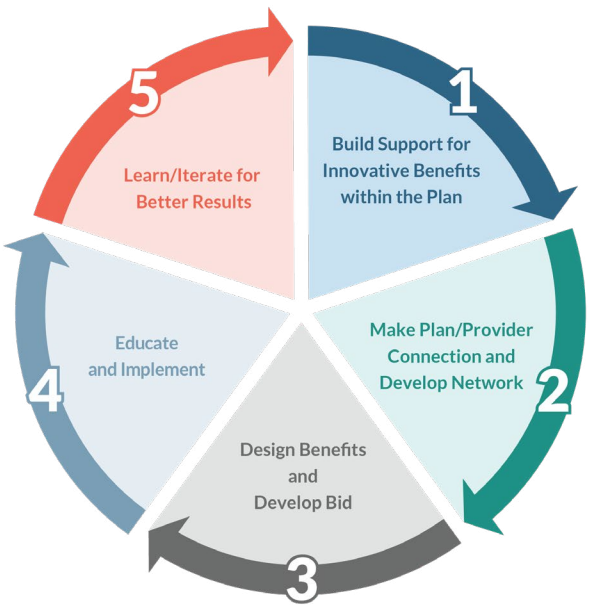
A Roadmap for Plans and Providers

Part 3: The Emerging Roadmap

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.[1,2]

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.

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[1] **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.

[2] 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/do/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

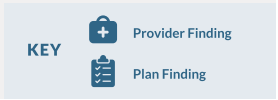
- Target costly benefits to the highest need members

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

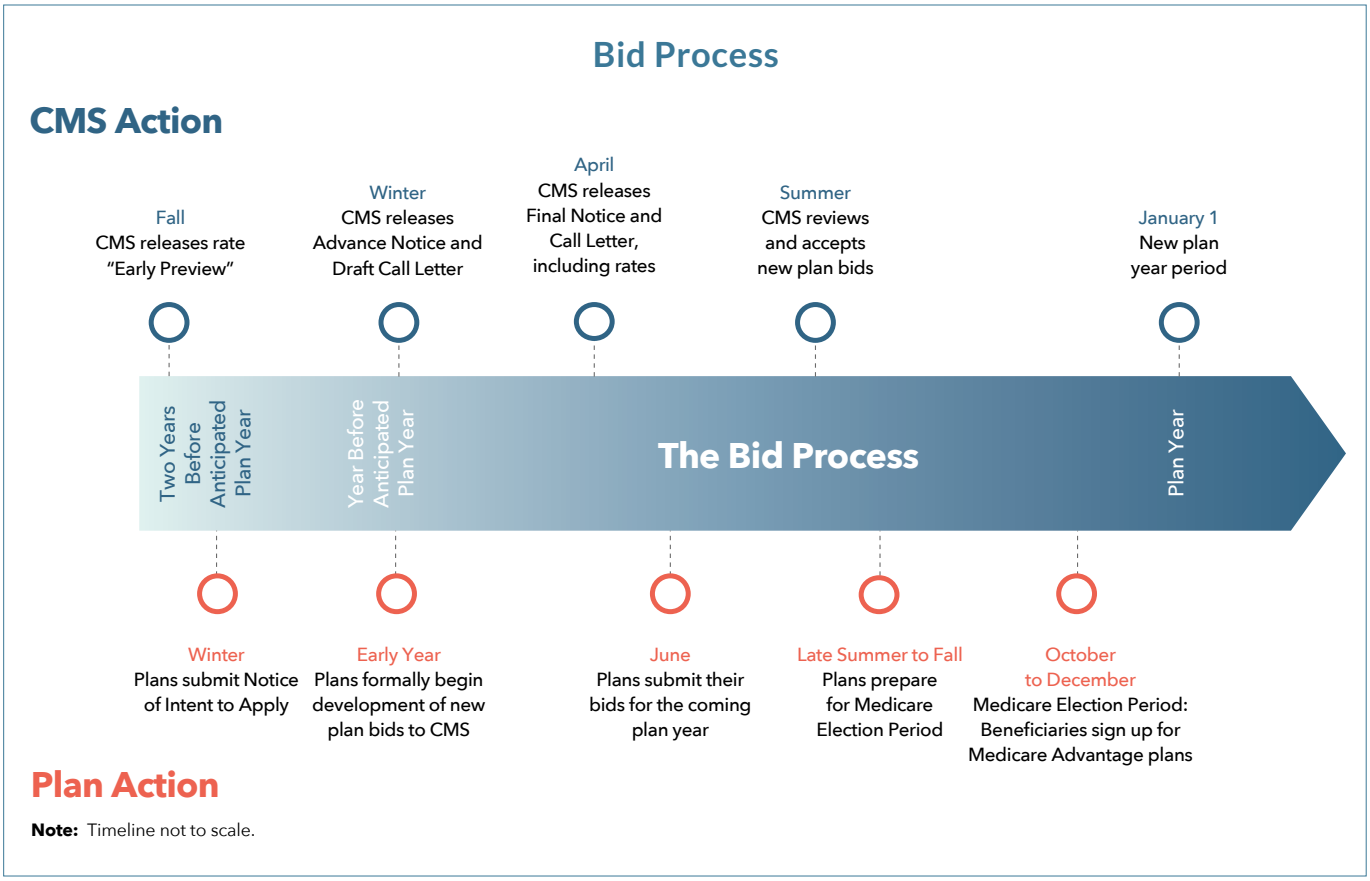
- Design benefits to meet statutory and regulatory requirements



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).[3]

[3] 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.[4] 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.

[4] 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 though 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:

1 provide members something they want

Help with attracting and retaining members and member satisfaction

2 show a positive return on investment

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

3 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.

Read the full Roadmap *here*.