



POLICY REPORT

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# Fulfilling the Promise of the *CHRONIC Care Act*:

## Policy Recommendations for Congress to Advance New Supplemental Benefits in Medicare Advantage

May 2022

### Executive Summary

In the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act*, Congress took a significant step to advance whole-person care and improve the health status and quality of life of Americans with complex needs receiving Medicare. Through the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI), effective in 2020, Congress provided Medicare Advantage (MA) plans with a new platform and unprecedented flexibility to address beneficiaries' individualized needs, including those that are not strictly medical. Based on several years of research tracking the initial implementation and progress of these new supplemental benefits, ATI Advisory and Long-Term Quality Alliance have developed three policy recommendations for Congress to consider to advance new supplemental benefits in MA, as outlined in this report. The recommendations are focused on the areas of eligibility, data reporting, and evaluation.

Three years into the implementation of these benefits, Congress has a vital opportunity to strategically build upon the promising framework of SSBCI and bolster SSBCI as a tool to improve care for Medicare beneficiaries with complex care needs. This policy report provides additional detail and considerations around each of our recommendations for Congressional action.

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## Introduction

Medicare expenditures are expected to continue to rise as the U.S. population continues to age. By 2030, one in five Americans are projected to be over the age of 65, surpassing the number of children.<sup>i</sup> Enrollment in Medicare Advantage (MA) has doubled over the past decade, currently accounting for 46% of all Medicare beneficiaries.<sup>ii</sup> The growth of MA is likely attributable, in part, to its ability to meet the needs of low-income older adults, compared to Traditional Fee-For-Service (FFS) Medicare.<sup>iii</sup> In 2022, the average MA plan enrollee had access to nearly \$2,000 in extra benefits (including lower cost sharing, lower premiums, and supplemental benefits) compared to FFS Medicare beneficiaries.<sup>ii,iv</sup>

The creation of a new type of supplemental benefits, known as Special Supplemental Benefits for the Chronically Ill (SSBCI), under the *CHRONIC Care Act*, was a significant turning point in Medicare policy. For the first time, effective in 2020, Medicare would cover services that were not primarily health-related but rather addressed social and economic needs and could be individually targeted. This statutory change reflected Congress' recognition of the important impact of health-related social needs (HRSN) on health status.<sup>v</sup>

In response to this major policy shift, supported by The SCAN Foundation, ATI Advisory (ATI) and Long-Term Quality Alliance (LTQA) launched a multi-year initiative to research and inform the delivery of these benefits. In 2020, ATI and LTQA outlined actionable strategies for plans and providers, as well as opportunities for policymakers to advance these benefits. One year later, we released a follow-up report on the progress of the supplemental benefits landscape along with policy recommendations for the Centers for Medicare & Medicaid Services (CMS). Building upon the policy opportunities and administrative recommendations outlined in prior reports, this policy report will present legislative recommendations for Congress to consider, including longer-term visioning for the future of new supplemental benefits in Medicare Advantage.<sup>1</sup>

## Background

### OVERALL LANDSCAPE OF NON-MEDICAL BENEFITS AND SERVICES IN MEDICARE ADVANTAGE

This report focuses on SSBCI, building off of research and lessons learned in the four years since the passage of the *CHRONIC Care Act*. However, it is important to also consider how SSBCI fits into the broader context of other pathways to offer non-medical benefits and services. Effective 2019, CMS expanded the definition of “primarily health-related benefits” (expanded PHRB) to include services that “diagnose, prevent, or treat an illness or injury, compensate for physical impairments; act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization.”<sup>vi</sup> Additionally, CMS instituted “Uniformity Flexibility” (UF) that enabled plans to offer “specific tailored supplemental benefits” to “similarly situated enrollees” rather than all members in order to “help MA plans better manage healthcare services for particularly vulnerable enrollees.”<sup>vi</sup> Plans can also test supplemental benefit designs targeted based on chronic conditions or socioeconomic characteristics under the Center for Medicare and Medicaid Innovation (CMMI) Value-Based Insurance Design (VBID) Demonstration.<sup>vii</sup>

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1 Our recommendations are focused on Medicare Advantage since that is the existing structure for delivery of SSBCI. However, we recognize that all Medicare beneficiaries—not only those in MA—could benefit from receipt of SSBCI. Opportunities to expand SSBCI to original Medicare Fee-For-Service are worthy of further exploration.

## THE PROMISE OF SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

### THE ORIGINAL VISION FOR SSBCI

The *CHRONIC Care Act*, passed as part of the *Bipartisan Budget Act of 2018*, was a collaborative, bipartisan piece of legislation to address the growing number of Medicare beneficiaries with chronic conditions, the associated increase in spending, and challenges with care coordination for this population. Within the Act, Congress defined the newly-created supplemental benefits as those “that, with respect to a chronically ill enrollee, have a **reasonable expectation of improving or maintaining the health or overall function** of the chronically ill enrollee and may not be limited to being primarily health-related benefits”.<sup>viii,ix</sup>

Thus, the overarching impetus for the creation of SSBCI can be summarized in three main categories:

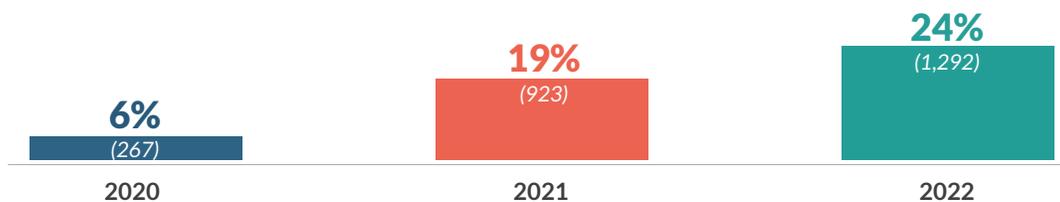
- 1 To provide plans and providers with the flexibility to better meet beneficiaries’ needs, including those that are not strictly medical;
- 2 To improve and maintain health status and function of beneficiaries; and
- 3 To reduce avoidable healthcare utilization and Medicare spending.

Moreover, there is an opportunity to build upon the existing SSBCI framework to achieve other critical aims, such as preventing Medicare beneficiaries just above the income threshold for Medicaid from spending down their resources and spiraling into poverty.

### GROWTH OF SSBCI SINCE ENACTMENT

First available in Plan Year (PY) 2020, the proportion of MA plans offering SSBCI has grown from 6% to 24% in 2022 (Figure 1).<sup>x</sup> Examples of SSBCI include Food and Produce, Extended Meals, Pest Control, Transportation for Non-Medical Needs, Indoor Air Quality Equipment, and other services.<sup>xi</sup>

Figure 1. Growth in SSBCI Over Time, PY 2020-2022  
Percentage of Plans Offering SSBCI (Number of Plans)



Source: ATI Advisory analysis of CMS’ 2022 Plan Benefit Package (PBP) file, excludes Employer Group Health Plans, Prescription Drug Plans, Medicare-Medicaid Plans, Part B-only Plans, and PACE.

For more information on non-medical supplemental benefit growth since 2020, see our [data brief](#).

## CONGRESSIONAL MANDATE FOR AN EVALUATION OF SSBCI

In the *CHRONIC Care Act*, Congress also charged the U.S. Government Accountability Office (GAO) with producing an evaluation of SSBCI within five years of enactment including analyses of the following:

- 1 The type of supplemental benefits provided, total number of enrollees receiving each benefit, and whether the supplemental benefit is covered by the standard benchmark cost of the benefit or with an additional premium;
- 2 The frequency in which supplemental benefits are utilized by such enrollees; and
- 3 The impact of benefits on indicators of quality of care, including the overall health and function of enrollees receiving benefits; utilization of items and services covered under Parts A and B of the original Medicare FFS program, and the amount of bids submitted by Medicare Advantage Organizations (MAOs).<sup>viii</sup>

As of 2022, the third year since plans could start offering SSBCI, data are not publicly available to conduct this evaluation. In developing an evaluation framework, it is important to consider the policy goals for SSBCI as well as a realistic process for collecting data to support such an evaluation. With growing budgetary pressure on Medicare and three years into implementation, now is the time to chart a path forward for maximizing the reach of these benefits and collecting the data needed to highlight their impacts on the MA beneficiaries that need them the most.

SSBCI are a powerful tool for improving care for Medicare beneficiaries with complex needs that can be further leveraged if Congress is intentional about building upon this promising framework. **In this report, we offer recommendations for three legislative actions that Congress can take now to advance SSBCI and to fulfill the promise of the *CHRONIC Care Act*.**<sup>2</sup>

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2 While we ultimately decided to focus our recommendations on the topic areas of eligibility, data reporting, and evaluation, additional topic areas we explored include: stakeholder education and awareness; the role of states in influencing the design, marketing, and delivery of these benefits; and more sustainable financing options. These areas are also important to the future advancement of SSBCI and are worthy of further exploration.

## Recommendations for Congress to Advance SSBCI

**1**

**Modify eligibility criteria for SSBCI to maximize the potential value of the services in a person-centered way**

**a**

**Clarify that functional need/frailty and cognitive need meet the definition of “chronic condition” for purposes of determining SSBCI eligibility and waiving uniformity requirements**

**b**

**Broaden eligibility criteria for SSBCI to allow for additional flexibilities that may include health-related social needs and indicators of high healthcare utilization**

**2**

**Implement requirements and incentives for plans to report on utilization of SSBCI**

**3**

**Mandate and provide funding for the Department of Health and Human Services (HHS) to work with an evaluation partner to conduct a meaningful and realistic evaluation of non-medical benefits using a phased approach**

# 1

## Modify eligibility criteria for SSBCI to maximize the potential value of the services in a person-centered way

**Policy Questions:** *Who should be the target population for these benefits? Do the eligibility criteria limit the impact of these benefits?*

The goal of SSBCI eligibility criteria should be to maximize the potential value of the services in a person-centered way. Expanding the aperture of SSBCI eligibility criteria to include a more holistic view of health and function would aid plans in more meaningfully targeting these benefits. Below is a summary of two major opportunities for Congress to modify SSBCI eligibility criteria.

Person-centered care is care in which individuals' values and preferences guide all aspects of their healthcare and support their realistic health and life goals.

Source: [The American Geriatrics Society Expert Panel on Person-Centered Care](#)

# a

## Clarify that functional need/frailty and cognitive need meet the definition of “chronic condition” for purposes of determining SSBCI eligibility and waiving uniformity requirements



### Beneficiary Example:

### Meilin

Meilin is 91 years old. She does not have any clinically diagnosed chronic conditions. She has mild mobility and visual impairments, and needs assistance with preparing meals and transportation. She relies on her daughter as her primary caregiver, but her daughter is strained by her full-time work and caregiving responsibilities.

Meilin would benefit greatly from services such as meals and transportation, though it is not clear to Meilin's MA plan whether she qualifies for SSBCI under the current eligibility criteria.<sup>3</sup>

<sup>3</sup> This example uses fictional names and situations to illustrate how a beneficiary might be affected by the policy challenge discussed in this section. It does not reflect any protected health information. The same applies to other beneficiary examples throughout this report.

With respect to SSBCI, the *CHRONIC Care Act* defined a chronically ill Medicare beneficiary as someone who:

- 1 Has one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit overall health or function;
- 2 Has a high risk of hospitalization or other adverse health outcomes; and
- 3 Requires intensive care coordination.<sup>viii</sup>

While Congress did not define any of these criteria in statute, there is an opportunity for Congress to specify that functional need/frailty and cognitive need are included in the first “chronic condition” criterion. From their inception, SSBCI were intended to improve or maintain Medicare beneficiaries’ health or overall function. Explicitly codifying that the “chronic condition” criterion for SSBCI eligibility includes functional need/frailty and cognitive need will provide CMS and plans with clearer direction around Congress’ target population for these benefits.

In the absence of an explicit definition from Congress, CMS initially defined “chronic condition” for purposes of SSBCI eligibility to be consistent with existing CMS policy toward eligibility for Chronic Condition Special Needs Plan (C-SNP) enrollment, which included a set list of 15 qualifying conditions.<sup>xii, xiii</sup> However, in subsequent guidance effective PY 2021, CMS introduced broad flexibility for plans to identify conditions outside of the initial list, acknowledging CMS’ intent to allow plans the flexibility to address conditions and needs within their unique plan populations.<sup>xiv</sup> In the same guidance document, CMS also noted that two of the existing eligibility criteria “refer to the function of the enrollee, so [CMS believes] it is sufficiently clear that this is something that can be considered when determining if an enrollee is a chronically ill enrollee.”<sup>xiv</sup> However, neither the *CHRONIC Care Act* nor CMS guidance clearly specifies that functional need/frailty and cognitive need are included in the definition of “chronic conditions” for purposes of SSBCI eligibility determination.

In considering opportunities to improve eligibility criteria for SSBCI, Congress should ascertain which sub-population or issue is most inadequately captured by the current eligibility criteria, based on the population the *CHRONIC Care Act* was meant to cover. It is our assessment that functional need/frailty and cognitive need represents the largest opportunity for improving care for Medicare beneficiaries, especially with the growing aging population with longer life expectancies. Based on an ATI analysis of Medicare survey and claims data, Medicare

## KEY TERMS

A ***functional need or limitation*** is broadly defined as a condition or status that interferes with one or more basic life activities, such as bathing, eating, or dressing. Ability to perform activities of daily living (ADLs) are used as an indicator of an individual’s functional status.

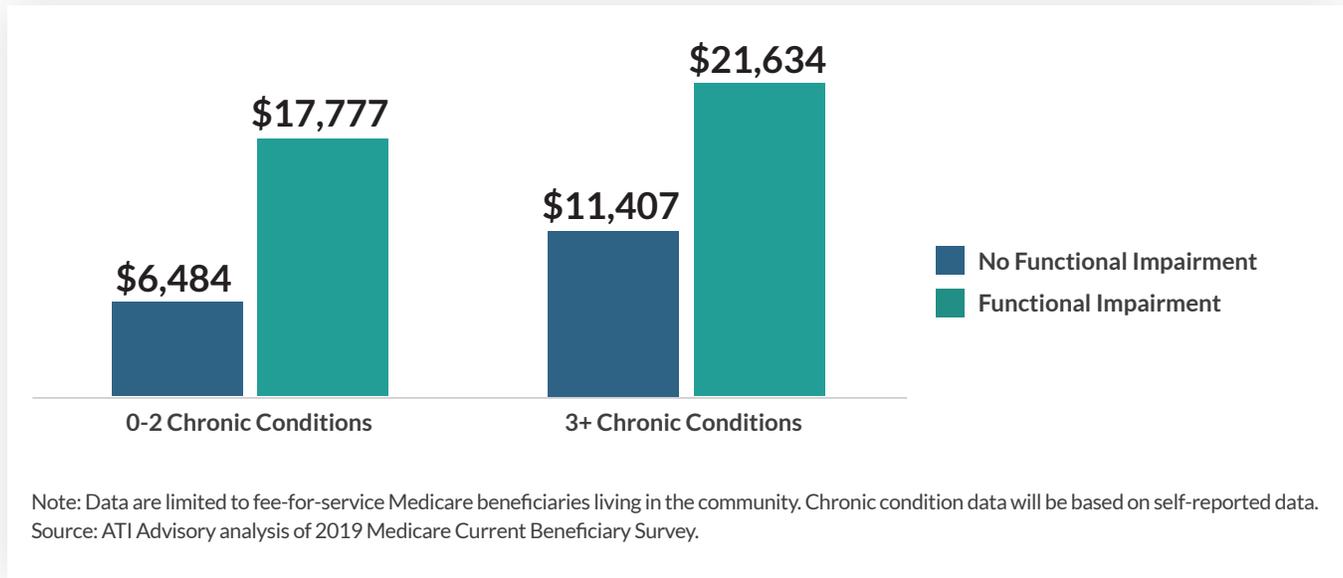
***Frailty*** is defined as a “state of age-related physiologic vulnerability resulting from impaired reserve and a reduced capacity to respond effectively to stressors. Signs of frailty frequently are cited as components of the syndrome; these include decreased muscle mass, balance and gait abnormalities, deconditioning, and decreased bone mass.” (Fried, L.P. and Walston, J. “*Frailty and Failure to Thrive.*” 1999.)

A ***cognitive need or limitation*** is broadly defined as a condition or status that interferes with one or more types of mental tasks, such as understanding or processing information, solving problems, or responding to stimuli. Examples include intellectual and developmental disabilities, mild cognitive impairment, brain injury, Alzheimer’s Disease and other dementias, severe mental illness, etc.

Sources: [National Committee on Vital and Health Statistics \(NCVHS\)](#); [Centers for Medicare and Medicaid Services \(CMS\)](#); [Coleman Institute for Cognitive Disabilities](#)

beneficiaries with multiple chronic conditions (i.e., limited to clinical diagnoses) and functional impairment are more than twice as expensive to Medicare than individuals who have multiple chronic conditions but no functional impairment (**Figure 2**).<sup>xv</sup> Specifying that the definition of chronic condition includes those with functional need/frailty and cognitive need would capture those Medicare beneficiaries with high functional needs and would therefore maximize the potential of these benefits to impact spending for the highest-cost Medicare beneficiaries.

Figure 2. Per Capita Medicare Spending, 2019



Moreover, Congress has previously specified that “chronically ill” individuals include those with functional and cognitive needs. The *Health Insurance Portability and Accountability Act (HIPAA) of 1996* defines a chronically ill individual as any individual who has been certified by a licensed healthcare practitioner as one of the following:

- 1 Being **unable to perform (without substantial assistance from another individual) at least 2 activities of daily living** for a period of at least 90 days due to loss of functional capacity;
- 2 Having a **level of disability** similar (as determined under regulations prescribed by the Secretary) to the level of disability described in clause 1; or
- 3 Requiring substantial supervision to protect such individual from threats to health and safety due to **severe cognitive impairment**.<sup>xvi</sup>

Additionally, 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.”<sup>xvii</sup> Most recently, in the Calendar Year (CY) 2023 Requests for Applications for VBID, CMMI specifies that frailty indicators (e.g., Claims-Based Frailty Index) can be used to identify enrollees with a chronic health condition.<sup>xviii</sup>

Using these definitions of chronic condition for purposes of SSBCI eligibility would broaden the population of high-risk Medicare beneficiaries who can benefit from SSBCI and enable a more person-centered approach in targeted SSBCI.

**Considerations:** Using functional and cognitive need as targeting criteria for SSBCI may be challenging for MA plans to operationalize due to lack of standardized data on functional need for Medicare beneficiaries. Currently, Health Risk Assessments (HRAs) may capture functional data but there are no consistent standards for how these are captured across plans. Additionally, only Special Needs Plans (SNPs) are required to conduct an HRA. In its [Updated Policy Roadmap on Caring for Those with Complex Needs](#) (March 2022), the Bipartisan Policy Center recommends that Congress “direct the HHS Secretary to develop a uniform functional assessment tool”, which would help to facilitate the collection of standardized data on functional need.

**b**

## **Broaden eligibility criteria for SSBCI to allow for additional flexibilities that may include health-related social needs and indicators of high healthcare utilization**

More expansive and flexible eligibility criteria will allow plans to better target benefits to individual need to provide more holistic, person-centered care. Two options for broadening the existing eligibility criteria for SSBCI are described below.

### **1 Health-Related Social Needs**

Recognizing the important role that HRSNs—such as food insecurity, housing instability, and lack of transportation—play in whole person health, SSBCI would also benefit individuals with HRSN in the absence of a chronic condition. Current eligibility criteria prohibit social determinants of health (SDOH) from being used as a primary targeting criterion for SSBCI.<sup>xii</sup> On the other hand, under VBID, plans can test different eligibility criteria such as Medicare Part D low-income subsidy (LIS) status or dual-eligibility status for specific supplemental benefits.<sup>xviii</sup>

The *Addressing Social Determinants in Medicare Advantage Act of 2021* was introduced in Congress in June 2021 to add eligibility categories to the existing criteria for SSBCI.<sup>xix</sup> This bill proposes striking the “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. Defining the eligibility criteria in this way would, again, broaden the population of high-risk Medicare beneficiaries who can benefit from SSBCI and enable a more person-centered approach.

#### **Considerations:**

- ▶ **HRSNs are broad and far-ranging.** This makes it difficult to define which HRSNs should qualify and how to measure severity of need for purposes of determining a threshold and standardizing eligibility across plans. Stakeholders may disagree on which HRSNs should be addressed using public dollars dedicated for healthcare and whether risk is enough basis for eligibility or whether the need must be present and documented.
- ▶ **Plans currently do not capture HRSN data consistently for all MA members.** Some plans are currently collecting these data for their members, but this is not currently required. Without baseline data on a

member's HRSNs, plans are unable to determine eligibility consistently and to provide denominators for the population eligible for the benefits. However, some plans have access to predictive modeling based on the information they do have (e.g., zip code) that they can use to estimate probability of social risk until they can conduct a direct member screen.

- ▶ **CMS is actively working to develop requirements and standardized tools to facilitate collection of HRSN data.** The recent [CY 2023 Medicare Advantage and Part D \(MAPD\) Final Rule](#) includes a requirement for SNPs to include in their HRA at least one question on each of the three topics of housing stability, food security, and access to transportation. While only limited to SNPs, this standard data collection requirement can serve as a starting point to enable targeting of SSBCI by HRSNs. Work is underway at CMS to develop standardized survey questions for collecting HRSN information, including through the CMMI [Accountable Health Communities Model](#). Furthermore, in the recent [CY 2023 Advance Notice](#), CMS solicited feedback on opportunities to advance health equity, including incorporation of factors related to health equity and social determinants of health into risk adjustment models for MA.
- ▶ **Some potential approaches for identifying these populations with HRSNs that may be easier to operationalize include expanding eligibility criteria to include Part D low-income subsidy (LIS) status and dual-eligibility status.** As previously mentioned, VBID allows plans to target benefits using LIS status and dual-eligibility status; Congress could consider expanding SSBCI criteria to include these as well. This would allow plans to leverage existing structures for determining need based on income as a proxy for other HRSNs. In particular, there is an opportunity to target partial duals and pre-duals who are near the income threshold for qualifying for Medicaid benefits but do not yet receive services and try to prevent spillover into Medicaid eligibility.

## 2 Indicators of High Healthcare Utilization

Another opportunity to expand SSBCI eligibility criteria is to use high utilization markers as a proxy for medical complexity in the absence of a chronic condition diagnosis. Allowing plans to target SSBCI to individuals with high rates of hospitalization, emergency services use, and/or institutionalization would likely capture a broader population of high-need and high-cost individuals who would benefit from SSBCI compared to diagnosis-based eligibility alone, thereby maximizing intervention potential of SSBCI. This would expand upon the existing SSBCI eligibility criterion that requires a beneficiary to have a “high risk of hospitalization or other adverse health outcomes” by allowing plans to target using this criterion even where a chronic condition diagnosis is not present.

**Considerations:** This eligibility change may increase confusion among beneficiaries regarding their eligibility for benefits since their healthcare utilization may vary year-to-year. The implementation of said criteria should be designed to minimize variation in eligibility year over year.

## 2

### Implement requirements and incentives for plans to report on utilization of SSBCI

**Policy Questions:** *Do all beneficiaries who are eligible for SSBCI have access to them? Are benefits being offered and delivered to beneficiaries consistently and equitably?*

As SSBCI offerings grow, it is important for Congress to facilitate the collection of benefit utilization data from plans in order for policymakers to track progress of implementation and evolve regulations accordingly. Utilization data are necessary to evaluate the impact of these new supplemental benefits over time, including who is accessing these benefits and how often. Since the new authority to offer SSBCI was introduced, we only have a line of sight into plan offerings, but no quantitative data to demonstrate whether the benefits are actually being delivered to Medicare beneficiaries. Without information on beneficiary uptake of these SSBCI, it is not possible to assess—even on the most basic level—whether these benefits are having the intended impacts on beneficiaries. Additionally, lack of data impedes assessment of whether benefits are being delivered equitably to individuals of diverse backgrounds (e.g., gender, race, ethnicity, language, geography, disability).



#### Beneficiary Example: **Eduardo**

Eduardo is 65 years old. He has Parkinson’s disease and has recently experienced several bad falls resulting in hospitalizations and institutionalizations. His mobility will continue to decline; however, SSBCI may be used to help maintain his function, even if for a short period of time.

To ensure equitable access, it is important to recognize the prevalence of a disability in the receipt of these benefits and that individuals with severe disabilities can still access the services they are entitled to despite the limited impact the service may have to improve their condition.

Note: This example uses fictional names and situations.

In the CY 2023 MAPD Final Rule, CMS is requiring MA plans to report expenditure data by supplemental benefit category for Medical Loss Ratio (MLR) reporting.<sup>xx</sup> The specific list of supplemental benefit categories for which MA plans will be required to report expenditures separately is yet to be finalized in a revised package, which will be updated annually and made available for public comment. Notably, CMS clearly signaled its intent to include “Non-Primarily Health-Related SSBCI” as one of the supplemental benefit categories that require expenditure reporting. This will help CMS assess the impact of its policy change that allowed these services to be included in the MLR numerator as of 2021. In future years, CMS may consider adding individual SSBCI to the list of supplemental benefit categories for which expenditure reporting is required.<sup>xxi</sup> This new reporting requirement will allow for increased line of sight into how much plans are spending on SSBCI; however, the reporting will not provide information on who is receiving these benefits, which benefits, and at what frequency.

Given the current void in SSBCI utilization data reporting, Congress should direct CMS to develop a mechanism for appropriate reporting of supplemental benefit utilization at the beneficiary-level. Beneficiary-level data will allow CMS and researchers to connect these data on SSBCI utilization to members’ demographic data and encounter data for other healthcare services. There are two existing reporting mechanisms for MAOs to submit data on supplemental benefit utilization; however, neither mechanism is required for SSBCI currently. The existing reporting mechanisms are outlined in the table below:

Mechanism	Description	Considerations
<b>Encounter Data Reporting</b> <sup>xxii,xxiii</sup>	<p>CMS began collecting encounter data from MA plans in 2012. CMS defines encounter data as “data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner.” However, since MA plans are not required to submit encounter data for any supplemental benefits, including dental, vision, and hearing, encounter reporting on these benefits is minimal.</p> <p>Encounter data reports include: beneficiary ID, claim type, organization provider number, dates of service, claim processing date, claim control number, diagnosis and procedure codes.</p>	<ul style="list-style-type: none"> <li><span style="color: green;">+</span> All MA plans are already reporting encounter data for other items and services outside of supplemental benefits. This option aligns with the Medicare Payment Advisory Commission (MedPAC)’s recommendation to ensure the completeness and accuracy of encounter data.<sup>xxiv</sup></li> <li><span style="color: red;">-</span> Further work may be needed to establish standardized encounter reporting mechanisms for these new benefits (e.g., diagnosis and procedure codes for SSBCI and related needs). In addition, non-traditional providers, especially smaller providers and community-based organizations, may lack capacity and systems to generate encounter data records at this time.</li> </ul>
<b>CMMI Value-Based Insurance Design (VBID) Demonstration Reporting</b> <sup>xviii</sup>	<p>MAOs participating in VBID are required to submit to CMMI quarterly reports with beneficiary-level data on whether an enrollee has been targeted (or is eligible to receive) and whether they received the VBID Flexibility being offered (e.g., reduced cost-sharing, additional supplemental benefits, etc.). Data are reported at the benefit-level or combination package where applicable (e.g., flexible benefit package). None of these data are publicly reported but an evaluation is currently underway and will be publicly released.</p>	<ul style="list-style-type: none"> <li><span style="color: green;">+</span> MAOs participating in VBID are already collecting these data on supplemental benefit utilization. This approach is less granular and more flexible than encounter data reporting (i.e., does not involve providers to generate a standard encounter data report).</li> <li><span style="color: red;">-</span> CMMI is not currently collecting data on utilization of supplemental benefits, but will begin to collect them for benefits related to their promising focus areas for health equity, beginning with food and nutrition, transportation, and housing.<sup>xxv</sup></li> </ul>

Any reporting requirements should be applied consistently across all supplemental benefits to avoid differential treatment of SSBCI that may cause plans to stop offering these optional benefits. There also should be a clear process and stakeholder input for developing the reporting mechanisms and infrastructure (e.g., developing thoughtful standardized reporting elements). Policymakers should continue to monitor the utility of the data being reported through the existing mechanisms and identify any challenges plans and providers would face in applying a similar reporting framework to SSBCI, including through input from stakeholders.

Furthermore, any changes to reporting requirements should be incremental and coupled with guardrails and incentives to promote plan buy-in. Overall, in addition to not revealing beneficiary-identifiable data, it is critical that any publicly reported data not inadvertently reveal competitive information regarding MA plan benefit design or details about provider contracts and rates. MA plans may be more willing to share data provided appropriate guardrails are put in place and policymakers are clear on how the data will be used and shared.

Reporting burden should not be so great that it deters the provision of SSBCI, and should not be greater than information required for other benefits.

We have identified several potential approaches to increase reporting of data on SSBCI utilization:

- **Impose mandatory reporting** – Congress could require plans to report data as a condition of offering supplemental benefits. Importantly, if implemented, this requirement must be standardized across all supplemental benefits.
- **Provide payment incentives in initial years** – Congress could also consider an incremental approach to data reporting requirements. For instance, Congress could offer incentives such as pay-for-reporting in the initial years, similar to the reporting bonuses in the Merit-Based Incentive Payment System (MIPS) under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).<sup>xxvi</sup> New reporting requirements will require plans to invest additional resources into staffing and/or system changes. Providing a pay-for-reporting bonus can help to mitigate increased costs and burden in the first several years. If reporting requirements are too burdensome or imposed too quickly without additional payment incentives, it may negatively impact the number of plans offering SSBCI.
- **Create a learning collaborative** – Congress could mandate that CMS create a learning collaborative to collect and aggregate SSBCI data from MA plans. No individual MA plan's data would be published, but plans would receive a regular report benchmarking their individual plan's data against the aggregated data of all participating companies. In addition to promoting continuous learning and improvement for plans, this approach would outsource the analysis of data to a central entity rather than requiring plans to develop internal systems for reporting and analysis, but its success would depend on the number of plans participating.

### Considerations:

- ▶ **Reporting utilization data should also be coupled with an understanding of the various factors outside of an MA plan's control that may impact utilization.** For example, there may be low uptake of some SSBCI in early years due to challenges associated with early implementation and the COVID-19 pandemic.
- ▶ **Plans face challenges with collecting demographic data, which would impede their ability to disaggregate utilization data by demographic group.** While some plans collect demographic data like age, zip code, and LIS eligibility right now, race and ethnicity data are not collected consistently.\* Researchers may be able to overcome some of these challenges by linking encounter data to the Medicare Beneficiary Summary File.
- ▶ **Policymakers should also balance the risk that adding reporting requirements may deter plans from offering these benefits altogether.**

\*The lack of comprehensive data on race and ethnicity is a major focus of CMS broadly as the agency seeks to measure and address health disparities. In January 2022, CMS announced an [opportunity](#) for the public to comment on CMS' intention to pilot the collection of race and ethnicity data on Part C and D enrollment forms. CMS appears to be moving forward with this initiative.

### 3

## Mandate and provide funding for the Department of Health and Human Services (HHS) to work with an evaluation partner to conduct a meaningful and realistic evaluation of non-medical benefits using a phased approach

**Policy Questions:** *Are SSBCI meeting their intended goals? How can this be meaningfully and realistically be evaluated in the near-term? What data are needed to support this evaluation?*

Now that SSBCI have been available to beneficiaries for several years, Congress has a critical opportunity to mandate and fund an evaluation of the impact of these benefits. Given that SSBCI represent a significant change in Medicare policy, a robust evaluation is needed to assess the impact of this new authority on beneficiaries and the healthcare system and to support Congress, CMS, and stakeholders' decisions on how to improve the future delivery of these benefits. Congress initially charged GAO with evaluating SSBCI, as described in the Background section, but without publicly available data on SSBCI utilization rates, the beneficiaries receiving SSBCI, and healthcare utilization data for SSBCI recipients, it is unrealistic to conduct the requested evaluation.

However, even if all the data on SSBCI and other healthcare utilization were publicly available, it would be extremely difficult to isolate an individual benefit's impact on a beneficiary's Medicare spending. It is challenging to establish causation with these limited, upstream benefits, especially when a benefit is used along with a broad suite of other interventions and confounding variables.

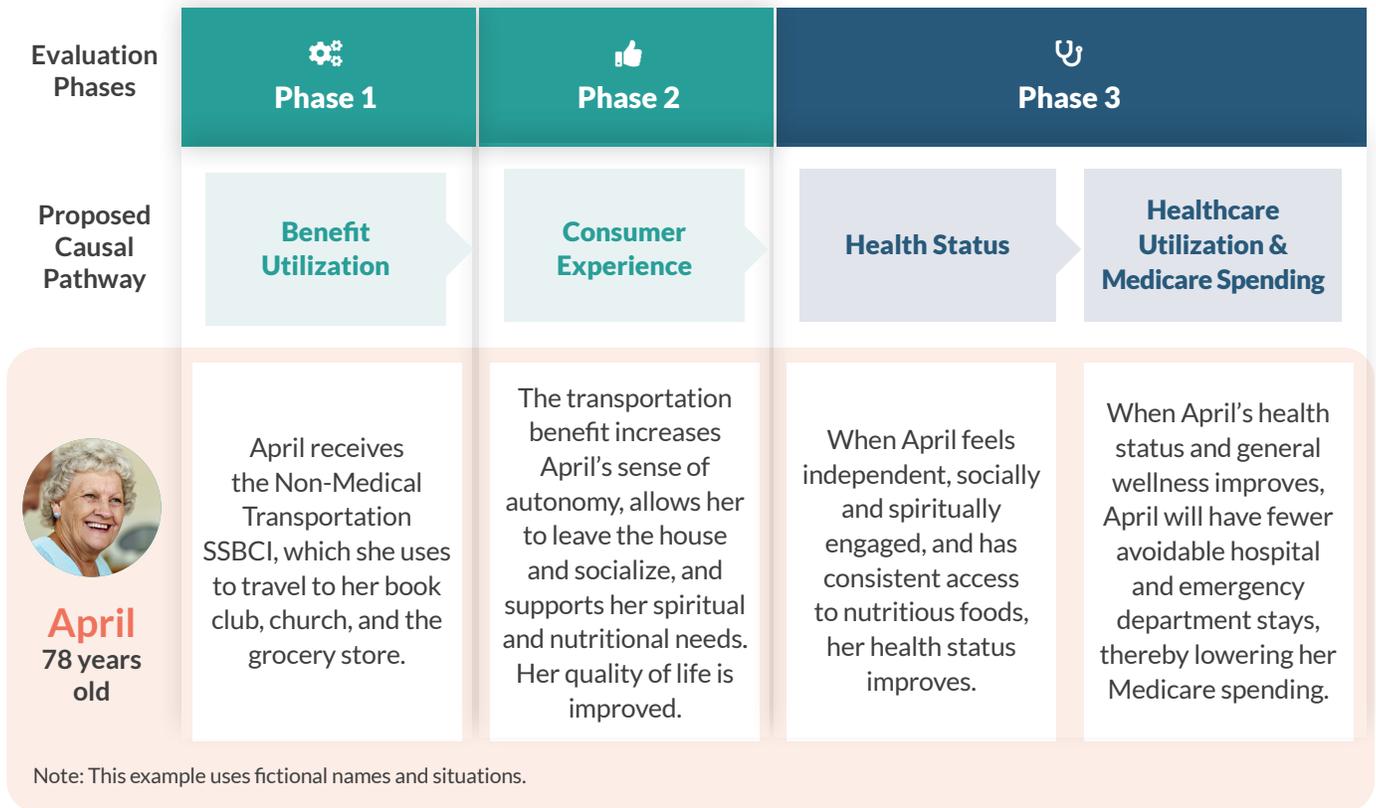
While impact on healthcare utilization may be hard to demonstrate, this should not lead Congress to conclude a lack of value associated with SSBCI. An evaluation focused on who is utilizing these benefits and their impact on the consumer experience would be a more pragmatic approach to assessing the value of these benefits in the near-term, and as a potential pathway to a future evaluation of the benefits' impacts on avoidable utilization and health outcomes.

We recommend that Congress mandate and fund HHS (and its evaluation partner(s)) to take a phased approach to evaluating these benefits for several reasons:

- 1 It will take time to develop the reporting infrastructure to support more robust outcomes reporting and evaluation.
- 2 It will take time to see the impacts – consumer experience measures may lie on the causal pathway towards lower utilization – and could be viewed as outcomes in and of themselves (**Figure 3**).

For example, while it is reasonable to assume Pest Control would have a positive impact on one's health, it may be difficult to prove a direct association with reduced healthcare utilization.

Figure 3. Proposed Causal Pathway and Corresponding Evaluation Phases



We recommend focusing the initial phases of an evaluation on the variables highlighted in green.

We describe, at a high-level, what a phased approach to evaluation may entail below.

**Phase 1: Benefit Utilization**

Given the lack of transparency into uptake of these benefits at present, the first logical step is to assess how these benefits are being delivered to and experienced by beneficiaries. We first need to understand how many people are receiving these benefits, who they are, which benefits, and at what frequency.

**Phase 2: Consumer Experience**

Once evaluators have a sense of uptake of these benefits, they could examine how consumers experience the benefits as they have great potential to improve their quality of life. There are many possible mediating variables lying on the causal pathway between benefit utilization and impacts on health status and total healthcare utilization. For instance, in the beneficiary example highlighted in the graphic above, Transportation for Non-Medical Needs may lead to many outcomes that are valuable and worthy of measuring, including a greater sense of autonomy, decreased social isolation, and other needs being met including spiritual and nutritional needs.

## Phase 3: Health Status, Healthcare Utilization, and Medicare Spending

The final phase of the evaluation should culminate in measuring health status, overall healthcare utilization (including avoidable emergency department use and hospital and institutional stays), and Medicare spending for Medicare beneficiaries who use SSBCI and a similar group of beneficiaries who do not. A centralized evaluator that can aggregate data across plans can link claims or encounter data from plans with the Medicare beneficiary enrollment file and conduct regression analyses to evaluate the healthcare spending and utilization of beneficiaries who accessed SSBCI compared to a comparison group that is similar in demographic and clinical characteristics but did not receive SSBCI.

It is important to underscore that these benefits were not designed as a test of specific interventions with a control group—by definition, benefits are available to all beneficiaries who qualify—and so the ability to assess direct causality will be limited. There would be value in designing a test specifically to evaluate the impact of the most promising SSBCI (e.g., a randomized controlled trial of providing a specific benefit to a specific sub-population of Medicare beneficiaries to assess any effect on healthcare utilization and health outcomes).

## Conclusion

Over the past three years since MA plans were first allowed to offer these benefits, the number of MA plans offering SSBCI has grown substantially. To support the continued growth and impact of SSBCI, there are several, clear next steps Congress can take to build upon this promising framework. This report outlines three key legislative recommendations for maximizing the potential value and reach of SSBCI for Medicare beneficiaries that can benefit from them, as well as for measuring the utilization of SSBCI and any associated impacts. Three years into the implementation of these benefits, it is now a critical juncture for Congress to develop the necessary supports for SSBCI to prove their value and meet their full potential to improve the lives of the Medicare beneficiaries that stand to benefit from them.

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

### For More Information

With support from The SCAN Foundation, ATI Advisory and LTQA have released a number of reports and resources on new, non-medical benefits in Medicare Advantage, including implementation reports, policy recommendations and briefs, data briefs, rule summaries, and blogs. This work, and more, are all available on the [Advancing Non-Medical Supplemental Benefits in Medicare Advantage landing page](#).

## Endnotes

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- iii Better Medicare Alliance. “Data Brief: Medicare Advantage Outperforms Fee-For-Service Medicare on Cost Protections for Low-Income and Diverse Populations.” (April 2022). <https://atiadvisory.com/wp-content/uploads/2022/05/BMA-Medicare-Advantage-Cost-Protections-Data-Brief.pdf>.
- iv MA plans finance supplemental benefits (i.e., services not covered by FFS Medicare), including SSBCI, through rebate dollars. These rebate dollars are available when an MA plan bids below the benchmark from traditional FFS spending in the same geographical area. CMS shares a portion of the difference with the plans, and plans can then use rebate funds to fund supplemental benefits and reductions in cost-sharing and premiums.
- v Health-related social needs (HRSN) are acute individual- or family-level social and economic challenges that impede one’s health, well-being, and safety. Examples include housing instability, food insecurity, and exposure to interpersonal violence. Social determinants of health (SDOH) are “the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life”, according to the World Health Organization. Examples of SDOH include structural factors such as local housing policies and the availability of affordable housing, number of grocery and food options in the area, and availability of quality education.  
  
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- viii U.S. Congress. Bipartisan Budget Act of 2018. <https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>.
- ix In 2015, the Senate Finance Committee launched a bipartisan effort to “improve care delivery for Medicare beneficiaries battling chronic illnesses without adding to the deficit”. The committee’s Chronic Care Working Group developed a set of policy options that eventually resulted in the CHRONIC Care Act showed “great promise to improve care transitions, produce better patient health outcomes, and increase efficiency”. During the Senate Finance Committee hearing in May 2015, a key goal was to construct a model that would allow plans and providers the flexibility to be patient-centric, meeting patients where they are and organize around a group of chronically ill beneficiaries. U.S. Senate Committee on Finance. “Bipartisan Chronic Care Working Group Policy Options Paper.” (December 2015). <https://www.finance.senate.gov/imo/media/doc/CCWG%20Policy%20Options%20Paper1.pdf>.  
  
U.S. Senate Committee on Finance Hearing Summary. “A Pathway to Improving Care for Medicare Patients with Chronic Conditions.” (May 2015). <https://www.finance.senate.gov/imo/media/doc/99934.pdf>.
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- xx The Centers for Medicare and Medicaid Services 2023 Final Rule. (May 2022). <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>.
- xxi In the CY 2023 MAPD Final Rule, CMS clarified that the list of supplemental benefit categories in the proposed rule should be viewed as an example of categories of interest to CMS, but that more specific data requirements would be published in a revised package and made available for public comment. CMS emphasized the importance of maintaining flexibility to modify the scope of data fields and the list of required supplemental benefit reporting categories. CMS outlined four standards it will use to determine supplemental benefit data reporting requirements:
1. Data elements and categories should enable a thorough reporting of data elements in categories that support MLR calculation, reduce errors in reporting, and increase our ability to verify data reporting accuracy.
  2. Data elements and categories for supplemental benefits should be selected to **provide transparency into how MA program payments are allocated and may focus on specific benefits, such as the non-primarily health related supplemental benefits offered to the SSBCI population**, for the purposes of providing CMS with information on the impact of a specific benefit change.
  3. CMS will consider the **percentage of MA plans that offer each type of supplemental benefit** in the most recent year for which PBP data are available.
  4. CMS will balance the trade-offs between the additional information gained and the additional reporting burden placed on MA organizations and Part D sponsors.
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## ABOUT ATI ADVISORY

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](http://atiadvisory.com).



## ABOUT LTQA

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 [ltqa.org](http://ltqa.org).



## ACKNOWLEDGEMENT

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 [thescanfoundation.org](http://thescanfoundation.org).

## ACKNOWLEDGMENTS

We would like to thank the many organizations and individuals that, in the spirit of collaborating for improvement, shared their experiences and insights with us. The policy recommendations outlined in this brief are those of LTQA and ATI Advisory only.