Delivering on the Promise of the CHRONIC Care Act:
Policy Recommendations for the Administration to Advance Non-Medical Supplemental Benefits

In recent years, Medicare Advantage (MA) plans have had unprecedented flexibility to offer a wide range of supplemental benefits and to target them to members with specific conditions and individual need. In 2019, a group of national experts developed a set of Guiding Principles (Appendix A) to advance these new, non-medical Special Supplemental Benefits for the Chronically Ill (SSBCI). In 2020, ATI Advisory (ATI) and Long-Term Quality Alliance (LTQA) conducted quantitative and qualitative research which culminated in an actionable Roadmap Report for plans and providers seeking to implement these new supplemental benefits, as well as a Policy Brief identifying opportunities for policymakers to help promote the provision and uptake of these benefits (see Appendix B for 2020 policy opportunities).

One year later, this second policy brief builds upon the prior work, outlining administrative policy opportunities for the Centers for Medicare and Medicaid Services (CMS). Recommendations are based on the experiences of plans, providers, and beneficiary advocates with these benefits in 2021. An accompanying Progress Report provides a more detailed summary of the implementation landscape and progress made on roadblocks identified in last year’s Roadmap Report.
Background

Historically, CMS has required that MA supplemental benefits, or benefits not covered by traditional Medicare, be "primarily health-related" and available to all members uniformly. However, the past several years have marked a significant turning point in the Medicare program. For the first time, MA plans could offer supplemental benefits that were not "primarily health-related", and could target these benefits by health population. This advancement can be attributed to two policy changes (Appendix C):

1. CMS' reinterpretation of the definition of "primarily health-related" benefits (PHRB), which expanded the scope of these benefits (effective in 2019); and
2. The creation of SSBCI by Congress in the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (effective in 2020).

Throughout this policy brief, "non-medical supplemental benefits" refer to benefits provided under both SSBCI and the expanded definition of PHRB ("expanded PHRB"). While this brief is focused on expanded PHRB and SSBCI, it is important to acknowledge that some Medicare Advantage Organizations (MAOs) have opted to provide non-medical services through alternative pathways, including Quality Improving Programs and the MA Value-Based Insurance Design (VBID) demonstration. VBID, in particular, has seen significant growth this year; CMS has reported that over 1,000 plans are participating in the VBID demonstration for Plan Year 2022.

Recent Progress of Non-Medical Supplemental Benefits

Over the past several years, MA plans have become better equipped to design and implement these benefits. 2021 saw plans increase their offerings across both authorities, and there appears to be greater awareness and uptake of these benefits among beneficiaries. The marketplace remains competitive and is maturing, as plans are more willing to offer these benefits and view them as a market differentiator to attract or retain members. Plans are also learning to design benefits that are tailored to individual need and are building systems to work with providers to deliver these benefits.

At the same time, plans continue to be challenged by complicated authorities and eligibility requirements, particularly for SSBCI. There is room for improvement in educating beneficiaries, plan staff, agents and brokers, and other beneficiary counselors such as the State Health Insurance Assistance Program (SHIP) counselors on these benefits. While there is anecdotal evidence of increased beneficiary utilization, there is no central data repository on utilization across plans or benefits and no way of measuring uptake or the impact of these benefits more broadly. More information regarding the current landscape of these non-medical supplemental benefits can be found in the Progress Report.

Administrative Policy Recommendations for CMS to Support Implementation of the Guiding Principles in Practice

In alignment with the Guiding Principles published by a group of national experts (addressed as the "SSBCI Leadership Circle") in 2019, this policy brief outlines recommendations for CMS to advance non-medical supplemental benefits. Table 1 summarizes the more detailed content in the remainder of the report. These recommendations are organized into those that are more feasible to implement in the near-term and those that may take longer to implement or will lay the groundwork for longer-term initiatives or policy changes.

*Throughout this Policy Brief, the priority recommendations identified as having the greatest potential impact are indicated in bold text with an asterisk.*

Table 1. Administrative Policy Recommendations for CMS

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<thead>
<tr>
<th>Guiding Principle</th>
<th>Status Report</th>
<th>Administrative Policy Recommendations for CMS</th>
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<tbody>
<tr>
<td>Core Principle: SSBCI Reflect Individual Needs</td>
<td>Improving</td>
<td><img src="image.png" alt="Image" /></td>
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<tr>
<td>Provide guidance clarifying that members with functional need meet the chronic condition criterion in the three-part eligibility criteria for SSBCI.*</td>
<td><img src="image.png" alt="Image" /> Near-Term</td>
<td><img src="image.png" alt="Image" /> Long-Term</td>
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<tr>
<td>Test new targeting criteria [e.g., functional need, other indicators of social determinants of health (SDOH) need outside of low-income subsidy (LIS) status] in the Center for Medicare and Medicaid Innovation (CMMI) Value-Based Insurance Design (VBID) demonstration.*</td>
<td><img src="image.png" alt="Image" /> Near-Term</td>
<td><img src="image.png" alt="Image" /> Long-Term</td>
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<tr>
<td>Consider using evidence from VBID to expand SSBCI eligibility criteria to include LIS eligibility through CMMI authority, if the evidence base is sufficient and the Office of the Chief Actuary approves such a change.*</td>
<td><img src="image.png" alt="Image" /> Near-Term</td>
<td><img src="image.png" alt="Image" /> Long-Term</td>
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<tr>
<td>Convene a workgroup, in collaboration with the U.S. Administration for Community Living (ACL), to develop guidance around braiding of MA plan funding with other sources of funding, such as the Older Americans Act (OAA) funds, to address SDOH.</td>
<td><img src="image.png" alt="Image" /> Near-Term</td>
<td><img src="image.png" alt="Image" /> Long-Term</td>
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<td>Guiding Principle</td>
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<td>Near-Term</td>
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<td>Long-Term</td>
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<tr>
<td>Balancing Principle 1: SSBCIs Are Clear and Understandable</td>
<td>Needs Improvement</td>
<td>Develop resources and training for SHIP counselors about non-medical supplemental benefits and provide information on the available benefits each year as early as possible.*</td>
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<tr>
<td>Balancing Principle 2: SSBCIs Are Equitable</td>
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<td>Balancing Principle 3: SSBCIs Are Manageable and Sustainable</td>
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<tr>
<td>Balancing Principle 4: SSBCIs Evolve with Continuous Learning and Improvement</td>
<td>Needs Improvement</td>
<td>None identified</td>
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*Recommended for CMS to consider implementing as a permanent policy.
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Implementation Observations:

- Plans are learning how to design benefits so they can be tailored according to individual needs. Many plans are offering flexible benefits with a package of offerings limited to a set dollar amount or a package of benefits from which members can select.
- It is still difficult to provide a meaningful benefit, which can significantly impact health, under limited financing mechanisms.
- In addition to SSBCI, plans are navigating other benefit authorities, such as the VBID demonstration and Uniformity Flexibility (UF), to offer non-medical benefits.
- CMS has continued to maintain flexibility and encourage innovation, approving nontraditional benefits including coverage for utilities, cell phones, and Internet, which many MAOs felt were critical to support the health and wellbeing of members during the pandemic.

Remaining Challenges

- **Benefit Eligibility/Targeting** - MAOs remain challenged by the chronic condition requirement within the three-part eligibility criteria for SSBCI. It can be administratively and technically burdensome for MAOs to identify and document that a member has been diagnosed with a chronic condition. Furthermore, the chronic condition criterion does not fully capture all determinants that are vital to health, such as functional limitations and SDOH needs.

MAOs are continuing to pursue alternative pathways to offering non-medical supports that provide greater flexibility for targeting and count toward the numerator of their medical-loss ratio (MLR). Notably, there has been substantial growth in the number of MA plans opting to offer supplemental benefits through the VBID demonstration. MAOs noted that VBID is attractive due to its option to target benefits based on qualification of LIS status, which is not possible under expanded PHRB or SSBCI authorities. However, it does not appear that VBID allows plans to target benefits according to functional need.  

Status Report:

Policy Innovation

In June 2021, the **Addressing Social Determinants in Medicare Advantage Act of 2021** was introduced in Congress to add eligibility categories to the existing criteria for SSBCI. This bill proposes striking the SSBCI “chronically ill” criterion and replacing it with “specified enrollee”, to be defined as someone who: (I) meets the current three-part criteria; (II) is a low-income enrollee; or (III) “meets any other criterion determined appropriate by the Secretary, such as criteria relating to social and socioeconomic risk.” If enacted, this amendment would be effective beginning or after January 1, 2023.

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Policymakers should consider expanding eligibility for SSBCI to enhance plans’ ability to target meaningful benefits to people who need them. While allowing plans to make SSBCI available to all members would have the greatest impact, an additional approach is to allow functional limitations to qualify as a chronic condition within the SSBCI eligibility criteria.\(^5\)

The Centers for Disease Control and Prevention (CDC) defines chronic disease as “conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.”\(^6\) According to ATI analysis of Medicare survey and claims data, there appears to be a strong correlation between functional limitations and healthcare spending. Medicare beneficiaries with multiple chronic conditions and functional impairment are more than twice as expensive to Medicare than individuals who have multiple chronic conditions but no functional impairment (Figure 1).\(^7\) Given the potential to impact spending for this high-cost population, there is a strong case for clarifying that the presence of functional limitations qualifies as a chronic condition.

### Figure 1: Per Capita Medicare Spending, 2015

<table>
<thead>
<tr>
<th>0-2 Chronic Conditions</th>
<th>3+ Chronic Conditions</th>
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</thead>
<tbody>
<tr>
<td>No Functional Impairment</td>
<td>$5,467</td>
</tr>
<tr>
<td>Functional Impairment</td>
<td>$11,584</td>
</tr>
</tbody>
</table>

**Note:** Data are limited to fee-for-service Medicare beneficiaries living in the community.  
**Source:** 2015 Medicare Current Beneficiary Survey linked to claims.

Alternatively, CMMI could consider using demonstration authority to add to the VBID demonstration new eligibility categories, such as functional need and other indicators of SDOH need outside of LIS status. This would allow plans to test and collect evidence on these new targeting criteria before potentially expanding them to SSBCI. Further eligibility expansion for SSBCI may require congressional action.

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5 In the CY2021 Final Rule, CMS noted that “functional status can be considered when determining if an enrollee is a chronically ill enrollee.” The Centers for Medicare and Medicaid Services Final Rule. (June 2020). https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf


Contracting with Community-Based Organizations (CBOs) - While MAOs indicated a strong desire to work with CBOs, several factors inhibit them from doing so, including difficulties with competitive pricing, meeting service area expectations, and achieving economies of scale relative to non-CBO providers. To address some of these barriers, building upon work initiated by ACL, a multi-stakeholder workgroup is developing scalable plans to align social services with health care. This effort emphasizes the need to support CBO network contracts with health plans and systems to deliver services that meet the social needs of Medicare and Medicaid beneficiaries.

Another challenge CBOs are encountering is the emerging role of social care referral platforms. Plans often contract with companies that aggregate providers on their platforms to facilitate referrals from plans. These referrals are typically being made without accompanying payment; however, several initial pilots to test incorporating payment are currently underway. CBOs also face challenges with duplication due to the lack of interoperability of these new referral platforms with their existing systems.

Supports for older adults and people with disabilities are fragmented across federal and state benefit structures and multiple funding streams. There is an opportunity for greater coordination and shared visioning among multiple agencies. CMS should consider partnering with ACL to explore opportunities for braiding of MA plan funding with other sources of funding, such as the Older Americans Act (OAA) funds, to address SDOH. CMS should also partner with ACL to develop resources and provide technical assistance for plans to contract with CBOs, possibly through a learning collaborative.

Recommendations

CMS should:

**NEAR-TERM**

- Provide guidance clarifying that members with functional need meet the chronic condition criterion in the three-part eligibility criteria for SSBCI.*
- Test new targeting criteria (e.g., functional need, other indicators of SDOH need outside of LIS status) in the CMMI VBID demonstration.*

**LONG-TERM**

- Consider using evidence from VBID to expand SSBCI eligibility criteria to include LIS eligibility through CMMI authority, if the evidence base is sufficient and the Office of the Chief Actuary approves such a change.*
- Convene a workgroup, in collaboration with ACL, to develop guidance around braiding of MA plan funding with other sources of funding, such as the OAA funds, to address SDOH.
Delivering on the Promise of the CHRONIC Care Act: Policy Recommendations for the Administration to Advance Non-Medical Supplemental Benefits

Implementation Observations:
- Knowledge and understanding of these benefits are not widespread. Confusion still remains around eligibility.
- Plans are still challenged with how to communicate these benefits while making eligibility requirements clear.
- Resources intended to help beneficiaries evaluate their options, such as brokers and SHIPs, are not equipped with the information necessary to properly advise enrollees on the availability of these benefits.

Remaining Challenges
- Outdated Information in the Medicare Managed Care Manual - Chapter 4 of Medicare Managed Care Manual has not been updated to include the expanded definition of PHRB and still includes language explicitly prohibiting these services from being offered. Additionally, the manual does not include any information on SSBCI. The manual should be updated to reflect current guidance on non-medical supplemental benefits so plan staff and other stakeholders can reference the most current information.
- Lack of Standardized Disclaimer Language - While CMS added a requirement for plans to include an SSBCI disclaimer to required materials for current and prospective enrollees, CMS did not provide standardized disclaimer language for plans to use. As a result, plans are operationalizing this requirement differently, which poses challenges to beneficiary understanding of these benefits and their limits.
- Lack of Easy-to-Use Beneficiary Tools - There are limited resources available to beneficiaries to support them in understanding available non-medical supplemental benefits. Plans publish “Evidence of Coverage” documents which include a list of benefits; however, these documents are typically several hundred pages long and the supplemental benefits are not clearly identified and/or defined. Medicare Plan Finder lists a small number of supplemental benefits on the search results page, none of which

Status Report:

Policy Innovation

MyCare, My Choice is an online decision support tool developed by The SCAN Foundation to help individuals in California who are dually-eligible for Medicare and Medicaid explore the integrated care options available to them. With support from ACL, the National Council on Aging expanded this person-centered tool which will be piloted in 2022 with beneficiaries and counselors in the State Health Insurance Assistance Program in Ohio, and plans to add more states over time. CMS and ACL can build upon this tool to provide information on non-medical supplemental benefits as it is expanded to other states.

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[32] SSBCI Disclaimer. This is model content through which MA organizations must: (i) Convey the benefits mentioned are a part of special supplemental benefits. (ii) Convey that not all members will qualify. (iii) Include the model content in the material copy which mentions SSBCI benefits. [i.e., documents explaining benefits and rights] The Centers for Medicare and Medicaid Services Final Rule. (January 2021). [https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00538.pdf](https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00538.pdf)
Balancing Principle 1: SSBCI Are Clear and Understandable (Continued)

are SSBCI. The listed benefits are only defined as having “some coverage” or “not covered”. Adding more clarity around when limits apply (e.g., number of meals included in benefit; limits on the number of supplemental benefits members may receive; limits based on chronic conditions) would help beneficiaries better understand their choices.

- **Lack of Training and Data Tools for Beneficiary Counseling Resources** - Beneficiaries can also turn to brokers, agents, SHIP counselors, and other counseling resources for information as they navigate their Medicare choices. However, these entities lack training and appropriate data tools to advise enrollees on non-medical supplemental benefits. For brokers or agents, some of whom are contracted with multiple plans, it is vital that they understand these benefits and how to convey eligibility to prevent member confusion. SHIP counselors lack a centralized resource to reference for availability of non-medical benefits in the geographic areas they serve. Counseling beneficiaries on these benefits can be difficult as eligibility requirements are not always clear. A complicating factor is the tight timeline under which CMS and plans finalize benefit packages, which results in CMS releasing data on benefits directly before or concurrent to the Open Enrollment Period (October 15-December 7) and the Medicare Advantage Open Enrollment Period (January 1-March 31). Given these constraints, it would be valuable for CMS to provide SHIP counselors and brokers with clear information and resources on supplemental benefits and qualifying criteria to help them learn quickly.

**Recommendations**

**CMS should:**

- **NEAR-TERM**
  - Develop resources and training for SHIP counselors about non-medical supplemental benefits and provide information on the available benefits each year as early as possible.*
  - Require training on these benefits in the 2022 agent and broker training and testing guidelines.*9
  - Update Chapter 4 of the Medicare Managed Care manual to reflect current guidelines around non-medical supplemental benefits.
  - Establish standardized disclaimer language that clarifies that coverage of an SSBCI benefit is not guaranteed.10

- **LONG-TERM**
  - Expand the categories of supplemental benefits listed in Medicare Plan Finder and indicate more clearly when limits apply.*

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Delivering on the Promise of the CHRONIC Care Act: Policy Recommendations for the Administration to Advance Non-Medical Supplemental Benefits

Implementing Observations:
- For Plan Year 2022, CMS is requiring that plans indicate the chronic conditions to which the SSBCI are tied.
- These benefits are available in D-SNPs at a higher prevalence, suggesting that they are more available to those with greater socioeconomic needs.
- There are no public data available on benefit uptake and who accesses these benefits. This impedes assessment of whether benefits are being delivered equitably to individuals of diverse backgrounds (e.g., gender, race, ethnicity, language, geography, disability).

Remaining Challenges
- **Lack of Data on Uptake** - MA plans are not currently required to submit encounter data for any supplemental benefits (e.g., dental, vision, hearing, fitness). Additional reporting requirements may deter plans from offering these benefits. However, it is not possible to assess equity in receipt of services without demographic utilization data. Plans face challenges with collecting demographic data. While plans collect data on age, zip code, and LIS eligibility, they do not capture race and ethnicity data consistently. To ensure equitable access, it is also important to recognize the prevalence of a disability in the receipt of these benefits. In the CMMI Strategy Refresh White Paper\(^{11}\) released in October 2021, CMMI noted that they will “require and consider incentives and supports for model participants to collect data on race, ethnicity, geography, disability, and other demographics” and that results will be reported to CMMI to help providers address health disparities. There is an opportunity for CMS and CMMI to consider how to improve data collection and foster learning and sharing among MA plans, providers, and other stakeholders to assess the impacts of these benefits on underserved populations. In the meantime, researchers, including ATI and LTQA, can layer demographic data from other sources to track equitable benefit access and utilization.

Policy Innovation
In a 2017 report to Congress,\(^{12}\) CMS suggested collecting race and ethnicity data from beneficiaries upon Medicare enrollment. This information is not collected in Medicare enrollment forms. Specifically, Medicare lacks accurate race and ethnicity data that are compliant with either the OMB 1997 or Section 4302 standards for race and ethnicity data. Further, these data are not currently solicited and reported to CMS for most beneficiaries born after 1989. Given that plans do not have race and ethnicity data for all of their members, collecting these data at the point of Medicare enrollment would support efforts to track equitable benefit access and utilization.

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Balancing Principle 2: SSBCI Are Equitable (Continued)

sources (i.e., American Community Survey, ACS) onto publicly available data on SSBCI offerings by county to compare, for instance, the percentage of older adults living in poverty in a given county to the SSBCI offerings in that county.

- Tension Between Benefits’ Role in Marketing vs. Addressing Health Equity - Non-medical supplemental benefits are still largely viewed by plans as tools to differentiate their offerings. At the same time, many of these services are critical to addressing health disparities. However, the teams making decisions on these benefits are not typically the same teams focused on population health and health equity.

Recommendation

CMS should:

- Develop incentives for plans to submit data on utilization for all supplemental benefits, including key demographic information, to support efforts to measure and ensure equitable access to these benefits. Consider adopting a quality bonus payment for reporting of key data.*

Balancing Principle 3: SSBCI Are Manageable and Sustainable

Medicare program regulations and guidance, such as rate structures and quality measures, support MA plans in offering, managing, and sustaining their inclusion of SSBCI in MA plan benefit packages.

Implementation Observations:

- There is continued growth in the number of plans offering these benefits, indicating that plans view these benefits as manageable and sustainable.
- If a benefit is popular, plans are unlikely to want to remove a benefit they have previously offered.
- However, if MA payment rates are reduced or if fewer rebate dollars are available, plans would have to reduce benefit offerings. Moreover, dollars for these new benefits compete with other popular benefits and reduced cost-sharing.

Status Report:

Improving
Remaining Challenges

- **Risk Adjustment** - Given that plans that offer non-medical benefits may attract beneficiaries with higher costs, it is important for risk adjustment to account for social risk and functional limitations that are likely associated with these beneficiaries. The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, first implemented in 2015, present an opportunity to capture standardized data on SDOH through Z-codes. Z-codes are a subset of ICD-10-CM codes, used as reason codes to capture “factors that influence health status and contact with health services.” However, in 2019, only approximately 1.59% of Medicare FFS beneficiaries had claims with Z-codes due to low provider uptake. Increasing the use of Z-codes can help pave the way to provide standardized data on SDOH for risk adjustment in the future. Other workgroups and efforts are also underway to study incorporating functional limitations and social risk factors into risk adjustment and the impact of Z-codes on risk adjustment.

- **Possible Upcoming Changes to Medicare Policy** - Dental, vision, and hearing benefits are the “table stakes” for MA plans. If Congress’ proposal to make hearing a core Medicare benefit is passed, non-medical benefits would play a more critical role in differentiating MA products and shift towards becoming the new “table stakes.” Additionally, as policymakers continue to grapple with impending Medicare insolvency and look to ways to contain Medicare spending, policy changes reducing the dollars available to MA plans may impact the availability of these benefits.

Recommendation

**NEAR-TERM**

- Promote the use of ICD-10 Z-codes among providers (including any member of a person’s care team) to identify social needs through additional and broader training efforts, guidance on referrals to social services, and possible financial incentives. Consider leveraging plans to assist with this effort, including encouraging or incentivizing plans to provide financial incentives to providers for using ICD-10 Z-codes.

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13 “Factors influencing health status and contact with health services, Z00-Z99” [https://www.icd10data.com/ICD10CM/Codes/Z00-Z99](https://www.icd10data.com/ICD10CM/Codes/Z00-Z99)


Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement

The Department of Health and Human Services (HHS) and CMS, in conjunction with MA 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.

Implementation Observations:

- Plans track data on utilization, member satisfaction, member engagement, and retention to assess benefit experience.
- There is a considerable lack of data around outcomes for these benefits, due to the time it takes to measure outcomes, the non-experimental design of the interventions (they are available to all qualifying members in a plan), and the lack of reporting incentives or requirements.
- To date, there is little progress on building an evidence base about what works in meeting individual needs to inform delivery and future policy for Medicare.

Status Report:

Remaining Challenges

- **Limited Data and Evidence on Return-on-Investment (ROI)** - When asked about tracking and reporting data on outcomes of non-medical supplemental benefits, MAOs responded that they are not yet able to measure ROI. They tend to approach ROI with a broader framework, which includes the impact of these benefits on member attraction, experience, and retention. It can be difficult and resource-intensive to isolate the impact of a single intervention, when multiple interventions are working together, and the outcomes for SDOH interventions are often longer-term. While some providers reported challenges with receiving outcomes data from plans, several providers were able to collaborate with plans on matched case-control studies when their services were aligned with the MAOs’ strategic goals.

- **Considerations around Sharing Data and Learnings** - Plans are collecting data on utilization and could report these to CMS if required. Importantly, plans are not required to report data on other supplemental benefits, so there is no existing precedent for a reporting requirement. However, because of the experimental nature of these benefits and the strict targeting criteria that do not accompany other supplemental benefits, data will be extremely critical to proving the value of these benefits and evolving and improving the regulations around them.
When developing policy options to facilitate data reporting, it is important to consider plans’ intellectual property and assure that only appropriate information is shared publicly. Data made publicly available should be aggregated so that no beneficiary-level level data are shared. Policymakers also should balance the risk that adding reporting requirements may deter plans from offering these benefits altogether, especially if there are other avenues through which they can offer the services that are less administratively burdensome. In designing a potential mechanism, some dimensions to consider include: 1) requirement or a payment incentive; 2) all benefits or select benefits; and 3) per member per month (PMPM) spend, encounter data, and/or outcomes data. For example, policy options could include requiring MA plans to report supplemental benefit utilization in their encounter data submissions, encouraging reporting through additional quality measures tied to payment, or requiring participation in data sharing and learning collaboratives as a condition of offering the benefits. Another option to consider is standardizing data reporting requirements to level the playing field across different authorities for offering non-medical supplemental benefits.

Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement (Continued)

Policy Innovation

In Spring 2021, a roundtable of experts convened to discuss building the evidence base on the use and impact of these benefits. Several themes emerging from this discussion included the role of the federal government in collecting and disseminating more robust data on MA beneficiaries’ use and experience of these benefits through a new, multisector data aggregation; standardization of data to enable meaningful comparisons across benefit offerings and plans; and greater facilitation and accountability for plans’ collection and reporting of data on uptake and experience. The experts acknowledged that more robust data and measurement systems are needed to assess the impacts of these benefits and the long-term changes the program needs to meet the needs of its population.19

Recommendation

- Support the convening of a multi-stakeholder workgroup to develop recommendations around building, managing, and disseminating a stronger evidence base on non-medical supplemental benefits by December 2022.*

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Conclusion

The past few years have provided MAOs with the opportunity to experiment with unprecedented flexibility to address the non-medical needs of their enrollees. MAOs are increasingly embracing this flexibility and leveraging it to provide care to their members that meets individual need, which has been especially valuable during the continued public health emergency.

As CMS prepares its guidance on non-medical supplemental benefits for Plan Year 2023, there are a number of administrative changes that CMS can undertake in the short-term to move the needle, particularly in the areas of eligibility, marketing and education, and building the evidence base. The recommendations outlined in this brief have the potential to improve uptake and access to these benefits in the upcoming plan year as well as to lay the groundwork for longer-term policy changes, which will be presented in a future policy brief in Spring 2022.

More work is necessary to ensure that these benefits are delivered in a manner that addresses individual need and implements the Guiding Principles in practice. Through the continued guidance of the SSBCI Leadership Circle, ATI Advisory, the Long-Term Quality Alliance, and The SCAN Foundation intend to continue these conversations through data analysis, insights and research, and future discussions, to improve availability of SSBCI and other non-medical supplemental benefits, to promote future delivery of services and, ultimately, to help Medicare beneficiaries maintain and improve their health.
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 recommendations 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 and the quantitative data.

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 with 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

BALANCING PRINCIPLES

CORE PRINCIPLE
SSBCI Reflect Individual Needs

SSBCI Are Clear and Understandable
SSBCI Are Manageable and Sustainable
SSBCI Are Equitable
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

Progress Report on Policy Opportunities in 2020 Policy Brief

In the 2020 Policy Brief, ATI and LTQA identified several short- and long-term policy opportunities to advance non-medical supplemental benefits. The table below outlines progress updates on the three short-term policy opportunities outlined in the 2020 Policy Brief.

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<th>Short-Term Policy Opportunities for CMS</th>
<th>Policy Updates</th>
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<tbody>
<tr>
<td><strong>1. Provide clarity and technical assistance for MAOs on allowable benefits and targeting criteria</strong></td>
<td>In CY2022 Final Rule, CMS clarified that a recommendation from a licensed medical provider as part of a care plan is not needed to meet the “primarily health related” standard. CMS also provided continued flexibility for mid-year benefit enhancements in CY2021, since some plans may not have anticipated the public health emergency lasting as long as it has when they were designing benefits in early 2020. CMS has not yet released guidance on mid-year benefit enhancements for CY2022.</td>
</tr>
<tr>
<td><strong>2. Improve marketing guidance and consumer information</strong></td>
<td>In CY2022 Final Rule, CMS added a new requirement for a disclaimer to be used in marketing and communications related to SSBCI. This was to address confusion around a targeted benefit for which only a subset of members are eligible. In a memo released in October 2021, CMS expressed concerns around misleading advertisements around benefits and cost savings only available to limited groups. CMS reiterated that all marketing materials, including advertisements must be submitted to CMS for approval.</td>
</tr>
<tr>
<td><strong>3. Release guidance around non-medical supplemental benefits earlier in the bid process</strong></td>
<td>The CY2022 Final Rule, which included guidance on supplemental benefits in Medicare Advantage, was released in January 2021. The proposed rule was released in February 2020 for both CY2021 and CY2022 in combination. CMS should continue to release more timely guidance around these benefits to allow MAOs sufficient time to assess the market, design the benefit, and determine its net cost.</td>
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Several other policy opportunities were outlined in the 2020 Policy Brief as longer-term considerations, some of which may require legislative action. For reference, these recommendations are listed below.

**Long-Term Policy Opportunities**

1. Encourage learning between plans, providers, and other stakeholders.
2. Consider options to improve sustainability of non-medical benefits.

**Future Considerations**

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.
2. Assess the potential to test promising benefits in Medicare FFS, possibly using Center for Medicare and Medicaid Innovation (CMMI) authority.

Recommendations in this report and in a future Policy Brief, to be published in the Spring of 2022, will build upon these previously identified policy opportunities.
## Appendix C
### Requirements for Non-Medical Supplemental Benefits

<table>
<thead>
<tr>
<th>Requirements for Expanded Primarily Health-Related Benefits:</th>
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<tr>
<td>Previously, benefits were considered primarily-health related “if [the] primary purpose of the item or service is to prevent, cure, or diminish an illness or injury.”</td>
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<td>CMS expanded the definition in 2018 to include a three-part test:</td>
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<td>- “Must diagnose, prevent, or treat an illness or injury, compensate for physical impairments,”</td>
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<td>- Act to ameliorate the functional/psychological impact of injuries or health conditions,</td>
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<tr>
<td>- Or reduce avoidable emergency and healthcare utilization.”</td>
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<td>Benefits provided under this broader interpretation must be medically appropriate and do not include items or services solely to induce enrollment.</td>
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<tr>
<th>Other Considerations for These Benefits:</th>
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<tr>
<td>These benefits must be offered uniformly, meaning similarly-situated individuals receive the same services.</td>
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<tr>
<td>Benefits under this broader interpretation cannot be solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.</td>
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<tr>
<th>Examples of These Benefits:</th>
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<tbody>
<tr>
<td>- Adult Day Care Services (Adult Day Health Services)</td>
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<tr>
<td>- Home-Based Palliative Care</td>
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<tr>
<td>- In-Home Support Services</td>
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<tr>
<td>- Support for Caregivers of Enrollees</td>
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<tr>
<td>- Therapeutic Massage</td>
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</table>

### Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI):

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

A chronically ill enrollee is defined as an enrollee who:

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

<table>
<thead>
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<tr>
<td>Statute also gives plans the authority to waive uniformity requirements for these benefits, meaning that they can be targeted to each beneficiary’s individualized need.</td>
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<tr>
<th>Examples of These Benefits:</th>
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<tr>
<td>- Food and Produce</td>
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<tr>
<td>- Meals (beyond limited basis)</td>
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<td>- Pest Control</td>
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<tr>
<td>- Transportation for Non-Medical Needs</td>
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<tr>
<td>- Indoor Air Quality Equipment and Services</td>
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<tr>
<td>- Social Needs Benefit</td>
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<td>- Services Supporting Self-Direction</td>
</tr>
</tbody>
</table>

### Sources:
- CMS Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; April 2018 CMS Guidance.
- Bipartisan Budget Act of 2018; April 2019 CMS Guidance.