



ASPE
ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH,
DISABILITY, AND AGING POLICY

Comparing New Flexibilities in Medicare Advantage with Medicaid Long-Term Services and Supports: Final Report

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services

by
RTI International
Center for Health Care Strategies

January 2022

Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the U.S. Department of Health and Human Services (HHS) on policy development in health, disability, human services, data, and science; and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

Office of Behavioral Health, Disability, and Aging Policy

The Office of Behavioral Health, Disability, and Aging Policy (BHDAP) focuses on policies and programs that support the independence, productivity, health and well-being, and long-term care needs of people with disabilities, older adults, and people with mental and substance use disorders. Visit BHDAP at <https://aspe.hhs.gov/about/offices/bhdap> for all their research activity.

NOTE: BHDAP was previously known as the Office of Disability, Aging, and Long-Term Care Policy (DALTCP). Only our office name has changed, not our mission, portfolio, or policy focus.

This research was funded by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation under Contract Number #HHSP233201600021I and carried out by Research Triangle Institute. Please visit <https://aspe.hhs.gov/topics/long-term-services-supports-long-term-care> for more information about ASPE research on long-term services and supports (LTSS).

COMPARING NEW FLEXIBILITIES IN MEDICARE ADVANTAGE WITH MEDICAID LONG-TERM SERVICES AND SUPPORTS: FINAL REPORT

Authors

Molly Knowles, MPP
Jennifer Howard, PhD
Amarilys Bernacet, MPH
Cleanthe Kordomenos, BA
Edith Walsh, PhD
RTI International

Michelle Herman Soper, MHS
Nancy Archibald, MHA, MBA
Center for Health Care Strategies

January 2022

Prepared for

Office of Behavioral Health, Disability, and Aging Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHSP233201600021I

The opinions and views expressed in this report are those of the authors. They do not reflect the views of the Department of Health and Human Services, the contractor or any other funding organization. This report was completed and submitted on September 22, 2020.

TABLE OF CONTENTS

ACRONYMS	iii
1. EXECUTIVE SUMMARY	1
1.1. Main Findings	2
2. BACKGROUND	4
2.1. Expanded Supplemental Benefits	4
2.2. Medicaid Coverage of Benefits that Address LTSS and SDOH Needs.....	5
2.3. Project Purpose	6
3. METHODS	7
3.1. Environmental Scan	7
3.2. Case Studies	7
4. FINDINGS	9
4.1. Current Landscape of MAOs Offering Expanded Supplemental Benefits	9
4.2. Delivery and Administration of Expanded Supplemental Benefits	10
4.3. Opportunities Associated with Providing Expanded Supplemental Benefits	11
4.4. Challenges Associated with Providing Expanded Supplemental Benefits	12
4.5. Policy Implications of Overlapping Coverage with Medicaid.....	16
4.6. MAOs’ Future Plans for Expanded Supplemental Benefits.....	17
5. FUTURE CONSIDERATIONS	19
6. REFERENCES	22
APPENDIX A. LITERATURE SEARCH STRATEGY	25

LIST OF EXHIBITS

EXHIBIT 1.	Recent Changes to Supplemental Benefits Potentially Offered by MA Plans.....	5
EXHIBIT 2.	Overview of MAOs	8
EXHIBIT 3.	Types of Expanded Primarily Health-Related Supplemental Benefits Targeting LTSS Needs Offered by MAOs	9
EXHIBIT 4.	Types of SSBCI Offered by MAOs	10
EXHIBIT A-1.	Search Strategy	25
EXHIBIT A-2.	Publication Selection Process	26

ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

ASPE	Office of the Assistant Secretary for Planning and Evaluation
CBO	Community-Based Organization
CHCS	Center for Health Care Strategies, Inc.
CMS	Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus
CY	Calendar Year
D-SNP	Dual Eligible Special Needs Plan
FIDE-SNP	Fully Integrated Dual Eligible Special Needs Plan
HCBS	Home and Community-Based Services
LTQA	Long-Term Quality Alliance
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug plan
MAO	Medicare Advantage Organization
MCO	Managed Care Organization
MMP	Medicare-Medicaid Plan
PBP	Plan Benefit Package
ROI	Return on Investment
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SSBCI	Special Supplemental Benefits for the Chronically Ill
VBID	Value-Based Insurance Design

1. EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) has recently given new flexibilities to Medicare Advantage (MA) plans to provide supplemental benefits that address long-term services and supports (LTSS) needs and social determinants of health (SDOH) among their members. In 2019, CMS expanded its definition of “primarily health-related” benefits to include additional items or services that are LTSS-type services, such as adult day health, in-home personal care attendants, and support for beneficiaries’ family caregivers (e.g., respite). The Bipartisan Budget Act of 2018 (Public Law No. 115-123) further expanded supplemental benefits to include Special Supplemental Benefits for the Chronically Ill (SSBCI) that are not primarily health-related and offered non-uniformly to eligible chronically ill enrollees. However, limited information is available about the extent to which plans have provided or plan to provide these expanded supplemental benefits. Furthermore, Medicaid managed care plans may be concurrently offering similar benefits to Medicaid beneficiaries. This potential duplication is particularly relevant for dual eligible beneficiaries accessing services from Medicare and Medicaid managed care plans.

To examine the current landscape of MA plans that offer expanded supplemental benefits, and how the interaction with Medicaid benefits may affect dual eligible beneficiaries, we first conducted an environmental scan of publicly available peer-reviewed and grey literature supplemented with interviews of subject matter experts (SMEs). To gain insight into plans’ initial experiences with implementing expanded supplemental benefits in contract years 2019 and 2020, RTI and the Center for Health Care Strategies (CHCS) interviewed four Medicare Advantage Organizations (MAOs) offering these benefits among their various MA plans that also serve a large dually eligible population. The environmental scan and case studies were guided by the following research questions:

- What LTSS benefits did plans offer in contract year 2019 and why/how did plans select those specific benefits? How do these decisions about benefits offered in 2019 affect plans’ decision to offer SSBCI benefits in contract year 2020?
- How are the non-primarily health-related services offered by MA plans as part of SSBCI in contract year 2020 similar or different from non-primarily health-related benefits offered by Medicaid managed care plans, including, but not limited to LTSS targeted benefits? Types of services? Scope? Level of benefit? What are the policy implications of these similarities/differences for serving dual eligible beneficiaries? How does this vary by state?
- What challenges, if any, have state policy officials and plan administrators encountered with regard to the rollout and administration of the expanded supplemental benefits in contract year 2019 and the SSBCI benefits in contract year 2020? Which of these specifically pertain to Medicare-Medicaid dual eligible beneficiaries?

This report synthesizes information gathered from the environmental scan and case studies to provide an overview of early implementation of the expanded supplemental benefits.

Key Takeaways

1. Few MA plans adopted the expanded supplemental benefits in 2019 and 2020, but recent MA plan bid submissions indicate that the numbers are increasing.
2. Despite the challenges identified by MA plans during the early years of implementation, plans have found the benefits valuable to addressing the LTSS and SDOH needs of their members.
3. The impact of the expanded supplemental benefits on dual eligible beneficiaries can vary depending on the beneficiary's dual eligibility status (i.e., full or partial benefit dual eligible beneficiary) and the state's eligibility criteria for Medicaid LTSS.

1.1. Main Findings

The information we gathered provides insights into the current landscape of MAOs that provide expanded supplemental benefits, including their initial experiences and challenges with developing and administering the benefits to their members. Key findings include:

- **Current landscape.** Approximately 10% of MA plans offered expanded supplemental benefits in calendar year (CY) 2019 and 2020. Across the case study MAOs, there was more overlap in expanded primarily health-related benefits than in SSBCI. The types of SSBCI offered tended to be unique to the MAO's members. Overall, the MAOs also offered more primarily health-related benefits (e.g., post-acute discharge benefits and non-emergency medical transportation) than SSBCI.
- **Administration and delivery of expanded supplemental benefits.** The MAOs varied on whether the Medicaid or Medicare divisions of the organization had primary responsibility for administering the benefits. Reliance on outside vendors versus MAO providers depended upon the MAO's internal capacity and previously established relationships with local community-based organizations (CBOs).
- **Opportunities associated with the expanded supplemental benefits.** MAOs reported that the expanded supplemental benefits provided a key opportunity to better target and address the SDOH and LTSS needs of their members. The MAOs also mentioned their ability to develop unique benefits might enhance their competitive margin.
- **Potential increased benefits for dual eligible individuals.** The benefits provide the opportunity to improve access to needed supports and services for some dual eligible individuals. The expanded supplemental benefits can fill gaps in care and reduce future needs for more intensive Medicaid covered services among dual eligible individuals not yet eligible for Medicaid LTSS (e.g., partial benefit dual eligible beneficiaries). One MAO developed a process to build Medicare supplemental benefits to wrap around Medicaid LTSS benefits. Expanded supplemental benefits can also support full benefit dual eligible individuals who have some LTSS needs but who are not enrolled in a comprehensive home and community-based services (HCBS) Medicaid waiver.

- **Challenges associated with the expanded supplemental benefits.** We identified several challenges associated with MAO administration of the expanded supplemental benefits. These challenges included limitations with relying on rebates to fund the benefits; difficulties in identifying additional benefits to offer; inadequate data systems to track and differentiate between benefits; limited data to support return on investment (ROI) analyses; requests for more regulatory guidance and focus on beneficiary education; and specific challenges related to implementing the benefits during the COVID-19 pandemic.
- **Monitoring overlapping coverage with Medicaid.** States have limited ability to monitor and respond to their concerns about MAOs offering benefits similar to the state Medicaid program, and few states actively monitor MAOs' supplemental benefit offerings. Some of the MAOs have developed processes to monitor potential overlap of supplemental benefits.
- **Potential challenges for dual eligible individuals.** Beneficiary advocates and government officials reported concerns that overlapping benefits may confuse beneficiaries who are enrolled separately in a MA plan offering expanded supplemental benefits and their state's Medicaid program. If there is no coordination between Medicaid and the MAO, confusion about which payer covers a service may result in a barrier to access and denied claims for dual eligible individuals.
- **Future plans for expanded supplemental benefits.** Updated analyses of MA plan bid submissions indicate that an increasing number of MAOs are planning to offer some expanded supplemental benefits, both expanded primarily health-related benefits that target LTSS needs and SSBCI (ATI Advisory, 2020). The MAOs discussed plans to maintain their current benefits, and in some instances, add new benefits for 2021.

2. BACKGROUND

2.1. Expanded Supplemental Benefits

CMS has recently given new flexibilities to MA plans to provide supplemental benefits that address LTSS needs and SDOH among their members. MA plans have long been allowed to offer extra benefits (e.g., dental care, vision services, and gym memberships) (Noel-Miller & Sung, 2018; CMS, 2018a; CMS, 2018b). However, with the enactment of the Bipartisan Budget Act of 2018 (Public Law No. 115-123, henceforth referred to as the Chronic Care Act) that introduced SSBCI, and new guidance issued by CMS including the reinterpretation of “primarily health-related” and benefit uniformity, MA plans can now cover a wider array of extra benefits than was previously allowed. In addition, the Chronic Care Act required that the Medicare Value-Based Insurance Design (VBID) model be included in all 50 states and territories by 2020 (CMS, 2019b). The VBID model allows MA plans to target certain benefits to enrollees based on conditions and/or income level (e.g., low-income subsidy eligibility or dually eligible for Medicare and Medicaid).

CMS historically had required a supplemental benefit to: (1) not be covered by original Medicare; (2) be primarily health-related; and (3) require the MA plan to incur a non-zero direct medical cost. In 2019, CMS expanded its definition of “primarily health-related” benefits to include additional items or services used to “diagnose, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization” (CMS, 2018a). Some of these benefits are LTSS-type services, such as adult day health, in-home personal care attendants, and support for beneficiaries’ family caregivers (e.g., respite) (CMS, 2018b).

The Chronic Care Act further expanded supplemental benefits that may be offered by MA plans, which are referred to as SSBCI. SSBCI include supplemental benefits that are not primarily health-related and can be offered non-uniformly to eligible chronically ill enrollees. Although supplemental benefits must still focus directly on an enrollee’s health care needs, as of 2020, MA plans can cover a wider range of benefits that target SDOH. The regulations also made it possible for MA plans to target additional supplemental benefits to groups of chronically ill enrollees without having to provide the benefit to all plan participants (CMS, 2019b). *Exhibit I* provides an overview of the differences in the new types of supplemental benefits MA plans can offer.

For the purposes of this report, the new flexibilities offered to MAOs are collectively referred to as “expanded supplemental benefits.” Within the umbrella term of expanded supplemental benefits, the report distinguishes between two types of expanded supplemental benefits: (1) expanded primarily health-related benefits that target LTSS needs; and (2) SSBCI. These categories were generally used in discussions with MAOs.

EXHIBIT 1. Recent Changes to Supplemental Benefits Potentially Offered by MA Plans		
Announcement	Description	Example Benefits
CY2019 Call Letter: Reinterpretation of benefit uniformity and the scope of the “primarily health-related” supplemental benefit definition (CMS, 2018a, 2018b, 2018c).	<p>Beginning in CY2019, CMS reinterpreted the benefit uniformity requirement and expanded the definition of “primarily health-related” to consider an item or service as primarily health-related if it is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and health care utilization. A supplemental benefit is considered <i>not</i> primarily health-related under the previous or new definition if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or <i>social determinant</i> purposes.</p> <p>In order for CMS to approve a supplemental benefit, the benefit must focus directly on an enrollee’s health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one. MA plans can also offer benefits that target specific health status or disease states as long as similarly situated individuals are treated uniformly.</p>	<ul style="list-style-type: none"> • Adult day health • Home-based palliative care • In-home support services • Support for caregivers • Medically approved non-opioid pain management • Standalone memory fitness benefit • Home and bathroom safety devices • Transportation for non-emergency medical needs
CY2020 Call Letter: Announcement of the ability to offer SSBCI beginning in 2020 (CMS, 2019a)	<p>The intended purpose of the new category of supplemental benefits--SSBCI--is to enable MA plans to better tailor benefit offerings for the chronically ill population, address gaps in care, and improve specific health outcomes. SSBCI include supplemental benefits that are not primarily health-related and/or offered non-uniformly to eligible chronically ill enrollees.</p> <p>MA plans do not have to submit the processes by which they identify chronically ill individuals. CMS expects MA plans to develop and document mechanisms to identify chronically ill enrollees based on the definition used in Chapter 16b of the Medicare Managed Care Manual, including 15 specific chronic conditions (CMS, 2016).</p>	<ul style="list-style-type: none"> • Transportation for non-medical needs • Home-delivered meals (beyond the current allowable limited basis) • Produce, frozen foods, and canned goods • Access to community-based programs (e.g., community or social club memberships, access to companion care) • Home modifications • General supports for living (e.g., housing)
VBID Fact Sheet CY2020 (CMS, 2019c)	<p>In 2017, CMS tested the VBID model, allowing MA plans in 7 states, and later 3 more in 2018 and 15 in 2019, to target certain benefits to enrollees based on conditions and/or income level. In 2020, VBID was expanded to all 50 states and territories. Plans can test one or more of the following interventions:</p> <ul style="list-style-type: none"> • VBID by Condition, Socioeconomic Status, or both • Rewards and Incentives Programs • Telehealth Networks • Wellness and Health Care Planning 	<ul style="list-style-type: none"> • Reduced cost-sharing/copays for individuals with targeted conditions • Incentive to participate in a disease state management program • Telehealth services for behavioral health

2.2. Medicaid Coverage of Benefits that Address LTSS and SDOH Needs

Services that address LTSS and SDOH needs have historically been covered under Medicaid. Medicaid is the primary payer for LTSS in the United States, covering 51% of total LTSS expenditures in 2013 (Reaves & Musumeci, 2015). In addition to LTSS, many state

Medicaid programs look for ways to address SDOH among their Medicaid beneficiaries to improve health and cost outcomes because social needs disproportionately affect low-income individuals who are often served by Medicaid (Schroeder, 2007; ACAP & CHCS, 2018). Many Medicaid managed care plans have also developed interventions that address SDOH by linking clinical and non-clinical services to improve health outcomes and cost efficiencies among their beneficiaries (Gottlieb et al., 2016). States have also encouraged Medicaid managed care plans to focus on SDOH through state managed care contracts (Crumley et al., 2018). In May 2016, CMS finalized regulations that require Medicaid managed care plans to incorporate practices that look beyond clinical care to address the SDOH (Machledt, 2017).

2.3. Project Purpose

This study provides the Office of the Assistant Secretary for Planning and Evaluation (ASPE) with a better understanding of the current landscape of MA plans that offer expanded primarily health-related supplemental benefits that target LTSS needs and SSBCI, how these Medicare benefits interact with Medicaid managed care plans offering similar benefits to dual eligible beneficiaries, and the opportunities or challenges this presents. We used the following research questions to guide the study:

- What LTSS benefits did plans offer in contract year 2019 and why/how did plans select those specific benefits? How did these decisions about benefits offered in 2019 affect plans' decision to offer SSBCI benefits in contract year 2020?
- How are the non-primarily health-related services offered by MA plans as part of SSBCI in contract year 2020 similar or different from non-primarily health-related benefits offered by Medicaid managed care plans, including, but not limited to LTSS targeted benefits? Types of services? Scope? Level of benefit? What are the policy implications of these similarities/differences for serving dual eligible beneficiaries? How does this vary by state?
- What challenges, if any, have state policy officials and plan administrators encountered with regard to the rollout and administration of the expanded supplemental benefits in contract year 2019 and the SSBCI benefits in contract year 2020? Which of these specifically pertain to Medicare-Medicaid dual eligible beneficiaries?

3. METHODS

We conducted two main activities: (1) an environmental scan of publicly available peer-reviewed and grey literature supplemented with interviews of SMEs; and (2) case studies of four MAOs. The methods for each of these activities are described in detail below.

3.1. Environmental Scan

The environmental scan consisted of a thorough review of the peer-reviewed and grey literature, and discussions with SMEs. The literature review was guided by the best practices described by Haby et al. (2016) and entailed a comprehensive review of the peer-reviewed literature as well as several grey literature sources that focus on expanded supplemental benefits. See *Appendix A* for a detailed description of the methods employed for the literature review.

We conducted seven semi-structured interviews with federal and state government officials, managed care organizations (MCOs) representatives, beneficiary advocates, providers, and other stakeholders. Interview participants were identified based on recommendations from team members and ASPE staff and from the literature reviewed. We created interview guides tailored to each participant's expertise and shared the guides with participants prior to their 60-minute scheduled discussion. Interviews were recorded and transcribed for analysis.

3.2. Case Studies

We conducted case studies with four MAOs. Representatives from three MAOs participated in a series of semi-structured interviews and the fourth submitted written feedback.¹ Across the three organizations available for interviews, we conducted a total of 19 semi-structured telephone interviews with MAO representatives. Telephone interviews were typically between 45 and 60 minutes long and were conducted using Zoom, an audio-video conferencing platform. The four MAOs were selected by the following factors:

- The organization offered expanded primarily health-related benefits and SSBCI.
- Types of MA products offered (e.g., Medicare Advantage Prescription Drug Plan (MA-PD), Special Needs Plan).
- The geographic location of the MAOs.

¹ Due to the evolving international COVID-19 pandemic and associated restraints and burdens on MAOs during this time, one MAO was not able to participate in the series of semi-structured telephone interviews, but instead submitted responses via email.

We also selected organizations that operate in diverse Medicaid markets to determine variation and extent to which the expanded supplemental benefits overlap with Medicaid benefits for dual eligible beneficiaries. The case study MAOs are described in *Exhibit 2* below.

EXHIBIT 2. Overview of MAOs	
MAO	Market Characteristics
MAO 1	MAO 1 offers a traditional MA-PD plan and Dual Eligible Special Needs Plan (D-SNP). It also offers a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), which covers all Medicaid benefits, including LTSS.
MAO 2	MAO 2 offers MA-PD plans, D-SNPs, a Medicaid MCO that is part of a managed LTSS program, and a Medicare-Medicaid plan (MMP) participating in the state demonstrations under the Financial Alignment Initiative.
MAO 3	MAO 3 offers MA-PD plans, a FIDE-SNP, and an MMP participating in the state demonstrations under the Financial Alignment Initiative.
MAO 4	MAO 4 offers a MA-PD plan, D-SNPs, Medicaid MCOs, and an MMP participating in the state demonstrations under the Financial Alignment Initiative.

4. FINDINGS

4.1. Current Landscape of MAOs Offering Expanded Supplemental Benefits

Multiple publications report only a modest number of MA plans offering expanded supplemental benefits during the initial years plans were able to offer expanded supplemental benefits (Crook et al., 2019; Meyers et al., 2019; Murphy-Barron & Buzby, 2019). According to an analysis of MA plan benefit package (PBP) data conducted by Milliman on behalf of Better Medicare Alliance, Inc. (November 2019), in CY2019, 102 plans offered² one of the new primarily health-related supplemental benefits under the expanded definition: 51 offered in-home support services, 29 offered home-based palliative care, and 22 offered non-opioid pain management. In CY2020, 364 plans offered these expanded primarily health-related supplemental benefits (Murphy-Barron & Buzby, 2019). Results of similar analyses conducted by other organizations have pointed toward a similarly modest trend and similar supplemental benefit offerings as well as caregiver support, personal care services and adult day care (Crook et al., 2019; Avalere, 2018).

The types of primarily health-related benefits the case study MAOs offered were consistent with the literature findings. The most common types of primarily health-related targeting LTSS needs offered across the four MAOs were post-acute discharge benefits, which generally included meal delivery for a set amount of time (e.g., two weeks), and non-emergency medical transportation (*see Exhibit 3*). There was greater benefit overlap among the national MAOs compared to the regional-based plans. Additionally, the national MAOs offered adult day services and bathroom safety devices (e.g., grab bars).

EXHIBIT 3. Types of Expanded Primarily Health-Related Supplemental Benefits Targeting LTSS Needs Offered by MAOs				
Benefits	MAO 1	MAO 2	MAO 3	MAO 4
Post-acute discharge benefits ¹	X	X	X	X
Respite services	X			
Occupational therapy	X			
Adult day		X	X	
Non-emergency medical transportation		X	X	X
Personal care assistance			X	
Bathroom safety devices		X	X	
Education classes ²		X		X
iPads ³				X
<p>NOTE: MAOs did not confirm all benefits as being primarily health-related expanded supplemental benefits versus SSBCI. In some cases, the distinction is based on team’s best judgement.</p> <p>1. MAO 1: personal care assistance, post-discharge meal benefit, and care coordination; MAO 2: home-delivered meals; MAO 3: home-delivered meals; MAO 4: readmission prevention.</p> <p>2. MAO 2: Health education; MAO 4: Healthy aging classes, including cooking classes.</p> <p>3. iPads are delivered preloaded with health educational applications and socialization tools.</p>				

² It should be noted that these plans were the only ones in which a new expanded supplemental benefit could be distinguished.

Recent analyses of the CMS PBP files indicate that the number of plans offering SSBCI in CY2020 was low, with only 245 plans offering these benefits (ATI Advisory, 2020). The case study MAOs all offered SSBCI, but they offered a more limited number of these benefits compared to their expanded primarily health-related benefits (*Exhibit 4*). Additionally, while there was some overlap across the organizations offering meal delivery and non-medical transportation, the remaining SSBCI offered were unique to the MAO. MAO 4 offered the largest number of SSBCI; many of these benefits were targeted toward people living with dementia and their caregivers. Alternatively, MAO 3 offered SSBCI broadly to beneficiaries with any of the qualifying chronic conditions, instead of limiting SSBCI to one chronic condition.

EXHIBIT 4. Types of SSBCI Offered by MAOs				
Benefits	MAO 1	MAO 2	MAO 3	MAO 4
Non-medical transportation	X			X
Meal delivery	X		X	X
Personal emergency response system	X			
Air conditioner allowance		X		
Pest control			X	
Service dog support			X	
Caregiver support services ¹				X
Bathroom safety devices				X
Adult day and transportation ²				X
Animatronic cat				X
Independent living skills				X
Personal emergency response system				X
1. Includes respite care; psychotherapy, training/education, and coaching for caregivers; and transportation for caregivers. 2. Adult day and transportation benefits are SSBCI because the MAO targets the service for people living with dementia.				

As described below, several factors--including insufficient federal guidance, data, and time to adequately design and price the benefits--discouraged plans from expanding supplemental benefit offerings in CY2019. Government officials and experts believed it was too early to know if MAOs' experiences designing and implementing SSBCI in CY2019 influenced their decisions about whether to offer SSBCI in CY2020. Those decisions were predicted to rely heavily on whether the initial benefits offered helped to keep beneficiaries out of the emergency department or hospital (Daly, 2019) and whether plans view the benefits as prudent investments (Abrams & Bishop, 2019).

4.2. Delivery and Administration of Expanded Supplemental Benefits

The case study MAOs' administration and delivery of supplemental benefits varied by several factors. The MAOs varied on whether the Medicaid or Medicare divisions of the organization had primary responsibility for administering the benefits. In some cases, the MAOs included the benefit design and oversight functions within their Medicaid teams. In other cases, the MAOs assigned primary responsibility to their Medicare teams.

An MAO's internal organizational capacity and established relationships with local CBOs largely influenced how the MAO delivered expanded supplemental benefits. According to

available literature, although only a limited number of community-based providers interact with MA plans (only around 9% of CBOs had contracts with MA plans in 2018), these plans represent an important opportunity for CBOs, particularly with the new flexibility for plans to provide HCBS through the SSBCI (Aging & Disability Business Institute, 2020). The literature and conversations with SMEs indicated there may be limited experience among MA plans with regard to working with CBOs and third-party vendors (Kunkel et al., 2018).

The MAOs reported relying on a variety of providers, including existing and new partnerships with local CBOs to deliver the expanded supplemental benefits. Reliance on outside vendors versus MAO staff depended upon the MAO's internal capacity and established relationships with local CBOs. For example, one MAO's previous experience offering benefits addressing LTSS and SDOH needs of beneficiaries enabled them to offer SSBCI without many challenges. As the case study MAO noted, offering non-medical transportation to a portion of their members under SSBCI was "really easy to do because we already had a transportation contract in place."

Beneficiary advocates mentioned their concern about the potential for MA plans to exacerbate existing disparities for Medicare beneficiaries among underserved, under-resourced areas that do not have the CBOs required to provide these benefits. However, even in areas that have CBOs available, CBOs' limited MA plan contracting experience and capacity may prove challenging (Crook et al., 2019). Available research indicates that it will be important for MAOs to select CBO partners that are able to scale services to a plan's members (Thomas et al., 2019).

4.3. Opportunities Associated with Providing Expanded Supplemental Benefits

4.3.1. Potential to Address Members' LTSS and SDOH Needs

Several SMEs and case study MAOs highlighted that the key opportunity provided by the expanded primarily health-related benefits and SSBCI was plans' ability to better target and address their members' LTSS and SDOH needs. As one MAO explained, the new flexibilities had in effect "given [plans] permission to go a bit outside of the box" and that they "have a lot of opportunity to expand." According to another MAO, the SSBCI allowed them to provide support for SDOH needs that care management staff had identified through screenings and assessments.

4.3.2. Improve Market Competitiveness

In addition to improving the MAOs ability to meet their members' needs, several MAOs pointed out that the expanded supplemental benefits improved their competitiveness in highly competitive MA markets. The expanded supplemental benefits enabled MAOs to think through their member needs and provide available resources to develop unique additional benefits that might enhance their competitive margin. As one MAO noted, "supplemental benefits are important in differentiating plans."

4.3.3. Potential to Increase Benefits for Dual Eligible Beneficiaries

Although there is some potential for overlap, one subject matter expert raised several potential opportunities for expanded primarily health-related benefits and SSBCI to improve access to needed supports and services for some dual eligible individuals. However, the impact of these benefits differs depending on beneficiary characteristics. For example, for partial benefit dual eligible beneficiaries not yet eligible for Medicaid LTSS, the expansion of MA plans' supplemental benefits offers the potential to fill needed gaps in care and reduce future need for more intensive Medicaid covered services. For individuals with a certain degree of functional decline, expanded supplemental benefits can provide interventions that have the potential to delay institutionalization. The impacts of these benefits typically differ for partial versus full benefit dual eligible beneficiaries. Partial benefit dual eligible beneficiaries receive help with Medicare cost-sharing, but they are not eligible for Medicaid services, including Medicaid LTSS. As a result, MAO supplemental benefits could make some LTSS-type services available to partial benefit dual eligible beneficiaries, where full benefit dual eligible beneficiaries have access to LTSS available under Medicaid, depending on programmatic eligibility requirements like functional status. Lastly, these benefits can support full benefit dual eligible individuals who have some LTSS needs but who are not enrolled in a comprehensive HCBS Medicaid waiver.

The impact of expanded supplemental benefits can vary depending on a state's eligibility criteria for Medicaid LTSS. For states with stricter criteria that require high levels of functional impairment among Medicaid beneficiaries to qualify for HCBS, MAOs' ability to offer LTSS-type benefits may provide an opportunity for expanded access to certain services. HCBS waivers also have waiting lists, so MAOs can provide services in states with waiting lists to those who have demonstrated needs but do not yet have access to care.

Even in states with generous Medicaid coverage, MAOs can design targeted benefits to wrap around Medicaid benefits to expand services to dually eligible beneficiaries. One MAO developed a process, using the state's generous Medicaid LTSS benefits as a foundation, to build Medicare supplemental benefits to wrap around Medicaid LTSS benefits. However, keeping track of benefits across programs is onerous, and includes extensive crosswalk work across each program's policies to determine through which pathway to cover services.

4.4. Challenges Associated with Providing Expanded Supplemental Benefits

4.4.1. Funding Based on Rebates

Reliance on rebates to fund expanded supplemental benefits creates limitations and challenges to MAOs seeking to offer these benefits. All supplemental benefits, including the

expanded primarily health-related benefits and SSBCI, are funded through rebates.³ Rebates can vary substantially by region of the country. In collaboration with the Robert Wood Johnson Foundation, the Urban Institute released a report (2019) stating that the average MA plan received \$107 per member per month in rebates to spend on cost-sharing reductions or supplemental benefits. However, rebate amounts substantially varied across states. For instance, MA plans in North Dakota received \$2 per member per month, whereas in Florida, they received \$159 per member per month (Urban Institute, 2019). One provider SME commented on this variation, adding that provider practice patterns largely contributed to the state-by-state variance in rebate amount, and would likely influence the geographic spread of MA plans offering expanded supplemental benefits and SSBCI in CY2020. Several representatives of one MAO remarked that they lacked the funds (i.e., rebate dollars) to offer many expanded supplemental benefits.

Rebates are also time-limited, and the rebate amount allotted to each plan can change from year to year. The variability can make it difficult for MAOs to determine the amount of supplemental benefits they can offer. MAOs may hesitate to provide a certain level of benefits in one year if they may have to cut the benefits offered in the next year. Experts and the MAOs mentioned their concerns regarding the instability associated with the funding for expanded supplemental benefits. The MA plan members with LTSS and SDOH needs who these benefits target often require consistent access to needed benefits.

4.4.2. Determining Appropriate Benefits

Two MAOs reported difficulty in identifying viable and marketable supplemental benefits to offer. Representatives from one MAO explained that the state's Medicaid benefits package was robust and added that where coverage is not robust, such as dental, plans were already offering extended benefits. They further explained that "the majority of the benefits recommended [by CMS] were already covered for us by Medicaid, so we had a limited starting point of what to offer." Therefore, the MAO focused its expansion of supplemental benefits on SSBCI, where they had more flexibility to target specific populations.

Another MAO noted that aligning benefits with required criteria that were also attractive to beneficiaries shopping around for plans could be challenging. According to a representative from this plan, "the beneficiaries those benefits would be ideal for are not shopping for them. And seniors that are shopping are not looking for those things because they don't feel they yet need them." Two MAOs discussed difficulty in operationalizing benefits, including developing rates for a bid, staffing care managers to assess eligibility, and contracting with the right providers to offer services that would address key SDOH needs. Both MAOs noted being aware of specific SDOH needs, such as housing, but not yet understanding how best to address these needs as a

³ Rebates are a key component of MA payment rates. All plans that bid below the benchmark receive a percentage of the difference between the bid and benchmark as a rebate, ranging from 50% to 70% of the difference between the bid and the benchmark. The amount of the rebate paid to the plan is determined by the plan's quality star rating. Plans are required to use rebates to provide supplemental benefits, such as hearing, dental or vision, to reduce beneficiary cost-sharing, or to provide innovations in care delivery, such as telemedicine or home care (Better Medicare Alliance, 2018).

health plan. Two MAOs reported only selecting benefits that the MAO knew they could operationalize.

4.4.3. Inadequate Data Systems

Current data systems are not adequate to accurately track the use of these expanded benefits. The types of benefits offered, including expanded supplemental benefits, are included in the Medicare PBP bid submissions. Several studies used this database to determine the adoption of supplemental benefits across MA plans. However, because of differences in methodology and interpretations of services that qualified as supplemental benefits, the research varied when quantifying supplemental benefit uptake. As MAOs adopt supplemental benefits with greater frequency, this variation will make it difficult to accurately monitor MA plans' benefit expansion. For instance, where one study reported that 507 plans offered expanded primarily health-related supplemental benefits that targeted LTSS needs in CY2019 (Crook et al., 2019), another reported that 102 plans were offering expanded primarily health-related supplemental benefits (Murphy-Barron & Buzby, 2019).⁴

The PBP files also lack templates to capture benefit details, preventing analyses of benefit saturation to better understand the nuances of supplemental benefit uptake. One SME familiar with the data noted that the PBP data files included information on coinsurance and copayment required as part of a benefit offering, but no additional benefit detail such as quantity, setting, type, etc. For example, policymakers and researchers are currently unable to analyze PBP data files to examine how many rides and to which locations are being provided under a transportation benefit or how many hours or the type of respite are being offered under the caregiver support benefit.

One expert emphasized the challenge around creating a consistent count and labeling system for supplemental benefits--one that accounts for the wide interpretation of services that qualify as an expanded supplemental benefit. For instance, this expert explained that on the one hand, "home care" can imply that extra care is afforded during transitions from the hospital back to the patient's home (i.e., short-term), yet it also could be interpreted as ongoing in-home services and supports. Representatives from one MAO mentioned that due to limitations with current data systems, staff had to "get creative" to differentiate between benefits. MAOs must also increase coordination between departments to capture claims in the correct buckets.

4.4.4. Limited Data to Support Evidence Base

Several studies have identified MAOs' concerns about the expanded supplemental benefits' ROI, both in terms of financial viability and improved health outcomes for their members. Though medical services are understood in the current health system as a direct benefit to consumers, non-medical, health-related services, in contrast, are not as readily accepted as offering the same benefit of improved outcomes for consumers. As a result, MA plans that wish to address social needs through supplemental benefits will need to provide clear expectations for

⁴ Authors of the latter analysis indicated that the caregiver support benefit was not included in their analysis because "some of the benefits now classified as support for caregivers could have been classified differently and offered as a benefit to enrollees in prior years" (Murphy-Barron & Buzby, 2019, p.2).

member benefits. This will prove especially challenging given that determining ROI for prevention interventions, and health-related social needs in particular, is relatively new (Martinez et al, 2019). Several studies have called attention to the scarcity of evaluations examining the financial implications of addressing MA beneficiaries' SDOH, and even less is known about ROI for MA plans themselves (Sorbero & Kranz, 2019; Thomas et al., 2019).

One MAO commented on the rigorous research studies needed to determine ROI and medical cost savings for SSBCI before including them in the bid proposal. Speaking to this challenge one MAO representative shared, "Sometimes I get pushback on ROI... We need to support [what's included in the bid] with scientific evidence. My actuarial team will not allow me to take data from a vendor unless it's done via an independent study." In another MAO, a representative explained that since 90% of their business is conducted with fully capitated providers, any ROI that may accrue, such as reduced emergency utilization and expenditures, accrues on the provider side, and not for the plan.

4.4.5. Need for More Regulatory Guidance

Plans that chose not to include expanded supplemental benefits in their CY2019 bids shared that it was difficult to design and price these benefits, especially given the lack of clarity and guidance in CMS' original 2019 Call Letter (LTQA, 2019). This was echoed in a study that interviewed MA plan representatives--most interviewees expressed a need for additional CMS guidance before committing to addressing enrollees' social needs through supplemental benefits. Particularly, plan representatives were concerned with ongoing changes to CMS' regulations, and how SDOH would be defined in the final regulations (Thomas et al, 2019). MA plan representatives have reported that CMS' reaction to their submitted bids was more restrictive than what was implied in the original guidance documents (LTQA, 2019; Thomas et al, 2019). According to one SME, plans were expecting to be able to provide some of the supplemental benefits listed in CMS' 2019 Call Letter, but faced difficulty getting these new benefits approved in the audit process; they were "surprised... that they were turned down for something that they thought was going to be allowable."

4.4.6. Need for More Beneficiary Education

Experts and the MAOs discussed the need for a stronger focus on beneficiary education and federal oversight. Several experts suggested that CMS provide clearer guidelines for how MA plans should educate consumers about supplemental benefits, eligibility criteria, and appeals processes. CMS could address these concerns by: (1) developing transparency and oversight provisions in future regulations; (2) making information on eligibility requirements for approved supplemental benefits publicly available; and (3) providing education to MAOs about effective strategies for communicating the details of supplemental benefits that are not universally available and are often provided on a case-by-case basis to their members.

Additionally, there are marketing and enrollee engagement challenges for the plans. Many MAOs develop communications about plan benefits for the broad membership that is not tailored to specific enrollees. While plans may develop member materials to highlight new benefit offerings, it is important to be careful representing who is eligible, which can be very

complicated for the plans to describe and for beneficiaries to understand. Instead, MAOs often depend on brokers awareness and understanding the benefits, how the benefits connect to the needs of clients, and “hope that the agent/broker would make sure benefits that might be important would be highlighted for an individual.” Experts mentioned that enrollment brokers need very clear education and training to ensure they understand eligibility criteria for the members and how they connect to the needs of clients to able to communicate eligibility and the value-add of these benefits accurately. Several MAOs noted that they depended on their care managers to educate and communicate with members about benefit availability. One MAO mentioned that they had provided extensive training and materials to their care managers to support communication with their members about the expanded supplemental benefits.

4.4.7. COVID-19 Challenges

The current pandemic has also created novel challenges to implementation of the expanded benefits. COVID-19 has impacted utilization patterns, such that plans are unable to reliably predict utilization and member uptake of the new offerings. MAO representatives discussed how the pandemic may lead to larger than expected increased use of tablets and other technologies to address social isolation. By contrast, other MAOs shared that COVID-19 had reduced uptake of or suspended some benefits such as transportation and fitness benefits. A representative from one of these MAOs noted concerns about home care workers having adequate personal protective equipment and training.

4.5. Policy Implications of Overlapping Coverage with Medicaid

Despite the limited number of MAOs offering expanded supplemental benefits in 2020, there is potential for interaction with and overlap between Medicaid coverage and supplemental benefits that provide LTSS and SDOH related services. In addition to creating challenges for MAOs and government officials in monitoring benefits across plans, this can also cause confusion for dually eligible beneficiaries and providers.

4.5.1. Extent to Which MAOs and States Monitor Overlap

States face limitations with monitoring and responding to any concerns with MAOs offering benefits similar to their state Medicaid program. Few states actively monitor MAO supplemental benefit offerings, although some require D-SNPs with which they have State Medicaid Agency Contracts⁵ to report to the state all supplemental benefits offered (e.g., Arizona, Minnesota and Pennsylvania). A few other states require MAOs to submit bids to the state for review. However, most states do not have this requirement. There are even more limited mechanisms for states to monitor and/or require information from MAOs that are not D-SNPs, such as examining the limited information available in the Medicare data files. MAOs that offer integrated or aligned Medicare and Medicaid services are in a stronger position to reduce potential duplication.

⁵ The Medicare Improvements for Patients and Providers Act of 2008--as amended by the Affordable Care Act--required all D-SNPs to have contracts with the Medicaid agencies in the states in which they operate.

Some plans have developed processes to monitor potential overlap of supplemental benefits, although this varies across MAOs, and MAOs may not have a formal system in place to track Medicaid services and monitor overlap. Some MAOs have developed a single case management system in markets in which the potential for overlap currently exists. Others have developed system edits to monitor overlap between benefits and to ensure that duplication does not occur. One MAO created a benefits system that tracks coordination between its Medicaid and Medicare plans to check that claims are paid by the correct payer. MAOs might design a system to review potential benefits prior to Medicare bid submission to ensure that supplemental benefits are not currently being offered under Medicaid benefits. They can also educate care managers about different benefits to help them assist dually enrolled beneficiaries in the benefit selection, including determining whether a new supplemental benefit duplicates an existing Medicaid benefit.

Other plans may choose to discontinue supplemental benefits if overlap occurs. One MAO described an example in which benefit overlap occurred. To streamline coverage for enrollees, the plan chose to discontinue one of the benefits going forward.

4.5.2. Potential Challenges for Dual Eligible Beneficiaries

Beneficiary advocates and government officials have expressed concerns about the overall confusion that the potential for overlapping benefits may cause beneficiaries trying to determine which payer is covering a needed service. Medicare and Medicaid grievance and appeals processes for service denials differ. If there is no coordination between the two payers, the confusion may result in a barrier to access and denied claims for dual eligible beneficiaries.

4.6. MAOs' Future Plans for Expanded Supplemental Benefits

The MAOs all reported that CY2020 was greatly impacted by the COVID-19 pandemic. Due to the pandemic, there had been lower utilization of benefits overall. Therefore, in order to create stability for a population harder hit by the pandemic and properly assess the impacts of these newly offered supplemental benefits, CY2021 benefit decisions would not be based just on ROI. Rather, examining feedback from beneficiaries collected from care managers, conducting member satisfaction surveys, and piloting new benefits for at least two years were strategies described for benefit planning for CY2021.

While the MAOs were hesitant to divulge too many details regarding CY2021 benefits, MAOs indicated that in most cases current benefits would be maintained, and in some instances, new benefits would be added. One MAO mentioned that although Medicare payments may be reduced if the COVID-19 pandemic results in lower risk scores, leaving few dollars available for supplemental benefits, the MAO would continue to offer current benefits and expand to remain “appealing in the marketplace.” This MAO discussed expanding nutrition (i.e., grocery benefit and additional meals), in-home supports, and telehealth benefits.

All of the case study MAOs discussed expanding to other supplemental benefits. One MAO indicated a desire to use supplemental benefits to address housing. Supporting caregivers was described by multiple MAO representatives as another focus area for future supplemental benefit offerings. One MAO discussed how they were considering expanding their support through SSBCI to target caregivers of people with certain chronic conditions. Benefits targeting social isolation and loneliness were other areas MAO plan representatives pointed to for future supplemental benefits.

5. FUTURE CONSIDERATIONS

While the study findings indicate MAOs' relatively modest adoption of expanded supplemental benefits during the initial years these flexibilities were made available, recent analyses of the MA plan bid submissions and our discussions with MAOs indicate their increasing interest to offer benefits. Policymakers and researchers may wish to consider the following as MAOs more widely adopt expanded supplemental benefits:

- **Data Collection and Analysis.** Currently no consistent taxonomy exists for expanded supplemental benefits. These expanded supplemental benefits are entered into the PBP data files under a set of categories (separate categories for expanded primarily health-related supplemental benefits and SSBCI). However, plans may offer very specific benefits, such as providing eligible beneficiaries with animatronic cats as surrogate pets. As one expert explained, benefit descriptions may vary, leading to inconsistencies in the data entered and subsequent analyses. As a result, policymakers and researchers may face difficulties in accurately capturing trend details in MAOs offering expanded supplemental benefits.
- **Communication.** All stakeholders could benefit from improved communication from CMS and MAOs. The study results point to insufficient guidance from CMS to MAOs regarding expanded supplemental benefits as a factor for the MAO's initial conservative approach to benefit offerings decisions. Conversely, policymakers and other stakeholders lack information from MAOs regarding their decision-making processes and plan offerings. For example, if policymakers had detailed information regarding MAOs' offerings, they would be better positioned to potentially minimize duplication with Medicaid benefits and reduce provider burden and beneficiary confusion. Improved communication would allow MAOs to better prepare to offer expanded supplemental benefits, and would help policymakers and other stakeholders to understand future benefit possibilities and support providers and beneficiaries accordingly.
- **Equity.** As plans can now target certain beneficiaries for services, some beneficiaries who do not meet selected eligibility requirements may be excluded. Policymakers and other stakeholders may wish to continue to examine ways to balance the benefits of these expanded supplemental benefits with ensuring all beneficiaries' health and well-being are equitably addressed and educate them about options to appeal eligibility determinations.
- **Medicare and Medicaid Coordination.** Several experts suggested there may be instances in which, "both parties [MA plans and Medicaid] dropped the ball" because each is working under the assumption the other will tend to the needs of their beneficiaries. Increased coordination between Medicare and Medicaid regarding these benefits can help ensure dual eligible beneficiaries access to needed supports and services. States may consider increasing their involvement with monitoring D-SNPs through their contracts with these plans, including requiring the plans to report their

supplemental benefit offerings to the state or to offer certain supplemental benefits to their members.

- **D-SNP Look-Alike Plans.** Some MAOs offer D-SNP look-alike plans, which offer reduced premiums and beneficiary cost-sharing amounts similar to D-SNPs. These look-alikes may now also offer supplemental benefits to address LTSS and SDOH needs, making them appear even more like an integrated D-SNP that provides Medicaid benefits. However, because these are traditional MA plans, they are not required to coordinate with Medicaid. Offering expanded supplemental benefits may enable the D-SNP look-alike plans to market their benefits in a way that could cause confusion among dual eligible beneficiaries and enrollment counselors. CMS has proposed several provisions to restrict D-SNP look-alike plans (CMS, 2020), but these plans may continue to grow in the meantime.

MAOs considering expanding their supplemental benefit offerings may also want to consider the following:

- **Involvement of Medicaid teams.** Medicaid expertise is important for designing “LTSS-like” supplemental benefits, or benefits that otherwise address SDOH. MAOs that either house benefit design or oversight functions within Medicaid teams, or that demonstrate robust collaboration with Medicaid divisions, appear to have faced fewer challenges with benefit implementation. Conversely, the MAO with less Medicaid experience appears to have less knowledge about how these supplemental benefits interact with Medicaid and what types of LTSS-like benefits would be most useful to members.
- **Use of benefits as wrap around to Medicaid benefits.** One MAO explicitly uses some Medicare supplemental benefits to wrap around Medicaid LTSS benefits. They use the state’s generous Medicaid LTSS benefits as a foundation on which to build their supplemental offerings. However, keeping track of benefits across programs is onerous, including extensive crosswalk work across policies in each program to determine through which pathway to cover services.
- **Developing a process to target eligibility for benefits.** SSBCI eligibility criteria requires that an individual receiving a benefit have a specific diagnosis and in turn, requires a process across different plan staff to validate that a member receiving the services meets those eligibility criteria. Expanded primarily health-related supplemental benefits can be available to all members regardless of whether an individual has a specific diagnosis. In programs in which each member has an individual care manager, like in a D-SNP, it can be easier for care managers to identify benefit recipients and provide necessary information for authorization and reporting. But, in most traditional MA plans, fewer members have a designated care manager and identifying and tracking eligible members becomes more challenging.
- **Increased investments needed.** While plans appreciate the flexibility to offer new benefits, several MAOs discussed the increased efforts and investments a MAO must account for when considering expanding their supplemental benefit offerings. All four

MAOs reported that they have more work to do to understand the ROI for services that address SDOH. Although plans with missions to serve low-income and/or high-need beneficiaries have made progress on this research and are more open to offering benefits that target social needs with limited evidence, they acknowledged that rebate dollars are generally insufficient to cover the true investment needed to have a system-wide impact.

6. REFERENCES

- Abrams, M.K., & Shawn, B. (2019). *New Medicare Advantage Benefits Offer Social Services to People with Chronic Illness*. Commonwealth Fund. Retrieved from: <https://www.commonwealthfund.org/blog/2019/new-medicare-advantage-benefits-offer-social-services-people-chronic-illness>.
- Aging and Disability Business Institute. (2020). *A View from the Field: Future Directions for Contracting Between Health Care and Community-Based Organizations*. Retrieved from: <https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2020/04/Stakeholders-report-508.pdf>.
- ATI Advisory. (2020). *2020 SSBCI and New Primary Health-Related Benefits*. Retrieved from: <https://atiadvisory.com/wp-content/uploads/2020/08/2020-SSBCI-and-New-Primarily-Health-Related-Benefits.pdf>.
- Avalere. (2018). *Medicare Advantage Beneficiaries Will See a Jump in New Supplemental Benefit Offerings in 2019*. Retrieved from: https://avalere.com/wp-content/uploads/2018/10/1539906863_Avalere_MA_Plan_Supplemental_Benefits_Analysis.pdf.
- Centers for Medicare & Medicaid Services (CMS). (2016). *Medicare Managed Care Manual: Chapter 16-B: Special Needs Plans*. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>.
- Centers for Medicare & Medicaid Services (CMS). (2018a). *Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*. Retrieved from: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>.
- Centers for Medicare & Medicaid Services (CMS). (2018b). *Reinterpretation of “Primarily Health Related” for Supplemental Benefits*. Retrieved from: <https://www.aarp.org/content/dam/aarp/ppi/2018/10/reinterpretation-of-primarily-health-related-for-supplemental-benefits.pdf>.
- Centers for Medicare & Medicaid Services (CMS). (2018c). *Reinterpretation of the Uniformity Requirement*. Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27>.
- Centers for Medicare & Medicaid Services (CMS). (2019a). *Implementing Supplemental Benefits for Chronically Ill Enrollees*. Retrieved from: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_III_HPMS_042419.pdf.
- Centers for Medicare & Medicaid Services (CMS). (2019b). *Medicaid Managed Care Enrollment and Program Characteristics, 2017*. Retrieved from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>.

- Centers for Medicare & Medicaid Services (CMS). (2020). *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*, 85 Fed. Reg. 9002 (February 18, 2020). Retrieved from: <https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the>.
- Crook, H., Olson, A., Alexander, M., Roiland, R., Japinga, M., Boucher, N., Taylor, D.H., & Saunders, R. (2019). *Improving Serious Illness Care in Medicare Advantage: New Regulatory Flexibility for Supplemental Benefits*. Duke University. Retrieved from: https://healthpolicy.duke.edu/sites/default/files/2020-07/MA_SupplementalBenefits_2019.pdf.
- Crumley, D., Lloyd, J., Pucciarello, M., Stapelfeld, B., & Center for Health Care Strategies. (2018). *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*.
- Daly, R. (2019). *Medicare Advantage Plans Accelerating Their Move into SDOH, Advocate Says*. Healthcare Financial Management Association (HFMA). Retrieved from: <https://www.hfma.org/topics/news/2019/06/medicare-advantage-plans-accelerating-their-move-into-sdoh--advo.html>.
- Gottlieb, L.M., Quinones-Rivera, A., & Manchanda, R. (2016). States influences on Medicaid investments to address patient' social needs. *American Journal of Preventive Medicine*.
- Hagan, R, Manktelow, R, Taylor, B, & Mallet, J. (2014) Reducing loneliness amongst older people: A systematic search and narrative review. *Aging and Mental Health*, 18(6), 683-693.
- Kunkel, S.R., Lackmeyer, A.E., Straker, J.K., & Wilson, T.L. (2018). *Community-Based Organizations and Health Care Organizations: Building and Strengthening Partnerships*. Scripps Gerontology Center. Retrieved from: <https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6280/Kunkel-Community-Based-Organizations-and-Health-Care-Contracting.pdf>.
- Lewis, E., Eiken, S., Amos, A., & Saucier, P. (2018). *The Growth of Managed Long-Term Services and Supports Programs: 2017 Update*.
- Long-Term Quality Alliance (LTQA) & Anne Tumlinson Innovations. (2019). *A Turning Point in Medicare Policy: Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill*. Retrieved from: http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/2019-07-24_GuidingPrinciplesForSSBCI.pdf.
- Machledt, D. (2017). Addressing the Social Determinants of Health through Medicaid Managed Care. Retrieved from: https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2017_nov_machledt_social_determinants_medicaid_managed_care_ib_v2.pdf.
- Martinez, R.M. & Alper, J. (2019). *Investing in Interventions that Address Non-medical, Health-related Social Needs*. Retrieved from: <https://www.nap.edu/download/25544>.
- Meyers, D.J., et al. (2019). Early adoption of new supplemental benefits by Medicare Advantage plans. *JAMA*. 321(22), 2238-2240.

- Murphy-Barron, C., & Buzby, E.A. (2019). *Review of Contract Year 2020 Medicare Advantage Supplemental Healthcare Benefit Offerings*. Milliman & Better Medicare Alliance. Retrieved from: https://www.bettermedicarealliance.org/sites/default/files/2019-11/Review_of_Contract_Year_2020_Medicare_Advantage_Supplemental_Healthcare_Benefit_Offerings.pdf.
- Noel-Miller, C., & Sung, J. (2018). *Supplemental Benefits under Medicare Advantage--Part 1: An In-Depth Look at What They Are Today*. Retrieved from: <https://www.aarp.org/content/dam/aarp/ppi/2019/january-2019/supplemental-benefits-under-medicare-advantage-part-one.pdf>.
- Schroeder, S.A. (2007). We can do better--improving the health of the American people. Shattuck Lecture. *N Engl J Med*, 357(12), 1221-1228.
- Sorbero, M.E., & Kranz, A.M. (2019). Perspectives on opportunities and challenges for Medicare Advantage plans to address social determinants of health via the CHRONIC Care Act. *Inquiry*, 56.
- Spencer, A., Freda, B., McGinnis, T., & Gottlieb, L. (2016). *Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons*. Center for Health Care Strategies, Inc. Retrieved from: https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL.pdf.
- Taylor, L.A., Tan, A.X., Coyle, C.E., Ndumele, C., Rogan, E., Canavan, M., Curry, L.A., & Bradley, E.H. (2016). Leveraging the social determinants of health: What works? *PloS one*, 11(8), e0160217. doi.org/10.1371/journal.pone.0160217.
- Thomas, K.S., et al. (2019). Perspectives of Medicare Advantage plan representatives on addressing social determinants of health in response to the CHRONIC Care Act. *JAMA*, 2(7).
- Urban Institute. (2019). Are Medicare Advantage Plans Using New Supplemental Benefit Flexibility to Address Enrollees' Health-Related Social Needs? Retrieved from: https://www.urban.org/sites/default/files/publication/101067/sdh_medicare_advantage_1.pdf.
- Wright, L., Vance, L., Sudduth, C., & Epps, J. (2015). The impact of a home-delivered meal program on nutritional risk, dietary intake, food security, loneliness, and social well-being. *J Nutr Gerontol Geriatr*, 34(2), 218-227.

APPENDIX A. LITERATURE SEARCH STRATEGY

A1.1. Identification of Relevant Publications

The two searches were composed of multiple steps that included developing preliminary lists of search terms, exclusion and inclusion criteria, and databases and organizational and agency websites for conducting the searches. *Exhibit A-1* shows the organizations, agencies, and publications searched as well as the search terms used.

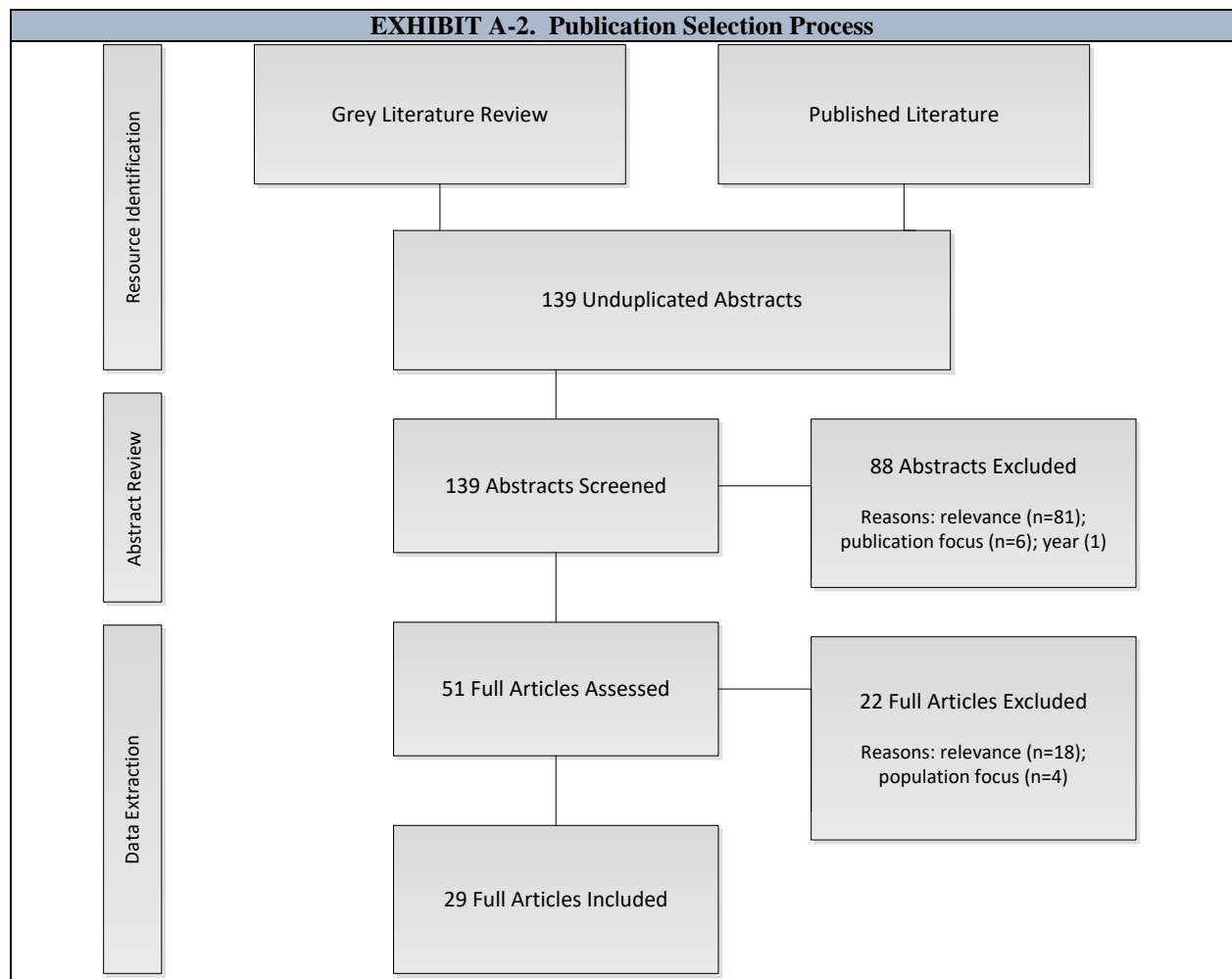
EXHIBIT A-1. Search Strategy		
	Source	Keywords
Peer-reviewed Literature	PsychINFO, ScienceDirect, Google Scholar, JSTOR, Web of Science, PubMed English, since Jan 2009	Medicare Advantage OR Medicaid Managed Care OR value-based purchasing OR value-based insurance design OR managed long-term services and supports OR chronically ill OR Medicaid benefits OR Medicare Part C OR value-based insurance OR value-based health insurance OR chronic illness AND supplemental benefits OR social determinants of health OR ((adult day health OR home-based palliative care OR in-home support services OR support for caregivers OR medically approved non-opioid pain management OR standalone memory fitness benefit OR home and bathroom safety devices OR transportation for non-emergency medical needs OR transportation for non-medical needs OR home-delivered meals OR produce, frozen foods, and canned goods OR companion care OR home modifications OR housing) AND (Medicare OR Medicaid)) AND challenges OR opportunities OR perspectives
Grey Literature	<ul style="list-style-type: none"> • ASPE • CMS • CDC • MedPAC • MACPAC • AARP • MedicareResources.org • JusticeinAging.org • MedicareAdvocacy.org • Milliman • Bipartisan Policy Center • Association for Community Affiliated Plans • Special Needs Plan Alliance • Avalere • National Academies of Science, Engineering, and Medicine 	<ul style="list-style-type: none"> • America’s Health Insurance Plans • National Council on Aging • Medicare Rights Center • N4A • Community Catalyst • AHRQ • Commonwealth Fund • LTQA • Fierce Healthcare • Better Medicare Alliance • Urban Institute • Kaiser Family Foundation

Once we identified an initial list of studies, we completed a high-level review of the resulting publication titles. After we agreed that all relevant studies were identified from all relevant sources, a team member imported the publication information and abstracts from selected relevant publications into the data charting tool, created to capture and organize information collected from the review. Concurrent with this review, we completed a search of the grey literature. Our team developed a list of 28 organizations, governmental agencies and health insurance companies to review (see *Exhibit A-1* above). All resources identified from the grey literature search were included in the data charting tool for additional review.

A1.2. Selection of Publications

Three members of the team reviewed the study abstracts to: (a) further refine the inclusion/exclusion criteria; and (b) begin the process of eliminating studies from further analysis. We then selected studies for further review and noted our reasoning for all publications we excluded from further analysis. Following the abstract review, each included article was reviewed in its entirety.

Through our search of the peer-reviewed and grey literature, we identified 139 publications. We reviewed in full 51 of those articles for relevance, and further culled 22 articles based on determination that the study population (4) was outside of our study's focus, or they were otherwise not relevant (18). Data were extracted and synthesized from the 29 publications that met our inclusion/exclusion criteria. The publication selection process is summarized in *Exhibit A-2* below.



A1.3. Data Extraction, Charting and Synthesis

The final step of our review process was to extract, chart, and synthesize the data. We began by extracting relevant content by research question and then charting the information in the data charting tool. We then synthesized the data by conducting a qualitative thematic analysis. This was done by identifying and documenting themes and subthemes within the content extracted by the research question. The initial themes were shared with ASPE for feedback.