As new, non-medical supplemental benefits in Medicare Advantage (MA) plans continue to be offered by more plans over time, Medicare Advantage Organizations (MAOs), providers, policymakers and other stakeholders must work together to ensure these benefits succeed. Seeking to advance these new, non-medical supplemental benefits, a group of national experts (addressed as the "Special Supplemental Benefits for the Chronically Ill (SSBCI) Leadership Circle") developed a set of Guiding Principles for these new benefits. Building on this work, this Policy Brief provides context on MA plan considerations for the inclusion of non-medical supplemental benefits in their 2021 bids and identifies short- and long-term policy opportunities to enhance the availability of non-medical supplemental benefits to Medicare beneficiaries.

The guiding principles are:

- **Core Principle:**
  SSBCI Reflect Individual Needs

- **Balancing Principle 1:**
  SSBCI Are Clear and Understandable

- **Balancing Principle 2:**
  SSBCI Are Equitable

- **Balancing Principle 3:**
  SSBCI Are Manageable and Sustainable

- **Balancing Principle 4:**
  SSBCI Evolve with Continuous Learning and Improvement

Please see Appendices A and B for full framework and descriptions.
Executive Summary

The purpose of this policy brief is to:

1. Provide context on plan considerations for the 2021 Bid Process and inclusion of non-medical supplemental benefits in Medicare Advantage (MA) plans; and

2. Highlight short- and long-term policy opportunities to enhance the availability of non-medical supplemental benefits to Medicare beneficiaries and to increase benefit utilization.

Background

In 2020, MA plans have unprecedented flexibility to offer non-medical supplemental benefits to members due to both the expanded definition of "primarily health-related” benefits (expanded PHRB) and the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI).

First available in 2019 and 2020 respectively, expanded PHRB and SSBCI continue to be offered by more plans over time. The number of MA plans offering an expanded PHRB has increased from 499 plans in 2020 to 737 plans in 2021. For SSBCI, the number of MA plans increased from 245 plans in 2020 to approximately 920 plans in 2021.

Top Plan Considerations and Challenges in Offering New Benefits

There are five key areas where Medicare Advantage Organizations (MAOs) encountered barriers that impeded their ability to offer and deliver non-medical supplemental benefits: lack of clarity around benefit eligibility, lack of consumer awareness and understanding, timing of guidance from the Centers for Medicare and Medicaid Services (CMS), sustainability concerns, and limited experience contracting with non-traditional providers.

Additional factors influencing MAOs’ decisions around offering and designing benefits included the MAOs’ internal culture and benefit marketability.
Policy Opportunities

Based on these key considerations, several short- and long-term policy opportunities were identified to advance the availability of non-medical supplemental benefits to Medicare beneficiaries and to increase benefit utilization (Table 1). Future considerations for expansion of non-medical supplemental benefits include offering them as a preventive benefit to address health needs and/or social risk factors and pilot testing promising benefits in Medicare Fee-For-Service (FFS) value-based models.

Table 1. Policy Opportunities for Advancing Non-Medical Supplemental Benefits

<table>
<thead>
<tr>
<th>Short-Term Policy Opportunities for CMS</th>
<th>Long-Term Policy Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide more clarity and technical assistance for MAOs on allowable benefits and targeting criteria</strong></td>
<td><strong>Encourage learning between plans, providers, and other stakeholders</strong></td>
</tr>
<tr>
<td>An immediate opportunity for policymakers to accelerate plan take-up of SSBCI is to provide guidance that clarifies statutory language around the targeting criteria for SSBCI. CMS should also provide examples of allowable and non-allowable benefits, while continuing to encourage creativity and innovation.</td>
<td>Policymakers should consider opportunities such as learning collaboratives or public forums to promote exchange of best practices, while respecting plans’ and providers’ intellectual property.</td>
</tr>
<tr>
<td><strong>Improve marketing guidance and consumer information</strong></td>
<td><strong>Consider options to improve sustainability of non-medical benefits</strong></td>
</tr>
<tr>
<td>Medicare beneficiaries do not have sufficiently clear and accessible information about these new benefits. With clear guidance from CMS on how these benefits can be marketed as well as improved information on Medicare Plan Finder, plans can do more to educate potential members on which non-medical benefits are available to them.</td>
<td>Given challenges posed by relying on rebate and premium dollars to finance supplemental benefits, there is an opportunity to develop better risk adjustment and explore a more sustainable funding mechanism for these benefits.</td>
</tr>
<tr>
<td><strong>Release guidance around non-medical supplemental benefits earlier</strong></td>
<td></td>
</tr>
<tr>
<td>In 2018 and 2019, MAOs faced a compressed timeframe to develop their bids for the following years. Releasing guidance in November or December (instead of the following April) will better support MAOs’ abilities to design and build new benefits for their beneficiaries.</td>
<td></td>
</tr>
</tbody>
</table>

Please see the accompanying Roadmap in the “For Plans and Providers” section of this page for actionable steps and tactics for plans and providers to overcome roadblocks and deliver new, non-medical benefits to Medicare beneficiaries.
Background

Historically, the Centers for Medicare and Medicaid Services (CMS) has required that Medicare Advantage (MA) supplemental benefits, or benefits not covered by traditional Medicare, be “primarily health-related” and available to all members uniformly. Two recent changes give MA plans new flexibility to offer a wide range of supplemental benefits under expanded or new definitions, and to target them to members with specific conditions.

In 2018, CMS re-interpreted the definition of “primarily health-related” benefits (PHRB) to include some non-medical items or services, effective in 2019. Previously, the definition was limited to “an item or service whose primary purpose is to prevent, cure, or diminish an illness or injury.”¹ CMS’ reinterpretation of what it means to be “primarily health-related” expanded the scope of PHRB to services that:

1. diagnose, prevent, or treat an illness or injury, compensate for physical impairments;
2. act to ameliorate the functional/psychological impact of injuries or health conditions; or
3. reduce avoidable emergency and healthcare utilization.²

In the same guidance from 2018, CMS also waived the uniformity requirement, permitting MA plans to offer tailored supplemental benefits for “similarly situated individuals” based on disease state or condition (“Uniform Flexibility”).³

The second change was the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI) by Congress in the CHRONIC Care Act, effective in 2020. SSBCI may include services that are not primarily health-related, such as pest control or non-medical transportation, as long as the service has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. The new law also

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² Ibid.
³ Ibid.
gave the Secretary of Health and Human Services the authority to waive, only with respect to SSBCI, uniformity requirements which necessitate that benefits be made available to all enrollees.\(^4\) Throughout this policy brief, “non-medical supplemental benefits” refer to benefits provided under both SSBCI and the expanded definition of PHRB. (Note: Learn more about these new benefits in this primer released by ATI Advisory.)

The number of MA plans offering expanded PHRB and SSBCI have grown exponentially since they were first made available in 2019 and 2020, respectively (Figure 1).\(^5,6,7\) The number of plans offering specific types of new supplemental benefits can be found in Appendix C.

**Figure 1. Plans Offering New, Non-Medical Benefits In Plan Year 2020 and Plan Year 2021**

<table>
<thead>
<tr>
<th>Expanded Definition of Primarily Health-Related Benefits</th>
<th>SSBCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year 2020</td>
<td>Plan Year 2021*</td>
</tr>
<tr>
<td>499</td>
<td>920</td>
</tr>
<tr>
<td>737</td>
<td></td>
</tr>
<tr>
<td>245</td>
<td></td>
</tr>
</tbody>
</table>

\(^*\)Note: Plan Year 2021 SSBCI numbers taken from CMS press release, which uses language “about X plans” so numbers are approximate.  

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\(^6\) ATI Advisory Analysis of CMS PBP files. 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.

Top Plan Considerations and Challenges in Offering New Benefits

Policymakers and other stakeholders seeking to increase plan uptake and beneficiary utilization of these new benefits should be aware of the key factors that may impede MAOs from offering these benefits. While the Roadmap shares actionable steps and tactics for plans and providers to overcome challenges, this policy brief takes a broader lens on the issues to provide critical context and nuances for policymakers as they consider system-level changes.

The MAOs interviewed were generally enthusiastic about the opportunity to add benefits that could provide greater non-medical supports and services for their members with complex care needs. However, there are a range of factors that MAOs consider when deciding whether or not to include these new, non-medical benefits in plan bids. The short- and long-term policy opportunities referenced in this section are further discussed in the next section.

Culture of Medicare Advantage Organizations

“We like to fail small and win big”

The internal culture of MAOs played a role in their decisions about whether or not to offer new, non-medical supplemental benefits. Some MAOs are more open to testing new interventions with limited evidence of their impacts on health outcomes and medical utilization. Other MAOs are less willing to take on the risk of designing and administering new benefits. Given the lack of certainty around whether CMS will accept their bids, some MAOs noted hesitancy to invest significant resources in designing benefits where they have little experience. MAOs with cultures that generally support innovation and risk tend to be more comfortable moving forward in the face of the considerable unknowns in these new benefits.
Overall, many MAOs are eager to test expanded PHRB and SSBCI, collect data on their impacts, and iterate on their offerings. With more time, resources, and shared learning dedicated to this area, we expect design and administration of these new benefits to improve and grow.

**Targeting of Benefits**

*“Being able to target benefits to those who need it – sometimes our hands are tied”*

For MA plans, targeting particular benefits to a specific subgroup of members is novel. MAOs identified a specific and significant barrier in the decision to offer SSBCI related to the statutory definition of benefit eligibility. The CHRONIC Care Act specified the following three criteria for defining someone as ‘chronically ill’ for the purpose of SSBCI eligibility:

1. 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;
2. has a high risk of hospitalization or other adverse health outcomes; and
3. requires intensive care coordination.\(^8\)

Several MAOs noted uncertainty in interpreting the second and third criteria. For instance, some may interpret the second criterion on hospitalization risk as requiring a beneficiary to have had a hospitalization within the past year while others may require only a diagnosis that is associated with a higher likelihood of hospitalization, regardless of actual utilization.

Furthermore, concerns regarding how CMS will audit these new benefits has led to increased administrative burden for MA plans who are offering SSBCI. One MAO commented that the staffing and resource burden of managing eligibility documentation was high and those resources may be better spent on the benefit itself. It should be noted that although the lack of clarity around the three-part targeting criteria was identified as a challenge, MAOs appreciated the spirit of the flexibility inherent in it.

A couple of MAOs also commented on the value of targeting benefits based on functional status and income. Functional status is currently not clearly specified as a targeting criterion under SSBCI, which some MAOs felt limited their ability to target the benefit to those who need it most. CMS has noted that while it is not explicitly listed as a criterion, two of the required criteria refer to the enrollee’s functional status. On the other hand, social determinants of health (SDOH) are allowable as a secondary targeting criterion (i.e., can be used as a factor to identify enrollees and to further limit SSBCI eligibility but cannot be used as the sole basis for determining eligibility).\(^9\) From our interviews, it does not appear that this is a widely used flexibility.

While this brief is focused on expanded PHRB and SSBCI, it is important to acknowledge that some MAOs have opted to provide non-medical services through alternative pathways. Several MAOs shared a preference to test a benefit with a smaller sample

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of members before rolling it out to a broader population. Quality Improving Programs and the MA Value-Based Insurance Design (VBID)\(^\text{10}\) demonstration are two alternative pathways MA plans noted using to test non-medical services or benefits. Appendix D outlines high-level opportunities and limitations presented by each pathway as a vehicle to offer non-medical supports.

**Marketability**

*“There’s often a very strong tension point between what’s going to sell and what’s meaningful to the member”*

Strategically, MAOs view supplemental benefits—including new, non-medical benefits—as an opportunity to differentiate their products in a highly competitive market. MAOs are also considering the extent to which these new, non-medical benefits can impact health outcomes, health care utilization, and member satisfaction. Some plans mentioned tracking metrics like hospital readmissions and self-reported member outcomes, as well as measuring the market response and whether the benefits support enrollment and member retention.

One plan noted that some benefits are viewed as more marketable than others, affecting which benefits MAOs may gravitate towards offering. There can sometimes be a tension between the benefits that are most attractive to beneficiaries and those that impact healthcare spending. For example, one MAO noted that Medicare beneficiaries shopping for plans are typically more interested in a fitness benefit than a post-discharge benefit, since most beneficiaries are not anticipating that they will be hospitalized in the near future. However, these less marketable benefits will be extremely valuable if a beneficiary’s situation or care needs change.

There is a desire among MAOs to evaluate the effectiveness of non-medical benefits and build an evidence base of what is working to meet the needs of MA enrollees; however, sharing learnings among plans may present challenges since MA plans view supplemental benefits as a market differentiator.

**Marketing**

*“The last thing we want to do is market [these new benefits] and then tell people they don’t qualify”*

MAOs also encountered difficulty with marketing and communicating non-medical supplemental benefits to members. Given these benefits are brand new, many beneficiaries may not know that these new benefits exist or how to access them. MAOs reported challenges with broadly marketing these benefits while effectively communicating they are limited to members meeting certain criteria. Some MAOs also commented on the need to educate their staff and contracted care managers and providers on these new benefits so they are prepared to assist beneficiaries. CMS has provided limited guidance on how these new, non-medical supplemental benefits can be marketed.

\(^{10}\) VBID is a Center for Medicare and Medicaid Innovation (CMMI) model that began in 2017 to test innovations in MA. Participating plans can offer supplemental benefits based on chronic condition and/or socioeconomic status, among other flexibilities. The Centers for Medicare and Medicaid Services Request for Applications. (March 2020). https://innovation.cms.gov/files/x/vbid-rfa2021.pdf.
Beneficiary advocates observed that a large number of beneficiaries are learning about these new benefits through television commercials sponsored by insurance broker companies. They also noted that confusion around eligibility for these benefits can lead to beneficiaries choosing a particular plan to access a benefit that they later learn they are not eligible to receive.

One important tool available to beneficiaries for shopping between plans is the web-based Medicare Plan Finder. However, non-medical supplemental benefits are not clearly displayed and easily navigable in this tool. On the results page, only eleven supplemental benefits are listed\(^\text{11}\) – beneficiary advocates commented that the list of benefits seems arbitrarily selected and omits important details describing the benefits. For example, “in-home support” is displayed as a benefit but the included services and eligibility criteria are not clearly defined. Beneficiaries are also unable to filter for specific supplemental benefits in Medicare Plan Finder.

**Timing of Guidance**

*“It is challenging for plans to estimate cost and utilization for new supplemental benefits [within a short timeframe]”*

Several MAOs mentioned that the compressed timeframe for building new, non-medical supplemental benefits into plan bids hindered their ability to offer these benefits in 2019 and 2020. Benchmark development, bid submission, and determination of each plan’s payment is a lengthy process, detailed in **Figure 2** below:

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\(^{11}\) The “extra benefits” listed on the Medicare Plan Finder search results page are vision, dental, hearing, transportation, fitness benefits, worldwide emergency, telehealth, over-the-counter drugs, in-home support, home safety devices and modifications, and emergency response device.
In 2018, CMS issued a Final Call Letter and Final Rule on April 2nd and provided guidance on the reinterpretation of the MA supplemental benefit provisions on April 27th. With bids due June 8th of the same calendar year, MAOs had a little more than a month to develop the supplemental benefits to include in their bid for calendar year 2019. MAOs faced a similarly compressed timeframe in 2019 to develop their bids for 2020. Some MAOs felt they did not have enough time to undergo their typical processes of market analysis, vendor selection, actuarial costing, and benefit design, impacting their ability to offer these new benefits.

**Sustainability**

*“Need to ensure that MA payment is stable and that we have the funding to innovate and experiment”*

Since non-medical supplemental benefits are financed through rebate or premium dollars, funding for these benefits is not reliable year-to-year depending on the size of the rebate the plan receives. Some MAOs are concerned about offering a benefit to members that they may not be able to offer in later years since members would likely perceive this as a reduction in benefits. Furthermore, given that rebate dollars are a finite pool, MA plans must weigh the value of offering traditional supplemental benefits such as dental, vision, and hearing benefits and lowering cost-sharing against offering new, non-medical benefits.

Additionally, many stakeholders have expressed concern for the potential effects of the COVID-19 pandemic on utilization in the Medicare program that may negatively impact 2022 benchmarks. Lower benchmarks result in lower rebates, which will hinder provision and sustainability of SSBCI and expanded PHRB.

**Contracting**

*“The administrative burden on some of these contracts takes a village”*

MA plans and providers attempting to implement new benefits cited contracting as a key area of concern. MAOs often had limited experience contracting with non-traditional service providers and observed gaps in these providers’ readiness for contracting with them. Some of these challenges include information technology infrastructure, high liability in contracts, confusion around whether Medicare certification and licensure are required for providers, and differences in geographic service area coverage. MA plans also noted additional administrative burden around authorizing payments to these providers.

While no clear policy opportunities have emerged to address contracting at this time, this is a promising area for potential policy recommendations in the future. Please see the accompanying Roadmap in the “For Plans and Providers” section of this page for best practices for mitigating contracting challenges at the plan and provider level.
Based on the key considerations and challenges outlined above, several short- and long-term policy opportunities were identified. Figure 3 below maps each consideration and/or challenge to a policy opportunity to address it (further described in the next section).

Figure 3. Mapping Plan Considerations to Policy Opportunities

*No policy opportunity identified to address this challenge at this time.*
Policy Opportunities

A number of short-term and long-term policy opportunities exist with the potential to enhance the availability of non-medical supplemental benefits to Medicare beneficiaries. These opportunities are aligned with the recommended next steps for the Guiding Principles identified by the SSBCI Leadership Circle in 2019 to the policy opportunities presented in this brief (see Table 2).

Table 2. Crosswalk of Next Steps from Guiding Principles to Policy Opportunities

<table>
<thead>
<tr>
<th>Guiding Principle</th>
<th>Next Steps from Guiding Principles</th>
<th>Policy Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Principle: SSBCI Reflect Individual Needs</td>
<td>□ None identified</td>
<td>□ Consider offering non-medical benefits as a preventive benefit to address health needs and/or social risk factors in the absence of chronic illness</td>
</tr>
<tr>
<td>Balancing Principle 1: SSBCI Are Clear and Understandable</td>
<td>□ Develop better beneficiary decision tools and information</td>
<td>□ Provide more clarity and technical assistance for MAOs on allowable benefits and targeting criteria</td>
</tr>
<tr>
<td></td>
<td>□ Increase beneficiary and family caregiver education</td>
<td>□ Improve marketing guidance and consumer information</td>
</tr>
<tr>
<td></td>
<td>□ Raise awareness</td>
<td>□ Release guidance around non-medical supplemental benefits earlier</td>
</tr>
<tr>
<td>Balancing Principle 2: SSBCI Are Equitable</td>
<td>□ None identified</td>
<td>□ Provide more clarity and technical assistance for MAOs on allowable benefits and targeting criteria</td>
</tr>
<tr>
<td>Balancing Principle 3: SSBCI Are Manageable and Sustainable</td>
<td>□ Develop better risk adjustment</td>
<td>□ Consider options to improve sustainability of non-medical benefits</td>
</tr>
<tr>
<td>Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement</td>
<td>□ Support plan collaboration and learning</td>
<td>□ Encourage learning and sharing among plans, providers, and other stakeholders</td>
</tr>
<tr>
<td></td>
<td>□ Build the evidence base</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Pilot and test ideas</td>
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</tr>
</tbody>
</table>
Short-Term Opportunities

CMS can pursue the following policy opportunities under current authorities and regulations.

1. **Provide more clarity and technical assistance for MAOs on allowable benefits and targeting criteria.**

   In alignment with the first and second balancing principles ("SSBCI Are Clear and Understandable" and "SSBCI Are Equitable"), CMS should support MAOs’ understanding of the opportunities and guardrails around the new supplemental benefits, while preserving the flexibility and space for MAOs to innovate.

   - **Allowable benefits** – MAOs would benefit from a greater willingness from CMS to engage in dialogue with them regarding their benefit design and to help provide clarity prior to bid submission. However, there is a fine line between releasing guidance and being overly prescriptive. CMS could highlight real-life examples of allowable SSBCI or expanded PHRB from prior years’ plan benefit filings to illustrate the types of benefits that are acceptable under the various authorities. Additional guidance should help provide directionality and ease MAOs’ concerns about expending resources on benefits that may be rejected while still encouraging them to exercise creativity and innovation.

     For example, CMS could specify whether MAOs can provide smartphones and/or tablets under SSBCI and any stipulations on how the devices can be used. CMS has stated that MAOs may provide smartphones and/or tablets under expanded PHRB, but these devices must only be used for primarily health-related purposes (e.g., the device is locked except for remote monitoring or to enable engagement with healthcare providers). Additionally, a cellular data plan can be provided if it is limited to only health-related activities.\(^\text{12}\) For SSBCI, CMS noted that a cellular data plan without limitations can be provided so long as it has a "reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee."\(^\text{13}\) However, based on current guidance, it is unclear whether devices may be offered as SSBCI and whether these devices would need to be locked. Adding clarity supports the first and second balancing principles and will help MAOs to better understand their options for using technology to support positive mental health and decrease the effects of social isolation outside of the current public health emergency.

   - **Targeting criteria** – As noted above, lack of clarity around the second and third criteria for targeting SSBCI was cited as a challenge in benefit design. CMS should provide additional examples of what does and does not qualify for these two criteria. Similar to the guidance around allowable benefits, these examples should be kept broad in interpretation to allow MAOs and providers flexibility to get services to those who need them while easing MAO concerns about future audit risk.

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\(^\text{13}\) Ibid.
2. **Improve marketing guidance and consumer information**

MAOs noted that there were substantial marketing and communication challenges with a supplemental benefit that is not universally available to plan enrollees. This policy opportunity also supports the first balancing principle (“SSBCI Are Clear and Understandable”) by encouraging standardized practices and improving consumer tools so beneficiaries and caregivers can better understand these new, non-medical benefits.

- **CMS marketing guidance** – CMS should provide clear guidance on how MAOs can communicate to beneficiaries and providers around non-medical supplemental benefits as they become available. For instance, some stakeholders recommended that guidelines could include standard language for marketing materials that clarifies that coverage of an SSBCI is not guaranteed. CMS should also establish guidance and guardrails for brokers who are often a key source of information for beneficiaries on these benefits. This policy opportunity aligns with a policy recommendation from the Bipartisan Policy Center.14

- **Medicare Plan Finder** – CMS should improve the quality of the information displayed on Medicare Plan Finder regarding non-medical supplemental benefits. Proposed modifications include redesigning the supplemental benefits listed on the results page and enhancing transparency on eligibility details and the scope of benefits offered by each MA plan (e.g., number of meals included in benefit; limits on the number of supplemental benefits members may receive; limits based on chronic conditions). The search function could also be improved by allowing users to filter by specific supplemental benefits. Not all beneficiaries will be eligible for the non-medical supplemental benefits, so there should be disclaimers informing beneficiaries of eligibility requirements.

3. **Release guidance around non-medical supplemental benefits earlier**

Also in accordance with the first balancing principle (“SSBCI Are Clear and Understandable”), CMS should release more timely guidance around these benefits to allow MAOs sufficient time to assess the market, design the benefit, and determine its net cost. The release of guidance in November or December of the prior year (instead of the following April) would better support MAOs’ ability to build new, non-medical supplemental benefits into their bids, and likely increase overall MAO uptake of these benefits.

**Long-Term Opportunities**

MAOs and other stakeholders shared varying perspectives and recommendations on the future of non-medical benefits and improving care for Medicare beneficiaries. In addition to the short-term opportunities for CMS outlined above, policymakers and other stakeholders should be aware of the following longer-term opportunities worthy of further analysis and consideration.

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1. **Encourage learning and sharing among plans, providers, and other stakeholders**

   As highlighted in the fourth balancing principle (“SSBCI Evolve with Continuous Learning and Improvement”), CMS should explore ways to foster learning and sharing among MA plans, providers, and other stakeholders, while respecting the plans’ and providers’ intellectual property. For instance, this could be through a learning collaborative facilitated by a neutral and trusted third-party entity. Another potential route is to encourage neutral and trusted third-party entities, such as trade associations, to encourage sharing of learnings through webinars, conferences, public forums, etc. This would provide stakeholders with a macro-level view of how provision of these benefits is impacting beneficiaries, which interventions are having the most impact, and how to best advance the policy field.

   It may be challenging to evaluate outcomes across MA plans due to the lack of standard desired outcomes of offering these benefits. Efforts to evaluate the impact of these benefits should seek to minimize additional administrative burden to plans and providers.

2. **Consider options to improve sustainability of non-medical benefits**

   Given the challenges posed by relying on rebate and premium dollars to finance these benefits, there is an opportunity to develop better risk adjustment and explore other strategies to provide a more sustainable funding mechanism for these benefits. This opportunity aligns with the third balancing principle (“SSBCI Are Manageable and Sustainable”).

   Some MAOs may be reluctant to offer or expand non-medical benefits due to the challenges posed by relying on rebate and premium dollars to finance these benefits. In addition to the general unpredictability of rebate dollars year-to-year, risk adjustment presents an additional challenge to the sustainability of this funding mechanism. The rebate amount a plan receives depends on the plan’s risk-adjusted base payment rate. However, risk adjustment currently does not capture functional limitations which are typically associated with higher Medicare costs. Plans that offer non-medical benefits may attract beneficiaries with higher costs that will not be captured in risk adjustment.

   Policymakers should consider opportunities to promote the sustainability of these benefits in the short- and long-term. In the immediate term, assessing the impact of the COVID-19 pandemic on medical utilization and spend and the ensuing impact on benchmarks will be a critical component of the provision of SSBCI and expanded PHRB in 2022. If 2020 utilization and spend are deflated as a result of COVID-19, CMS should consider adjusting the benchmarks as plans prepare their bids for Calendar Year 2022. If these benchmarks are not adjusted, plans will receive a lower rebate amount in 2022, which will, in turn, limit the availability of non-medical benefits.
Future Considerations for Expansion of Non-Medical Supplemental Benefits

As evidence is collected on the effectiveness of certain non-medical interventions, there may be value in expanding the provision of promising benefits and populations served. Several opportunities for potential future consideration are outlined below.

1. **Consider offering non-medical benefits as a preventive benefit to address health needs and/or social risk factors in the absence of chronic illness**

   While SSBCI are currently targeted toward individuals with chronic conditions, several stakeholders expressed interest in expanding the parameters to allow for provision of non-medical benefits to individuals with certain health risk factors but who do not yet have a chronic condition diagnosis. Expanding these guardrails may allow MAOs to be more proactive in preventing chronic illness among beneficiaries.

   Policymakers can also consider allowing social risk factors as a primary criterion for non-medical supplemental benefits. Currently, a social risk factors alone cannot be used to determine SSBCI eligibility – a beneficiary must have a chronic condition diagnosis in order to be eligible. Some MAOs chose to offer benefits through the VBID demonstration rather than SSBCI, citing VBID’s flexibility to target benefits based on socioeconomic status. Policymakers can refer to the growing body of evidence that SDOH impacts health.15 This policy opportunity supports the core principle (“SSBCI Reflect Individual Needs”).

   Focusing on medical diagnoses as a condition for receiving non-medical services leaves out a population with functional limitations for whom these services and supports could prevent medical events. Policymakers may also want to consider better ways to incorporate functional limitations (defined in terms of need for assistance with activities of daily living (ADLs)) to get beyond diagnoses and medical conditions and broaden the population of Medicare beneficiaries who can benefit from these services.

2. **Assess the potential to test promising benefits in Medicare FFS, possibly using CMMI authority**

   Testing promising non-medical benefits in traditional Medicare FFS through a value-based model, possibly through a CMMI demonstration, would allow for strong and public evaluation and facilitation of learning and sharing. However, testing new benefits in Medicare FFS should be done in a way that preserves incentives for market differentiation and rewards MA plans for innovation.

   Some stakeholder organizations would also like to see non-medical supplemental benefits made more available to Medicare FFS beneficiaries in addition to MA benefits.

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beneficiaries. This would expand access to promising benefits as well as move the Medicare program towards a more integrated approach overall. However, this is a controversial issue due to key differences in the Medicare FFS and MA models. For instance, there is currently no funding mechanism available to fund these benefits in Medicare FFS. Total cost of care value-based models in Medicare may provide an opportunity to offer these benefits in FFS, but additional analysis is needed. MA plans provide supplemental benefits using rebate dollars, which they only receive if they are able to better manage spending on Medicare Parts A and B benefits compared to FFS. Furthermore, these new, non-medical benefits are not the only supplemental benefits that are only available under MA—for example, dental, vision, and hearing services are not covered under Medicare FFS.

Conclusion

New MA non-medical supplemental benefits are here to stay. MAOs, providers, policymakers and other stakeholders must work together to ensure these benefits meet beneficiaries’ needs. This policy brief outlines the factors MAOs are considering when deciding whether, and how, to offer expanded PHRB and SSBCI as well as potential short- and long-term policy opportunities to increase the availability and utilization of these benefits among Medicare beneficiaries.

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. Please see the accompanying Roadmap in the “For Plans and Providers” section of this page for actionable steps and tactics for plans and providers to overcome roadblocks and deliver new, non-medical benefits to Medicare beneficiaries. A future policy brief will present more specific, concrete recommendations based on further insights from implementing these new benefits in Calendar Year (CY) 2021 and planning for CY 2022.
Acknowledgments

We would like to thank the many organizations that, in the spirit of collaborating for improvement, contributed to this report through sharing their experiences and insights. The policy opportunities outlined in this brief do not reflect the views of each individual organization we interviewed, rather they draw from the various perspectives that were shared with us during the interview process.

The Long-Term Quality Alliance and ATI Advisory would also like to acknowledge the members of the SSBCI Leadership Circle who provide guidance and insights on the direction of this project, including the development of the SSBCI Guiding Principles. A full list of SSBCI Leadership Circle members and organizations can be found on this page.
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.

Acknowledgment

Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.
Appendix A

Guiding Principles for New Flexibility Under SSBCI

- SSBCI Are Clear and Understandable
- SSBCI Are Equitable
- SSBCI Are Manageable and Sustainable
- SSBCI Evolve with Continuous Learning and Improvement

SUGGESTED NEXT STEPS
- Develop Better Beneficiary Decision Tools
- Build Evidence Base
- Pilot and Test Ideas
- Support Plan Collaboration and Learning
- Develop Better Risk-Adjustment
### Appendix B

Description of Guiding Principles for New Flexibility Under SSBCI

<table>
<thead>
<tr>
<th>Core Principle: SSBCI Reflect Individual Needs</th>
<th>SSBCI flexibility—in benefit flexibility, types of services, and providers—allows for Medicare Advantage plans to meet the individual needs of chronically ill beneficiaries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balancing Principle 1: SSBCI Are Clear and Understandable</td>
<td>Key stakeholders, including Medicare beneficiaries and their caregivers, providers, payers, enrollment counselors, and states, understand SSBCI as well as their limitations and the circumstances under which they are available.</td>
</tr>
<tr>
<td>Balancing Principle 2: SSBCI Are Equitable</td>
<td>Chronically ill Medicare Advantage enrollees receive SSBCI in a consistent, equitable, and nondiscriminatory manner that determines and meets individual need based on chronic illness and functional status.</td>
</tr>
<tr>
<td>Balancing Principle 3: SSBCI Are Manageable and Sustainable</td>
<td>Medicare program regulations and guidance, such as rate structures and quality measures, support Medicare Advantage plans in offering, managing, and sustaining their inclusion of SSBCI in MA plan benefit packages.</td>
</tr>
<tr>
<td>Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement</td>
<td>The federal Department of Health and Human Services (HHS) and CMS, in conjunction with Medicare Advantage plans and other stakeholders, evaluate and measure the extent to which SSBCI are contributing toward meeting the needs of chronically ill enrollees and adapt SSBCI accordingly based on learnings.</td>
</tr>
</tbody>
</table>
Appendix C

Number of Plans Offering Non-Medical Supplemental Benefits in Plan Year 2020 and Plan Year 2021

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Number of Plans Offering in 2020:</th>
<th>Number of Plans Offering in 2021:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Primarily Health-Related Supplemental Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Home Support Services</td>
<td>223</td>
<td>429</td>
</tr>
<tr>
<td>Adult Day Health Services</td>
<td>84</td>
<td>127</td>
</tr>
<tr>
<td>Home-Based Palliative Care</td>
<td>61</td>
<td>134</td>
</tr>
<tr>
<td>Support for Caregivers of Enrollees</td>
<td>125</td>
<td>95</td>
</tr>
<tr>
<td>Therapeutic Massage</td>
<td>230</td>
<td>176</td>
</tr>
<tr>
<td>TOTAL (offering at least 1 new primarily health-related supplemental benefit):</td>
<td>499</td>
<td>737</td>
</tr>
</tbody>
</table>

| **Special Supplemental Benefits for the Chronically Ill** |                                   |                                   |
| Food and Produce                                 | 101                               |                                   |
| 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.

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.
## Appendix D

### Opportunities and Limitations of Different Pathways for Non-Medical Supports

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Opportunities</th>
<th>Challenges/Limitations</th>
</tr>
</thead>
</table>
| **SSBCI**                     | • Can offer "non-primarily health-related" benefits to eligible chronically ill enrollees, including non-medical transportation, pest control, social needs, capital or structural improvements to homes, and a more expansive meal provision benefit than expanded PHRB.  
• Benefits can vary, or be targeted to an individual’s specific condition and needs (i.e., SSBCI can take into account the needs of an individual and the likelihood the benefit will improve or maintain their health).  
• Could be beneficial for partial-benefit dual-eligible individuals who meet the chronic condition criteria but do not qualify for Medicaid LTSS benefits. | • Three-part criteria can be limiting and administratively burdensome  
• Only available to individuals with a chronic condition diagnosis who have a high risk of hospitalization or other adverse health outcome and require intensive care coordination.  
• Cannot target benefits based solely on financial need.  
• Financed through limited/variable rebate dollars or premiums. |
| **Expanded Definition of PHRB** | • Can target benefits to particular groups based on health status or disease state through uniform flexibility  
• Can offer non-medical benefits, including services like adult day care services, home-based palliative care, in-home support services, and support for caregivers of enrollees. | • Must be "primarily health-related".  
• Financed through limited/variable rebate dollars or premiums. |
| **Value-Based Insurance Design (VBID)** | • Can target benefits based on condition and/or socioeconomic status.  
• Can target entire dual-eligible population  
• Can test Part D cost-sharing benefits (i.e., offer lower cost-sharing or support for medication adherence based on condition and/or socioeconomic status). | • Requires MA plans to apply and receive approval to participate in this demonstration (formerly limited to certain states).  
• More reporting requirements than expanded PHRB and SSBCI.  
• Financed through limited/variable rebate dollars or premiums. |
| **Quality Improving or Clinical Programs** | • Can target activities or services without using a clinical diagnosis or meeting three-part criteria of SSBCI.  
• Unlike a benefit that is provided to all who qualify, practitioners can tailor the services from a clinical program to specific needs in an individual care plan.  
• Provides a way to test a potential benefit for a smaller group of beneficiaries or a smaller geography.  
• Financing is not limited to rebate and premium dollars. | • Not a filed benefit, limiting the number of members that can be served.  
• Cannot be marketed as a benefit.  
• Must be evidence-based and require clinical expertise. |
| **Uniform Flexibility (UF)** | • Can identify and select target population(s) based on clinical criteria for expanded benefits (e.g., MA plans can use UF to target an existing post-discharge meal benefit to members with a certain diagnosis).  
• May be used to target reductions in cost-sharing and deductibles for similarly situated enrollees, in addition to items and services. | • Not a filed benefit, limiting the number of members that can be served.  
• Cannot be marketed as benefit.  
• Must be evidence-based and require clinical expertise.  
• Cannot be used to tailor benefits as individually as SSBCI.  
• Cannot target benefits based on socioeconomic status, or any other status except for health and disease state (using specific clinical criteria). |
Appendix E

Key Terms

Centers for Medicare and Medicaid Services (CMS): The federal agency responsible for administering Medicare and working with States to administer Medicaid. Part of the Department for Health and Human Services (HHS).

Expanded Definition of Primarily Health-Related Supplemental Benefits (PHRB): In 2018 (to go into effect for Calendar Year 2019), CMS expanded the scope of “primarily health-related” from simply an item or service whose primary purpose is to prevent, cure, or diminish an illness or injury to also 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.\(^\text{17}\)

Long-Term Services and Supports (LTSS): Services, such as personal care, that individuals may require to perform activities of daily living, such as bathing and dressing.

Medicare Advantage (MA): MA plans (or Medicare Part C) are a type of Medicare health plan offered by a private health insurance company that contracts with Medicare to provide, at a minimum, Medicare Part A and B benefits. MA plans may also offer coverage of supplemental health benefits that are not covered by Medicare Parts A or B, and are required by law to cover preventive care and limit out-of-pocket spending.

Medicare Advantage Organization (MAO): MA plans are provided by Medicare Advantage Organizations (MAOs). An MAO is the legal entity that has a contract with the Medicare program to provide coverage. An MA plan is the package of Medicare benefits offered by the MAO to the beneficiary. An MAO may offer multiple MA plans from which beneficiaries can choose when selecting a plan that best meets their health care needs.

Medicare Advantage (MA) Supplemental Benefits: MA Supplemental Benefits provide coverage for services that are not available in original, fee-for-service Medicare, such as dental care.

Special Supplemental Benefits for the Chronically Ill (SSBCI): The CHRONIC Care Act, included in the Bipartisan Budget Act of 2018, created a new MA supplemental benefit category in statute: Special Supplemental Benefits for the Chronically Ill (SSBCI). A chronically ill enrollee is defined as having one or more complex chronic conditions that are life threatening or reduce the health and functioning of the enrollee; having a heightened risk of hospitalization or other negative health outcomes; and requiring coordination of care.\(^\text{18}\)


Appendix F

Methods

Quantitative and qualitative data used to inform this policy brief were gathered using a number of sources. The quantitative analysis was based on Plan Benefit Package (PBP) Data, made available publicly by CMS. This data source provides information on which plans are offering the expanded definition of PHRB and SSBCI in Plan Year 2020 and the expanded definition of PHRB in Plan Year 2021, as well as information on the counties where these plans are offering these benefits. For all analyses, a ‘plan’ is defined as the combination of a Contract Number, Plan ID, and Segment ID. Analyses also excludes the following plan types: Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE.

Interviews were also conducted with numerous stakeholders, including 10 Medicare Advantage Organizations (MAOs) (1 MAO responded through a questionnaire), 11 providers, and 2 beneficiary advocacy 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 additional stakeholder groups.