above in the PBP files and do not capture benefits filed under “Other” categories. ATI Advisory analysis excludes Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE.

Benefit Details

The continued growth of these new, non-medical benefits from Plan Year 2020 into Plan Year 2021 indicates that plans are increasingly interested in the ability of these services to better meet beneficiary need. Additionally, demand for non-medical services has grown throughout the COVID-19 pandemic. These authorities have provided plans additional flexibility to meet Medicare beneficiary needs during the COVID-19 pandemic, particularly for services that address key challenges like food insecurity and social isolation, exacerbated by the pandemic's effect on caregivers. At the same time, some services, such as Adult Day Health, are less likely to be used during the pandemic.¹⁶

We provide a more detailed view of the structure and generosity of three of the more popular of these benefits: In-Home Support Services, Meals (beyond limited basis), and Transportation for Non-Medical Needs. We also provide details on Social Needs Benefits. Though only 34 plans offered Social Needs Benefits in 2020, we expect these offerings, along with others, to grow significantly in 2021 given the needs arising from the COVID-19 pandemic.

As ATI Advisory and LTQA continue research in this space, we will explore what factors have encouraged continued uptake and growth of non-medical benefits as a whole. While plans have limited dollars to offer these new benefits, there is important opportunity to test services that can improve members' well-being. As part of this, plans and providers are navigating uncharted territory in the Medicare environment.

¹⁶ ATI Advisory and LTQA. (2020). "Meeting Medicare Beneficiary Needs During COVID-19: Using Medicare Advantage Supplemental Benefits to Respond to the Pandemic" https://atiadvisory.com/wp-content/uploads/2020/05/05-26-2020_Meeting-Medicare-Beneficiary-Needs-During-COVID-19.pdf.

What Are In-Home Support Services?¹



"In-home support services to assist individuals with disabilities and/or medical conditions in performing ADLs and IADLs within the home...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"

Which Plans Offered In-Home Support?²

In CY 2020,
available in **223 plans**

In CY 2021,
available in **429 plans**

In CY 2020,
48% of plans offering IHSS were a
Special Needs Plan (SNP)

43% of plans were offered by
Anthem and **36%** of plans were
offered by WellCare

In CY 2021,
45% of plans offering IHSS are a
Special Needs Plan (SNP)

33% of plans are offered by Anthem
and **24%** of plans are offered by
WellCare

What Did In-Home Support Services Look Like in CY 2020?³

170 plans had a maximum hour limit per year in their Evidence of Coverage document:

49% of these plans offer **24 hours or fewer** per year
18% of these plans offer **between 24 and 60 hours** per year
33% of these plans offer **greater than 60 hours** per year
2 plans offer a maximum limit of **248 hours per year**

44 plans had a maximum hour limit per discharge in their Evidence of Coverage document:

77% of these plans offer **20 hours or fewer** of services per discharge
23% of these plans offer **more than 20 hours of services** per discharge

What Are Meals (SSBCI)?¹



"Meals may be offered beyond a limited basis as a non-primarily health-related benefit to chronically ill enrollees. Meals may be home-delivered and/or offered in a congregate setting"

Which Plans Offered Meals (SSBCI)?²

In CY 2020, available in **71 plans**

In CY 2020,
44% of plans offering Meals as an SSBCI were a
Special Needs Plan (SNP)

61% of these plans were offered by Anthem and
17% were offered by Martin's Point Health

What Did Meals (SSBCI) Look Like in CY 2020?³

67 plans explicitly state the maximum number of meals in their Evidence of Coverage document:

27% allow fewer than **100 meals** over a certain period:
16 plans allow **20 meals or fewer**
2 plans allow **90 meals** over 30 days

73% allow **more than 100 meals** over a certain period:
1 plan allows **168 meals** over 12 weeks
41 plans allow **180 meals** over 90 days
7 plans allow 20 meals per month for a total of **240 meals** in one year

What Is Non-Medical Transportation (SSBCI)?¹



"Transportation to obtain non-medical items and services, such as for grocery shopping, banking, and transportation related to any other SSBCI, is a non-primarily health-related benefit. Such transportation may be reimbursed, arranged, or directly provided by an MA plan as a SSBCI"

Which Plans Offered Transportation (SSBCI)?²

In CY 2020, available in **88 plans**

In CY 2020,
32% of plans offering Transportation as an SSBCI
were a Special Needs Plan (SNP)

50% of plans were offered by Geisinger and
14% of plans were offered by SCAN Health Plan

What Is a Social Needs Benefit (SSBCI)?¹



"Access to community or plan-sponsored programs and events to address enrollee social needs, such as non-fitness club memberships, community or social clubs, park passes, and access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function"

Which Plans Offered Social Needs Benefits (SSBCI)?²

In CY 2020, available in **34 plans**

In CY 2020,
38% of plans offering Social Needs Benefits were a
Special Needs Plan (SNP)
35% of plans were offered by Martin's Point Health and
18% of plans were offered by Alignment Health Plan

What Did Non-Medical Transportation (SSBCI) Look Like in CY 2020?³

40 plans explicitly state the maximum
number of trips in their Evidence of
Coverage document:

58% of these plans allow **20 trips or
fewer** a year
42% of these plans allow **more than 20
trips** a year, **2 plans** allow **unlimited trips**
Where trip limitations were available, trips
varied between a maximum of **30 to 75
miles per trip**

Plans list the following types of locations as examples of plan-approved locations: banks, senior centers, fitness centers, or for errands

44 plans have an annual maximum
annual benefit:

98% of these plans limits services to a
maximum of **\$1,000** per year and **1 plan**
limits services to a maximum of **\$3,000**
per year
The annual maximum is distributed across
all SSBCI offered by the plan, including
meals, personal care, transportation, pest
control, air services, home modifications, and
transitional supports

What Did Social Needs Benefits (SSBCI) Look Like in CY 2020?³

15 plans limit companionship or social needs services to an hourly limit per year
in their Evidence of Coverage document:

67% of these plans limit services to **48 hours** or less a year
13% of these plans limit services to **96 hours** a year
20% of these plans limit services to **120 hours** a year

Additionally, **15%** of all plans offering this benefit allow beneficiaries beauty shop visits to increase social interaction and address enrollee isolation

Source(s): 1. April 2018 CMS *Guidance*; April 2019 CMS *Guidance*. 2. ATI Advisory analysis of CMS PBP files. **Note:** Analysis excludes Prescription Drug Plans, Medicare-Medicaid Plans, Part-B only plans, and PACE. 3. ATI Advisory analysis of Medicare Advantage Organization's Evidence of Coverage documents.

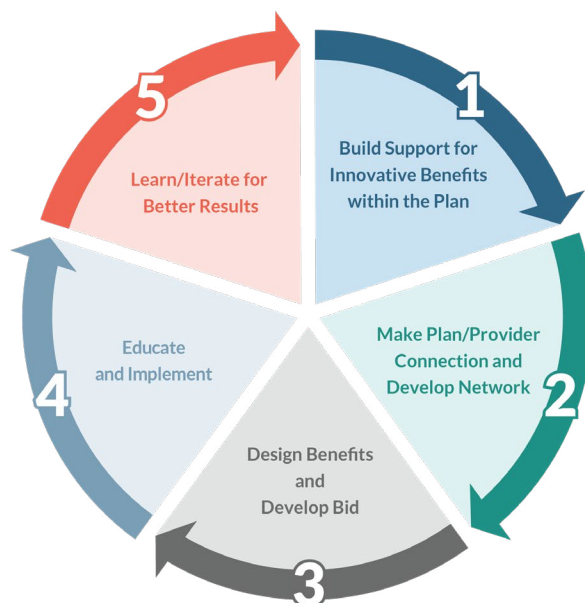


The Emerging Roadmap for Plans and Providers

Key themes emerged from our conversations with plans and providers that we organized into five steps to frame an overarching Roadmap. These steps are essential to maximize the potential reach of new, non-medical benefits, with consideration for beneficiaries, providers, and Medicare Advantage plans.





Early adopters emphasized these steps are not discrete or linear but, rather, there is a continuous development and improvement process. For example, a product design team might seek support internally for offering a new benefit while working on refined benefit design, and, simultaneously, the organization's network team might build or improve external provider and vendor relationships for that benefit.

Supplemental Benefit Development



1: Build Support for Innovative Benefits within the Plan

Roadblock: MA organizational culture and comfort with uncertainty deters uptake

-  Identify (or be) an internal advocate for new, innovative benefits
-  Identify the benefits members and staff want
-  Bring data and results to the conversation
-  Test a new benefit offering

KEY



Provider Finding



Plan Finding

Plan leaders must decide they want to use limited rebate dollars to offer non-medical supplemental benefits versus spending these dollars on other long-tested supplemental benefits or to reduce out-of-pocket spending. Depending on the historic approaches to supplemental benefits in an organization, deciding to undertake new, non-medical benefits may require building internal support and consensus slowly and iteratively.

Roadblock: MA organizational culture and comfort with uncertainty can deter uptake of new, non-medical benefits.

Plan Finding: Identify (or be) an internal advocate who can champion offering new, innovative benefits that align with larger organizational strategic plans and initiatives.

Plans offering non-medical benefits often have internal CHAMPIONS, who understand SDOH and/or LTSS and embrace innovation. The rules around offering these benefits are complex and varied, and require multiple teams within an MAO to work together to successfully file a benefit. Internal champions can help pull together the information and evidence outlined below and can map the new offering to successful realization of the company's strategic initiatives, such as delivering more care at home or nurturing relationships with family caregivers who may be a future member.

Plan Finding: Identify the benefits people want.

Multiple plans reported an important part of their benefit design process is engaging care managers, customer service staff, sales team, market leadership, and/or the clinical team on specific services or benefits for members. This engagement also can reflect member demand by capturing information about what benefits members are asking staff for. Providing the benefits members, staff, and providers identify as high-priority has the added benefit of easing burden during the education and implementation phase, as people are more likely to talk about, encourage, and use benefits they find valuable.

Example: One plan reported asking a plan member who served on their board what would help them with their monthly budget, and that resulted in the plan adding a specific benefit. The plan reported that the additional benefit resulted in increases in consumer satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS] scores) and was an attractor for enrollment.

As one provider put it, this should not be seen as a set of marketing tools but should be focused on helping people.

Plan Finding: Bring data and results to the conversation.

Return on investment (ROI) can take multiple forms, with plans pointing to reduced downstream medical costs, member attraction and retention, and member satisfaction as the most common goals for supplemental benefit offerings. Building support also requires discussions around how to define ROI and a re-orientation to benefit design focused on meeting individual member needs, more than as a marketing tool.

Internal champions should perform due diligence on potential benefit offerings – conducting desktop literature reviews and interviewing experts with a focus on making a pitch for interventions with strong evidence of one or all these outcomes in at least one instance/evaluation. Additionally, non-medical providers can provide evidence to MA plans on the outcomes related to the benefits they provide. More evidence is better, but multiple interviewees flagged that MA plans will still want to build and assess the evidence within their own membership.

Plan Finding: Test an offering.

If strong evidence is not available or if leadership has concerns about risk, you can pitch a test of the benefit. One way to build evidence and allay concerns about uncertainty is to start small to build the case. Many plans are willing to “test” a new offering using various authorities – quality improving activities (QIA) or offering a new supplemental benefit in a D-SNP.

There are multiple reasons to provide benefits in a Special Needs Plan (SNP). Providing supplemental benefits in a SNP allows you to target benefits to a particular high-need population (in the case of a D-SNP, a low-income population) more likely to benefit from specific services, and to leverage your existing care model and care coordination infrastructure. Further, if providing a new benefit, for example In-Home Support Services, in a D-SNP, a plan can leverage an existing network infrastructure from the Medicaid side of the MA plan’s parent company.

This finding is born out of the data: 12% of MA plans in 2021 are offering newly available benefits under the expanded definition of primarily health-related benefits but 25% of D-SNPs are offering a benefit and 35% of Chronic Condition Special Needs Plans (C-SNPs). Offerings that prove successful in a SNP can then be considered for broader application in MA plans available to all Medicare beneficiaries.

2: Make Provider/Plan Connection and Develop Network

Roadblock: Providers lack access to plan’s team that develops supplemental benefits



Use every tool available to connect to the right person in the plan

Roadblock: A single provider often cannot serve a plan’s entire service area



Digital health and third-party aggregators can provide solutions

Roadblock: Providers are experiencing contracting overload



National associations, franchisors, and third-party entities can help build infrastructure



Review contracts to streamline requirements

Roadblock: Lower-volume services may require a higher level of payment



Provide information about requirements that drive costs



Work with plans to offer high value, sustainable benefits

KEY



Provider Finding



Plan Finding

In addition to building internal support for providing new supplemental benefits, it’s imperative to have providers who can reliably deliver high-quality services. Providing new benefits – things like food delivery, homemaking services, social club memberships, or pest control – requires partnering with new provider types. These providers are often not “Medicare-certified” and have little or no experience contracting with MA plans. Likewise, MA plans do not have experience working with these groups.

In many instances, providing these benefits requires building a new provider network from scratch. Plans must provide benefits to all members who qualify for them; therefore, the provider network must be able to cover a plan’s entire service area, which usually stretches multiple counties, statewide, or even multiple states. Oftentimes, provider service areas do not align with the plan’s geographic coverage area.

Most findings in this tool focus on MA plan action, but because of the focus on plan/provider relationships and network development, this section includes findings for both plans and providers.

Roadblock: Potential providers do not connect to the individual or team who owns supplemental benefit development and vice versa.

We have frequently heard from providers how difficult it is for them to find the right person at an MA plan to talk to about becoming a provider of supplemental benefits. Plans are often large and complex, and getting to the right person can be difficult.

We heard from an interviewee that it is not clear who owns certain new benefits within plans – it could be the quality team, product team, marketing team – all depending on who sees the value in the program. Medicare and Medicaid staff are often siloed, so, even when a provider has a contract to provide services for Medicaid beneficiaries, they sometimes report difficulty connecting to the right person for Medicare benefit decisions.

At the same time, we heard from plans that they are always looking for higher quality providers, and if one can be identified, will end relationships with vendors who are underperforming. They are looking for vendors who can deliver benefits consistently across geographies and provide an excellent member experience.

Provider Finding: Providers successful at attaining contracts with MA plans use every tool they have to connect to the right person.

Start with Medicaid contacts if you are already providing services for an MA plan's Medicaid products. While there are often siloes between Medicare and Medicaid teams, plans reported leveraging existing relationships with Medicaid suppliers. Ask your Medicaid contact to connect you to the Medicare staff. Providers report significant effort building connections, including working through board members. Other provider organizations hire staff with experience contracting and working with MA plans. It's all about building relationships.

Roadblock: A single provider often cannot serve a plan's entire service area.

This is particularly common for local providers and community-based organizations (CBOs). Because of the administrative complexity and burden, plans don't want to contract with dozens or hundreds of providers and either opt for a national provider if one is available or opt not to provide the benefit at all. Plans sometimes report not being able to access services in certain geographies, for example in rural geographies.

Plan and Provider Finding: Digital health and third-party aggregators provide solutions.

Some plans have recognized they may benefit from bringing in aggregators to facilitate benefit provision across a plan's entire service area. Plans may harm their fulfillment and ultimately member satisfaction if they do not have a high-quality network to deliver services.

There are multiple solutions to solve for this issue. In some instances, a provider develops underlying infrastructure, using technology as the base, and scales up to cover the entire service area. This includes providers such as Uber, Lyft, and Papa. These solutions rely on the Gig Economy and independent contractors to perform individual tasks. Workers receive training and are put through a background check.

In other instances, a third-party entity develops a network of businesses and/or non-profits. No individual provider can cover the plan's entire service area, but the third-party entity created network can. With this solution, the plan usually contracts with the third-party aggregator and the aggregator enters sub-contracts with a network of providers. This is an emerging marketplace that is evolving with the expansion of supplemental benefits in MA. We have identified some examples of entities filling this role (this list is not exhaustive), including: healthAlign, Solera, and CBO Networks, like the Partners at Home Network, VAAACares, Western New York Integrated Care Collaborative, and Juniper. For sustainability, when providers contract with a third-party entity, it is important that they are paid reasonable rates for services provided.^{17,18}

Roadblock: Providers are experiencing contracting overload.

We heard from multiple providers that contracts from MA plans are written for Medicare providers and well-resourced organizations with experience working in the healthcare space—entities who by their nature are required to comply with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and have existing Medicare billing/claims infrastructures. These contract terms are medical in nature, describing health services, credentialing and accreditation, medical records, clinical data, insurance requirements, and network referrals. Plans have to meet a myriad of requirements to provide all Medicare services and to protect beneficiaries and their data. The costs to comply with these requirements can be significant and a substantial deterrent to potential partners.

Plan and Provider Finding: National associations, franchisors, and third-party entities can build the infrastructure necessary to contract with MA organizations.

This can include legal review of contract terms; securing adequate insurance, including cybersecurity insurance; developing HIPAA-compliant infrastructure; billing capabilities; or IT infrastructure for reporting and data collection. This approach spreads the infrastructure costs across multiple providers, reducing the per unit cost significantly. It also takes significant burden off local organizations to each build the infrastructure independently, enabling them to focus on delivering high-quality services.

¹⁷ **Note:** CBO Networks and health care organizations can work together to address social needs of beneficiaries. Leaders have called for scaling the CBO network model across the country, to correspond to markets for health care delivery and payment. CBOs interested in building networks can access support from the Aging and Disability Business Institute; including this [tool](#) designed to help organizations and groups of organizations gauge their current levels of readiness for building, sustaining, and growing a coordinated network of service providers that contracts with health care entities.

¹⁸ Lance Robertson, Bruce Allen Chernoff. "Addressing Social Determinants: Scaling Up Partnerships with Community-Based Organization Networks." Health Affairs Blog. (February 2020). <https://www.healthaffairs.org/doi/10.1377/hblog20200221.672385/full/>.

Plan Finding: Plans should review their contracts for these services to simplify terms and assure all the requirements are necessary.

As one plan put it, you cannot just take a large network contract and put that directly in front of a small CBO. Simplification of terms and lowering of unnecessary barriers will enable MA plans to contract with new providers by lowering unnecessary costs. Plans should also consider working together to simplify contracting and reporting for CBOs. Questions to ask: Could insurance policy levels be lowered? Can contracts be updated/customized for non-medical providers?

Roadblock: The lower-volume services associated with supplemental benefits may require a higher level of payment than plans are accustomed to paying.

Multiple providers discussed viewing these initial years of lower reimbursement and especially low volume as investments in future offerings. Providers will not be able to continue to provide services if rates are too low to cover their costs and volume is unpredictable and/or so low that it cannot cover the costs of contracting and coordinating with the plan. Furthermore, non-medical providers do not have the same urgency to accept Medicare business as the Medicare-certified providers do. For example, Medicare-certified Home Health Agencies (HHAs) rely almost exclusively on Medicare for revenue, and therefore are in a poor negotiating position with health plans. A private pay home care company already has a strong revenue stream and can be more of a price setter than taker.

Health plans should focus on developing relationships with trusted and high-quality agencies and providers. They should set rates that reflect research on the myriad of payment sources for many of these benefits, such as Medicaid, private pay, and Veterans Affairs (VA). In the case of In-Home Services and Supports, plans should be cognizant that direct care workers who receive a living wage are more likely to deliver a high-quality service.

Provider Finding: Provide information and education about regulatory and other requirements that drive costs.

For example, a provider reported that regulatory requirements in one state drive up costs of a benefit relative to costs in other states. A plan contracting across many states may not realize that these differences are driving meaningful differences in costs and would benefit from a provider sharing this information. If a small increase in rate per hour is needed to provide a sustainable benefit, a small decrease in the number of hours of services available may be required. Additionally, and particularly if costs are higher than competitors, providers must be able to highlight and demonstrate the added value of a more costly or comprehensive service. Sometimes a more expensive service can still be a higher value service. Providers should be prepared to clearly articulate their *value proposition*.

Plan and Provider Finding: Providers should work with plans to offer highest value, sustainable benefits.

When implementing a particular supplemental benefit, providers report discovering improvements that could be made to the structure of the benefit to increase efficiency or effectiveness of the service. For example, home care providers typically provide services in four- or eight-hour increments, but some Medicare plan benefits are designed in two-hour increments. Increasing the benefit to a four-hour increment results in easier fulfillment of service requests, less windshield time for providers, and more efficiency. Coupling a longer service period with more flexibility to provide individualized services a member needs can result in a higher-value benefit.

3: Design Benefits and Develop Bid

Roadblock: Benefits can be costly to provide to all members



Target costly benefits to the highest need members

Roadblock: Plans must determine who is eligible for the benefit



Make benefits available through a care manager



Advocate for CMS to provide examples of what does and does not meet the three-part test

Roadblock: CMS expresses concerns about a proposed benefit offering



Design benefits to meet statutory and regulatory requirements

KEY



Provider Finding



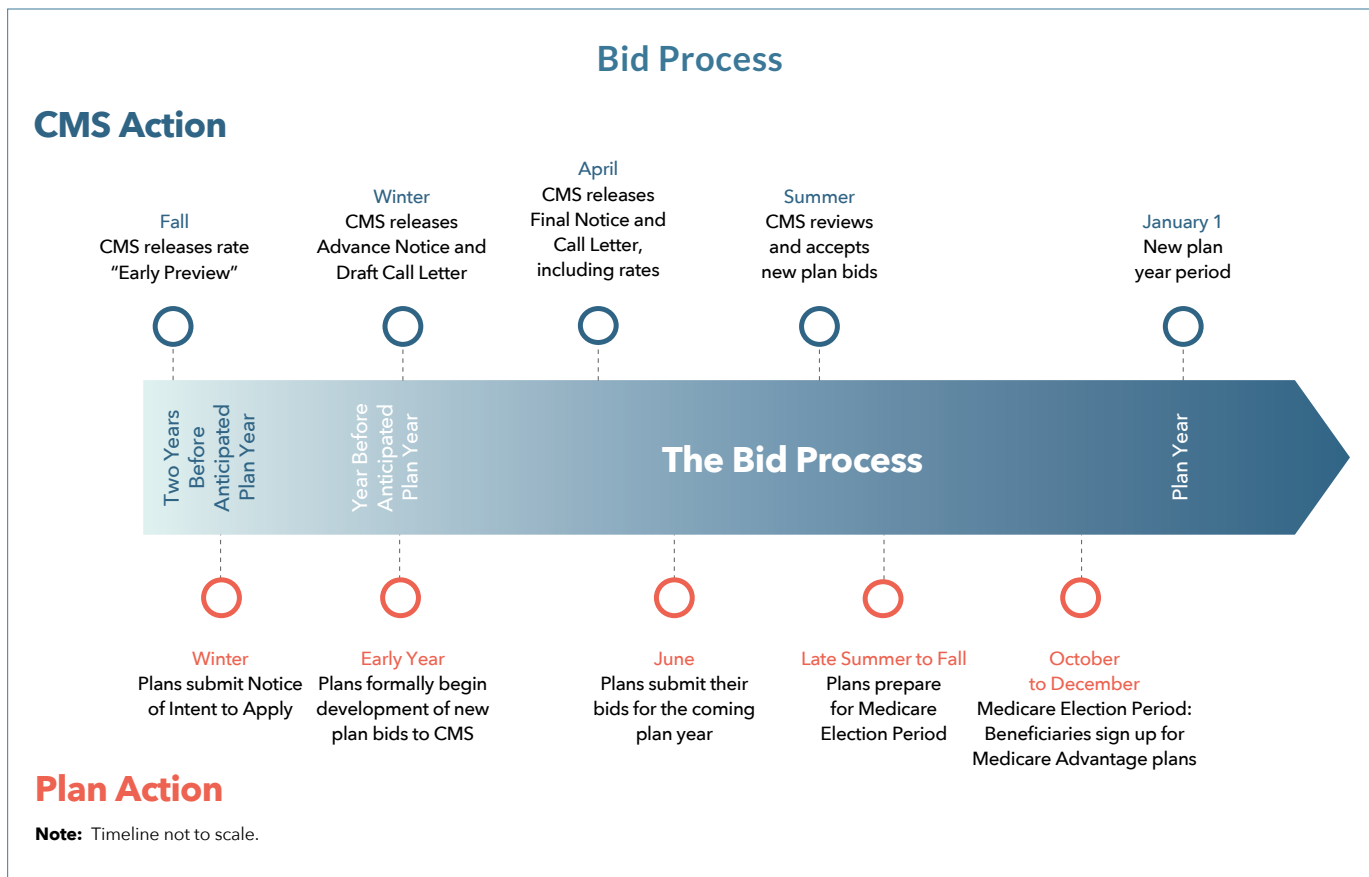
Plan Finding

Plans must provide all traditional Medicare-covered benefits under a “benchmark” payment they receive from CMS, which varies by county and is adjusted each year. If plans are able to cover traditional Medicare benefits for less than this benchmark, they must use their savings on supplemental benefits and reducing beneficiary out-of-pocket spending. Plans can also charge premiums to provide supplemental benefits.

Typically, the dollars available for these benefits are limited, on average rebates are \$122 per member per month. Because of this, non-medical benefits must compete with benefits like dental and vision for these limited dollars. Plans file their benefit packages with CMS in early June every year, but begin designing benefits as early as Fall of the prior year (i.e., Fall of 2020 for benefits available in January 2022).¹⁹

¹⁹ The Centers for Medicare and Medicaid Services. (2020).

<https://www.cms.gov/files/document/cy-2021-medicare-part-c-application.pdf>.



Roadblock: With limited funds, more meaningful benefits are too costly to provide to all members.

Plan Finding: Plans can target more costly benefits to the highest need members most likely to benefit from them.

As highlighted throughout this resource, dollars for these benefits are limited. More costly benefits will need to be targeted to those with chronic conditions and high needs, while less costly benefits can be made available to a broader swath of members. This downward pressure on costs per member is unlikely to go away, at least in the near-term.

Using the flexibilities CMS and Congress have provided, including the new uniform flexibility that allows plans to offer services tied to health status or disease state and the ability to further target SSBCI based on SDOH, plans can provide more comprehensive and costly benefits than they previously could afford. For example, an MA plan could, after identifying a member as chronically ill, consider SDOH as a factor to help identify members whose health could be improved or maintained with SSBCI.²⁰ Through our research, we have not identified plans using this additional flexibility to further limit or target eligibility for SSBCI. This appears to be an under-utilized authority that has the potential to allow for high impact interventions/benefits. Further exploration of why this authority is not being used more broadly is needed.

²⁰ The Centers for Medicare and Medicaid Services Guidance. (April 2019). https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

Roadblock: Determining who is eligible for the benefit, particularly for SSBCI.

Plan leaders may not want to take on the administrative complexity of offering non-medical supplemental benefits, including targeting to individuals rather than an entire group. In all benefit designs, benefits must be provided in a consistent, equitable, and non-discriminatory manner.

When designing benefit offerings, plan leaders assess the actual offering, the strength of likely providers, and which members should receive the benefit. Plans shared varying perspectives and strategies on benefit design – ranging from 1) designing benefits to be very targeted with generous benefits for greatest impact for a high needs population to 2) designing less costly benefits available to the broadest group of members. Who the plan is trying to reach matters a great deal, and each benefit authority brings with it different criteria around who can receive it and how it can be targeted. For SSBCI specifically, it can be difficult for a plan to determine that a member meets the three-part definition for being chronically ill, specifically that they are at a high-risk for hospitalization and require intensive care coordination. This roadblock is particularly acute for larger plans with many members with diverse needs.

Plan Finding: Plans can make benefits available through a care or case manager, who can, using the member’s medical record, assess that an individual meets the SSBCI criteria for being a high-needs chronically ill enrollee and facilitate the member actually accessing the benefit. Plans will want to document the assessment of SSBCI eligibility for potential CMS audits. Alternatively, a primary care provider or other physician can attest or confirm an individual meets the SSBCI criteria, and this must be documented. Some MAOs choose to offer SSBCI through a C-SNP, because they can immediately establish that all beneficiaries meet the three-part criteria.

Plan Finding: Plans need to advocate with CMS to provide examples of processes/ documentation that do and do not meet the three-part test. Examples demonstrating various approaches to meeting this three-part test will provide more clarity to MAOs, while continuing to support plan flexibility and innovation.

Roadblock: A plan files their benefit package and CMS expresses concerns about a proposed benefit offering.

Plan Finding: Benefits must be designed to meet the statutory and regulatory requirements. Understanding those requirements will go a long way in helping to assure that benefits meet CMS’ standards. We applaud CMS for the examples of benefits they have provided in previous guidance and encourage CMS to consider adding to their lists of example benefits concrete examples from plan benefit filings to illustrate the types of benefits that are and aren’t acceptable under the various authorities.

4: Educate and Implement

Roadblock: Key staff may not know the benefit is available or how to access it



Educate staff about benefit offerings



Educate care managers and discharge planners about a benefit and its impact



Educate network providers

Roadblock: Members do not know they are eligible for a service or how to access it



Communicate early and often



Build an infrastructure for eligibility and referral



Educate information providers

KEY



Provider Finding



Plan Finding

We heard from many plans and providers that doing all the work to win internal support, develop the benefit and bid, build the network, and work through contracting hurdles is just the first step. The massively important second step is educating the plan staff, providers, and members that the benefit is available, as well as what eligibility criteria are required, so members actually access the benefit. If members do not use the benefits, it could result in plans not meeting certain statutory requirements for the percentage of funding they spend on medical costs, known as Medical Loss Ratio (MLR) requirements.

One provider explained: “Having your benefit offered by a plan does not guarantee sudden member utilization. Member awareness and benefit utilization will be dependent on the plan’s skill and experience communicating benefits, generating awareness, and driving conversion. There is a wide range of ability across plans so results will vary significantly. Working closely with the plan to develop an effective member communications strategy is critical to driving benefit utilization.”

Quantitative data on service utilization is not available for these new benefits, so while we can definitively say where benefits are offered and by which plans, we cannot identify how many beneficiaries are eligible for the benefit, or how many actually used it. Many plans and providers reported low uptake in 2020. This is to be expected to some extent, with benefits that are so new, and in a year where COVID-19 has dramatically affected use patterns for medical and non-medical services. As sales teams, care managers, and beneficiaries become more accustomed to these benefits, we expect utilization to increase. Below are some steps plans and providers can take to increase uptake.

Roadblock: Care managers, discharge planners, providers, and agents may not know the benefit is available or how to access it; and therefore, do not tell members about it.

Plan Finding: Staff education – including the clinical team, the sales team, and the network team – is vital; after all, if staff don't know about a new benefit, they can't tell members about it. Clear, simple educational materials can go a long way: What is the benefit, who is eligible for it, how do you access it? This seems basic, but this step is vital to having a benefit that is used and can have the intended positive effect on members' lives.

Provider Finding: Supplemental benefit providers can also help educate care managers and discharge planners about a benefit and its potential impact for members.

We heard from providers that building relationships with the referring partners/care managers is a really important step that can increase referrals for services, communication, and feedback loops about service fulfillment, and ultimately result in better experiences for the member.

Plan Finding: Educate your network providers, particularly focusing on primary care providers (PCPs) and specialists who often act as PCPs for certain populations (e.g., Oncologists, Nephrologists, Gynecologists) about benefits available to members.

The more specific information a plan can share with providers the better – e.g., a list of members you see who have a history of a certain ICD-10 codes that likely make them eligible for this benefit or service.

One plan executive described “the primary care relationship as the most well recognized and influential relationship with a member.”

PCPs can help encourage members to access and use benefits available to them. We recognize this education is not easy – PCPs do not usually

work with just one insurance plan and the amount of information thrown at them can be overwhelming. But pushing out information through provider portals about members they see and benefits those members are eligible for has the potential to improve outcomes for the members and is a valuable service to them and the PCP.

Roadblock: Members do not know they are eligible for a service or how to access it.

Plan documents such as the Evidence of Coverage (EOC) are not every day reading for most people so including information there is necessary, but often insufficient to truly inform members.

Plan Finding: Communicate early and often.

One plan executive reminded us that sometimes you have to say things 3-5 times for them to stick. Educating members starts at the point of sale, continues through welcome calls, materials, and brochures, and requires explaining benefits clearly and simply to members.

Plan Finding: Plans should build an infrastructure to identify members who are eligible for benefits and refer them to services.

Plans take different approaches for outreach.

- 1) The plan identifies eligible members (via ICD-10 codes, care management processes, etc.) and refers them to the provider. The plan takes an active role in promoting the service and getting it to eligible members, ideally as part of a care management process. For example, one plan connects members to a care manager to get to know the individual member and their needs, and to connect them to supplemental benefits that are flexible but limited to a specific dollar amount. This approach puts the person at the center and allows the care manager to both use community resources and deploy supplemental benefits to meet the member need.
- 2) Providers can also outreach directly to plan members, but there is an added hurdle since the members may not know the provider, which can cause confusion. This approach can be successful though, and takes some burden off of the health plan. This step works best if the plan provides a vetted list of eligible members to the provider.
- 3) Member self-identification and direct outreach to providers can be difficult, as benefit structure and eligibility is sometimes confusing and often members are not actually eligible for the benefit. Often, members will reach out to the provider, the provider will do research to help the member, and the member will not be eligible for services. This approach is less efficient than the first two.

With any approach, it is vital that the plan assures all members who qualify for the benefit have equitable access to the benefit.

Plan Finding: Plans should educate information providers.

State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and MA insurance agents and brokers are all important sources of information for Medicare beneficiaries. Plans should provide information about available benefits, qualifying criteria, and how members can access benefits. Benefit information should be clear about what is and is not available. Plans should not over-promise in their educational materials, rather they should state in plain language what benefits are available and to whom.

5: Learn/Iterate for Better Results

Roadblock: Members are not using these benefits



Assess the “why”



Try innovative benefit offerings that provide more flexibility and choice

Roadblock: Collecting evidence is difficult



Identify a matched-comparison group



Use informal evaluations and feedback

Roadblock: Benefits may appear to cost more than they save, but care managers, providers, and/or members report high value



Assess how the benefit is sized and targeted

Roadblock: Plans are not incentivized to share their learnings with other plans



Share key findings through trusted and neutral third parties

KEY



Provider Finding



Plan Finding

Plans, providers, beneficiaries, and CMS are all learning in this early implementation phase for SSBCI and expanded primarily health-related benefits. This is necessarily an iterative process, and it is likely that some benefits will rise to the top and become more broadly offered in the future. Those benefits are likely to be ones that:

provide members something they want

Help with attracting and retaining members and member satisfaction

show a positive return on investment

Reduce unnecessary medical expenditures by an amount close to or greater than the cost of providing the benefit

can be provided across an entire service area

Benefits must be available to all eligible beneficiaries

This is part of the natural learning process and will result in better designed benefits over the longer-term. SSBCI and expanded primarily-health related benefits should evolve with continuous learning and improvement.

As plans and providers gain experience with offering these new benefits, they can also shift to more innovative payment arrangements with providers that base at least a portion of payment on outcomes, such as reduced re-hospitalizations. Aligning payment structures with outcomes and goals incentivizes providers to not just provide units of service but to provide services that result in better outcomes.

Roadblock: Members are not using the benefit available to them.

While this is common with all supplemental benefits (e.g., gym memberships, dental benefits), plans expressed particular concern with some of the newer non-medical benefits.

Plan Finding: Assess the “why”- is this an awareness issue, is the benefit too hard to access, or are members simply not interested in the offering?

Member feedback, collected through calls, surveys, or other means, can provide valuable information about how members view the supplemental benefits offered, their awareness and interest in them, and the perceived value of said benefits. If beneficiaries are aware of the benefit and still not using it, consider re-designing the benefit or the process to access it, finding new/better providers, or eliminating the benefit based on what you learn.

Plan Finding: Try innovative benefit offerings that provide more flexibility and choice for the member.

Plans report different approaches for providing more flexible benefits for members, allowing the member to have choice in what benefits they access based on what they value. Some plans offer a menu of benefits that members choose from, providing them control over the benefits they access. Other plans are providing a maximum dollar limit for a set of supplemental benefits, where the care manager works with the member to identify what would be most valuable for them. Still other plans are providing benefit cards, that members can use to buy specified services or products they need.

Roadblock: Collecting gold-standard randomized control trial information is nearly impossible – as benefits must be offered to all members who qualify.

Plan Finding: In the absence of a randomized control group, plans can identify a matched-comparison group – for example, a group of similar members in another plan or the same plan. Plans can also use before and after comparisons, and this is common as a less costly option, though evidence from this approach is less rigorous. Above all, plans should include an evaluation component in the design of the benefit and collect key metrics – hospitalizations, emergency room visits, overall spending for members receiving these benefits – and assess those results compared to what the plan expected.

As one interviewee put it, receiving an ROI is going to help with the staying power of a benefit as a supplemental offering – the benefit is then something a plan can invest in and grow over time.

Plan Finding: Less formal evaluations and feedback can also be highly informative and valuable. Less formal learnings can and should be incorporated. We heard from at least one plan that they will have a small subset of plans offer a new benefit, then monitor utilization and collect feedback from member and sales teams as part of assessing the potential for offering the benefit more broadly.

Roadblock: A benefit looks like it's costing significantly more than it saves, but care managers, providers, and/or members report the benefit is of high value to them.

Plan Finding: Assess how the benefit is sized and targeted. It is possible that a limited benefit provided to a broader group of members is costly with little impact, but a more robust benefit provided to a smaller group of high-need members could prove beneficial and cost-effective. Assess impacts across both lower-need and higher-need members with chronic conditions, and consider tailoring the benefit to meet the needs of the highest-need members.

Roadblock: Plans are not incentivized to share their learnings with other plans.

As plans compete for market share, they are incentivized to keep learnings close to maximize their competitive knowledge and advantage.

Plan Finding: It is in the best interests of the insurance sector to evolve their information sharing in a manner that lifts all boats and ensures continued policy support for these benefits. Neutral and trusted third-party entities, such as trade associations, can and should play a valuable role here. There is particular value in sharing: evaluation results for implemented interventions (benefits) and technical best practices around contracting – for example, sharing resources for a third-party entity to create a “sample” contract for non-medical providers.



Conclusion

MA plans and providers are very early in the implementation of these benefits and there has been significant progress in offerings, infrastructure, and market development, but there is still significant development and learning to come. We are seeing exponential growth, with nearly 4x the number of plans offering SSBCI in 2021 than in the first year of implementation in 2020. With this growth and because these authorities allow plans to meet member needs more flexibly, these non-medical benefits are here to stay. If we have learned anything in 2020, it is that flexibility to meet member needs is paramount.

There is a lot to be optimistic about in this space and there are also some gaps, described in three major categories below:

- 1) Gap between plan needs for provider networks and existing network infrastructure.
 - ▶ **Solutions:** Third-party aggregators; provider development of needed capacities; contract review and simplification
- 2) Gap between making these benefits available and members accessing and benefitting from them.
 - ▶ **Solutions:** Focused educational efforts and clear communications for staff, members, and other stakeholders; benefit design focusing on ease of access, use, and choice
- 3) Gap between these benefits' potential and the current early experience.
 - ▶ **Solutions:** Building internal support for offering these benefits; evaluating early implementation; sharing lessons learned and evidence; evolving benefits with continuous learning and improvement

This resource is full of approaches and practical solutions for overcoming barriers or gaps and using these new authorities to provide supplemental benefits to meet the individual needs of Medicare beneficiaries.

At a macro level, one thing is clear – Medicare beneficiaries will only realize the full benefit of these offerings if there is a focused effort on the part of all stakeholders – government, plans, providers, information-providers, and beneficiary advocates:

- To provide clear communication and information about available benefits and
- To collaborate for improvement

With the guidance of the SSBCI Leadership Circle and the support of The SCAN Foundation, LTQA and ATI Advisory plan to continue the conversation and provide more venues for collaboration and sharing through data analysis, insights, and additional research.

2020 Supplemental Benefit Offerings and 2021 SSBCI

For more information on what benefits (including SSBCI) were available in 2020, see ATI Advisory’s previous [analysis](#). ATI Advisory will publish a data brief on SSBCI when data become available in early 2021.

Methods

Quantitative and qualitative data used to inform this Roadmap were gathered using a number of sources. The first data source for supplemental benefit information was taken using the Plan Benefit Package (PBP) Data, available publicly by CMS. This data source provides information on which plans are offering the expanded definition of primarily health-related benefits and SSBCI in Plan Year 2020 and the expanded definition of primarily health-related benefits in Plan Year 2021, as well as information on the counties where these plans are offering these benefits. ATI Advisory analysis of the PBP files excludes the following plan types: Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE. For more detailed information on how plans offered these services to their beneficiaries, ATI Advisory reviewed plans’ Evidence of Coverage documents, available on plan websites. Finally, interviews were completed with numerous stakeholders including 10 plans (1 plan responded through a questionnaire), 11 providers, and 2 beneficiary advocate groups, to learn about their experiences with these non-medical benefits. Findings were further supplemented through conversations and guidance, from the SSBCI Leadership Circle, as well as other presentations and discussions with stakeholder groups.

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24 Hour Home Care

Anthem, Inc.

Blue Cross Blue Shield Association

CareOregon

CVS Health, Aetna

Element3 Health

FirstLight Home Care

Geisinger Health Plan

healthAlign

Kaiser Permanente Health Plan Mid-Atlantic States

Meals on Wheels America

Medicare Rights Center

Mom's Meals

National Council on Aging

Papa Inc.

Partners in Care Foundation

Project Well, Inc.

SCAN Health Plan

Solera Health, Inc.

UnitedHealthcare

UPMC Health Plan

WellCare, a Centene company

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About ATI



ATI Advisory is a DC-based advisory services firm that helps business and government leaders transform care delivery for frail older adults and their families. ATI conducts research, develops new ideas and insights, and enables strategic partnerships to break down public and private sector barriers that prevent innovative solutions to siloed, broken systems across acute, post-acute, and long-term services and supports (LTSS). For more information, visit atiadvisory.com.

About LTQA



The Long-Term Quality Alliance (LTQA) is a 501(c)3 membership organization aimed at improving outcomes and quality of life for persons who are managing functional limitations, and their families. LTQA advances person- and family-centered, integrated long-term services and supports (LTSS) through research, education, and advocacy. For more information, visit www.ltqa.org.

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