DATA INSIGHT

Growth in New, Non-Medical Benefits Since Implementation of the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act*

April 2022

In recent years, Medicare Advantage (MA) plans have gained unprecedented flexibility to offer a wide range of new supplemental benefits and to target these benefits to members with specific conditions and individual need. This data insight provides an analysis of non-medical supplemental benefit growth since 2020. We focus on two main authorities in this data brief:

- Special Supplemental Benefits for the Chronically Ill (SSBCI), which first became available in 2020 through the passage of the *CHRONIC Care Act* and
- A set of five Expanded Primarily Health-Related Benefits (EPHRB), which first became available in 2019 after the Centers for Medicare and Medicaid Services (CMS) expanded the definition of what could be considered "primarily health-related."

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We have selected this grouping of benefits as they address Medicare beneficiaries' broader social needs (e.g., food insecurity, social isolation, and long-term services and supports, or LTSS, needs). This data insight also explores additional authorities available for plans to target these benefits to certain high-need populations, and provides the most complete view of the availability of these benefits in MA.

Since 2020, there has been a dramatic increase in the number of plans offering these benefits, the number of beneficiaries enrolled in plans offering these benefits, and the availability of these benefits geographically. For Plan Year (PY) 2022, one in every four MA plans offers SSBCI, while one in every three plans offers SSBCI and/or EPHRB. Presently, 98 percent of MA beneficiaries reside in a county with at least one plan offering these new benefits, through any authority. Most commonly, we find that benefits designed to meet beneficiaries' nutritional needs and needs in the home, including help with activities like cleaning, meal preparation, and ambulating, are the most popular of the newer supplemental benefits. While these benefits are available more broadly in PY 2022, they are, by no means, ubiquitous. Continued study and evaluation of the availability and, most critically, utilization of these benefits is necessary in the future.

Non-Medical Supplemental Benefits Continue to Grow

The introduction of two key authorities, SSBCI and EPHRB, marked a noteworthy turning point in Medicare policy as these flexibilities allowed MA plans to provide new services, including, for the first time, services addressing social determinants of health needs through SSBCI. These types of newer, non-medical services allow MA plans to better advance wellbeing outside of traditional medical care to deliver whole-person care. Despite early challenges, the availability of non-medical benefits has risen extensively for the past three years, with several benefits emerging as popular offerings in PY 2022 *(see Table 1)*.

Additional Background

For more background on the authorities detailed in this data brief, including eligibility criteria and uniformity requirements, see our prior work on supplemental benefit authorities, including:

- Special Supplemental Benefits for the Chronically Ill (SSBCI)
- Expanded Primarily Health-Related Benefits (EPHRB)
- Uniformity Flexibility (UF)
- Value-Based Insurance Design (VBID) demonstration

Please note that the total enrollment values available in this data brief display the number of MA beneficiaries enrolled in a plan offering these benefit(s); not all beneficiaries may be eligible for the benefit, depending on the authority utilized. All analyses displayed in this data brief exclude the following plan types: Employer Group Health Plans (EGHPs), Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE plans.

Table 1: Growth in Number of MA Plans Offering Newer, Non-Medical Benefits, PY 2020 - 2022

	2020	2021	2022
Benefit	Number of Plans Offering Benefit(s) (Percentage of Total Plans in 2020)	Number of Plans Offering Benefit(s) (Percentage of Total Plans in 2021)	Number of Plans Offering Benefit(s) (Percentage of Total Plans in 2022)
Non-Primarily Health-Related Benefits through Special Supplemental Benefits for the Chronically Ill (SSBCI)			
Food and Produce	101 (2%)	345 (7%)	763 (14%)
Meals (beyond limited basis)	71 (2%)	371 (8%)	403 (7%)
Pest Control	118 (3%)	208 (4%)	326 (6%)
Transportation for Non-Medical Needs	88 (2%)	177 (4%)	375 (7%)
Indoor Air Quality Equipment & Services	52 (1%)	140 (3%)	166 (3%)
Social Needs Benefit	34 (1%)	211 (4%)	244 (5%)
Complementary Therapies	1 (<1%)	0 (0%)	123 (2%)
Services Supporting Self-Direction	20 (<1%)	96 (2%)	151 (3%)
Structural Home Modifications	44 (1%)	42 (1%)	57 (1%)
General Supports for Living	67 (2%)	150 (3%)	328 (6%)
"Other Non-Primarily Health-Related" Benefit	51 (1%)	191 (4%)	359 (7%)
TOTAL offering any Non-Primarily Health-Related SSBCI	245 (6%)	812 (17%)	1,126 (21%)
Offer only Primarily Health-Related SSBCI	22 (1%)	111 (2%)	166 (3%)
Offer any Primarily Health-Related SSBCI	94 (2%)	268 (5%)	492 (9%)
TOTAL SSBCI	267 (6%)	923 (19%)	1,292 (24%)
Expanded Primarily Health-Related Benefits (EPHRB)			
Therapeutic Massage	221 (5%)	170 (3%)	183 (3%)
Adult Day Health Services	84 (2%)	127 (3%)	50 (1%)
Home-Based Palliative Care	61 (1%)	134 (3%)	147 (3%)
In-Home Support Services	223 (5%)	429 (9%)	729 (14%)
Support for Caregivers of Enrollees	125 (3%)	95 (2%)	160 (3%)
TOTAL EPHRB	490 (11%)	731 (15%)	1,034 (19%)
Offer Any Benefit Listed Above			
TOTAL	626 (14%)	1,326 (27%)	1,851 (34%)

In 2020, only 6 percent of plans offered SSBCI; by 2022, nearly a quarter of MA plans nationwide now offer SSBCI. The number and percentage of plans offering EPHRB has grown steadily; the percentage of plans offering EPHRB has increased 4 percentage points each year. For 2022, these benefits, encompassing both SSBCI and EPHRB, can be found in 34 percent of all MA plans. Individual supplemental benefits have experienced strong growth, especially benefits addressing needs and care in the home.

Enrollment in plans offering Food and Produce and In-Home Support Services is the highest at **14%**

Benefits designed to help meet beneficiaries' nutritional needs, including Food and Produce and Meals (beyond limited basis), are the most popular SSBCI offerings. Food and Produce, the most popular SSBCI in 2022, has seen exponential growth since 2020 and is available in 14 percent of all MA plans. In addition to nutritional benefits, benefits assisting individuals in their home, including In-Home Support Services and the Social Needs Benefit, have risen in 2022. In-Home Support Services, in particular, far exceed other EPHRB and are available in 14 percent of all MA plans in 2022. General Supports for Living, which provide supports for housing and utilities, also grew markedly from 2021 to 2022, doubling from 150 plans to 328 plans.

A greater proportion of plans (7 percent in 2022, up from 1 percent in 2020) are offering "Other Non-Primarily Health-Related" SSBCI, outside of the ten example benefits CMS listed in their initial guidance to plans. In addition to these ten example benefits, plans may choose to offer additional benefits they believe meet the criteria for SSBCI, which must be approved by CMS. For 2022, these "Other Non-Primarily Health-Related" SSBCI include services such as Grocery and Prescription Delivery, Barber/Beauty Shop Visits, and Pet Services. These "Other Non-Primarily Health-Related" SSBCI benefits demonstrate plans' willingness to test these new authorities. We expect to see SSBCI continue to expand into PY 2023 as plans become savvier with the design and implementation of these benefits.

While most benefits have increased steadily since 2020, others have declined or stagnated. For example, the number of plans offering Adult Day Health Services decreased significantly from PY 2021 to PY 2022. This decline can likely be attributed to the decreased availability of Adult Day Health Services during the COVID-19 pandemic. In turn, other non-medical benefits, including Indoor Air Quality Services, Home Modifications, and many EPHRB, have been available across a similar percentage of MA plans over time.

In addition to a greater number of plans offering these benefits, enrollment in plans offering newer, non-medical benefits has increased similarly (*see Table 2*). Overall, the percentage of MA beneficiaries enrolled in plans offering at least one of these benefits has grown from 16 percent in 2020 to 25 percent in 2021 to now 31 percent in 2022. Enrollment in plans offering Food and Produce and In-Home Support Services is the highest at 13% and 14% of overall MA enrollment, respectively. These benefits are also offered by the greatest number of plans. Overall, the percentage of MA beneficiaries enrolled in these plans is generally comparable to the percentage of total plans where the benefit is available, with some exceptions. For example, the percentage of plans offering Non-Primarily Health-Related SSBCI in 2022, 21 percent, includes enrollment for only 17 percent of the total MA population.

Table 2: Growth in Enrollment in MA Plans Offering Newer, Non-Medical Benefits, PY 2020 - 2022

Benefit	2020 MA Enrollment in Plans Offering Benefit(s) (Percentage of Total Enrollment in 2020)	2021 MA Enrollment in Plans Offering Benefit(s) (Percentage of Total Enrollment in 2021)	2022 MA Enrollment in Plans Offering Benefit(s) (Percentage of Total Enrollment in 2022)
Non-Primarily Health-Related Benefits through Special Supplemental Benefits for the Chronically Ill (SSBCI)			
Food and Produce	710 (4%)	1,920 (9%)	2,930 (13%)
Meals (beyond limited basis)	280 (1%)	1,520 (7%)	1,990 (8%)
Pest Control	650 (3%)	1,450 (7%)	1,810 (8%)
Transportation for Non-Medical Needs	370 (2%)	990 (5%)	1,910 (8%)
Indoor Air Quality Equipment & Services	250 (1%)	740 (3%)	890 (4%)
Social Needs Benefit	150 (1%)	900 (4%)	740 (3%)
Complementary Therapies	40 (<1%)	0 (0%)	710 (3%)
Services Supporting Self-Direction	120 (1%)	550 (3%)	800 (3%)
Structural Home Modifications	90 (<1%)	90 (<1%)	160 (1%)
General Supports for Living	290 (2%)	860 (4%)	1,540 (7%)
"Other Non-Primarily Health-Related" Benefit	460 (2%)	830 (4%)	1,790 (8%)
TOTAL offering any Non-Primarily Health-Related SSBCI	1,200 (6%)	3,200 (15%)	4,030 (17%)
Total offering only Primarily Health-Related SSBCI	170 (1%)	830 (4%)	890 (4%)
Total offering any Primarily Health-Related SSBCI	410 (2%)	1,620 (8%)	2,320 (10%)
TOTAL SSBCI	1,370 (7%)	4,030 (19%)	4,930 (21%)
Expanded Primarily Health-Related Benefits (EPHRB)			
Therapeutic Massage	860 (4%)	460 (2%)	640 (3%)
Adult Day Health Services	520 (3%)	660 (3%)	80 (<1%)
Home-Based Palliative Care	420 (2%)	610 (3%)	640 (3%)
In-Home Support Services	1,070 (6%)	1,790 (8%)	3,220 (14%)
Support for Caregivers of Enrollees	880 (5%)	560 (3%)	780 (3%)
TOTAL EPHRB	2,440 (13%)	2,930 (14%)	4,420 (19%)
Offering Any Benefit Listed Above			
TOTAL	3,030 (16%)	5,290 (25%)	7,230 (31%)

Note: Above numbers displayed in thousands. Enrollment rounded to nearest 10,000.

Enrollment in a plan offering benefit(s) does not mean that all plan beneficiaries may qualify for the benefit or access the benefit. Benefits may carry additional eligibility criteria and, thus, be available to only a subset of the total plan population.

Special Needs Plans

Special Needs Plans (SNPs), especially Chronic Condition Special Needs Plans (C-SNPs) and Dual Eligible Special Needs Plans (D-SNPs), offer SSBCI at higher rates than other MA plans (*see Table 3*). SNPS are targeted to beneficiaries with special and/or complex needs who may be especially well served by SSBCI, as these benefits are designed to help address the holistic healthcare needs of individuals with complex chronic conditions. C-SNPs, in particular, are most likely to offer SSBCI, at 53 percent, compared to non-SNP plans, which only offer SSBCI in 19 percent of their plans. D-SNPs also offer SSBCI at a high rate, available in 42 percent of all D-SNP plans. As enrollment in SNPs is limited to beneficiaries who meet certain eligibility requirements, average enrollment for SNPs is often lower than their non-SNP counterparts, which may help to explain lower enrollment compared to number of plans in some instances (*enrollment data not shown*).

Table 3: Special Needs Plans Offering Any SSBCI, PY 2022

	Number of Plans Offering SSBCI	Total Number of Plans, 2022	Percent of Total (Row)
Chronic Condition Special Needs Plans (C-SNPs)	149	283	53%
Dual Eligible Special Needs Plans (D-SNPs)	308	729	42%
Institutional Special Needs Plans (I-SNPs)	42	186	23%
Total Number of Special Needs Plans (SNPs)	499	1,198	42%
Total Number of Non-Special Needs Plans	793	4,189	19%
TOTAL	1,292	5,387	24%

Availability of Benefits

While geographic distribution of these benefits (including the five EPHRB and any SSBCI) is not uniform across the country, the vast majority of MA beneficiaries live in a county with at least one benefit available for PY 2022. 83 percent of counties included in this analysis have at least one plan that offers one of these newer, non-medical supplemental benefits. Although accounting for 83 percent of counties geographically, 96 percent of total Medicare beneficiaries reside in these counties and 98 percent of total MA beneficiaries reside in these counties. Thus, the remaining 17 percent of counties without access to one of these benefits represents a slim portion of total Medicare enrollment. These counties are largely rural counties where fewer Medicare beneficiaries reside and where MA penetration is much lower than in urban geographies. These findings raise important questions around how plans may reach greater populations within the counties where they currently offer benefits, and what is necessary to enable plans to expand into rural geographies.

Additional Authorities Allow Plans to Offer Non-Medical Benefits

Non-Primarily Health-Related Benefits

While SSBCI remain the primary authority plans utilize to offer non-primarily health-related supplemental benefits, another flexibility, the Value-Based Insurance Design (VBID) model, provides an additional vehicle for plans to offer these benefits. This model is distinct from SSBCI in that it allows plans to target benefits using Low-Income Status, as well as chronic conditions. Participation in the VBID model has more than doubled since 2021. Despite this surge, a modest portion of plans in VBID, 132 plans (represented in total by the green bars in *Figure 1*), use VBID authority to offer non-primarily health-related benefits (*see Figure 1*). Of plans using VBID to offer these benefits, the vast majority offer Food and Produce, Meals (beyond limited basis), or Non-Medical Transportation. Combined with SSBCI authority, a total of 1,247 plans, with total enrollment of nearly 20 percent of MA beneficiaries, offer non-primarily health-related benefits (*data not shown*).

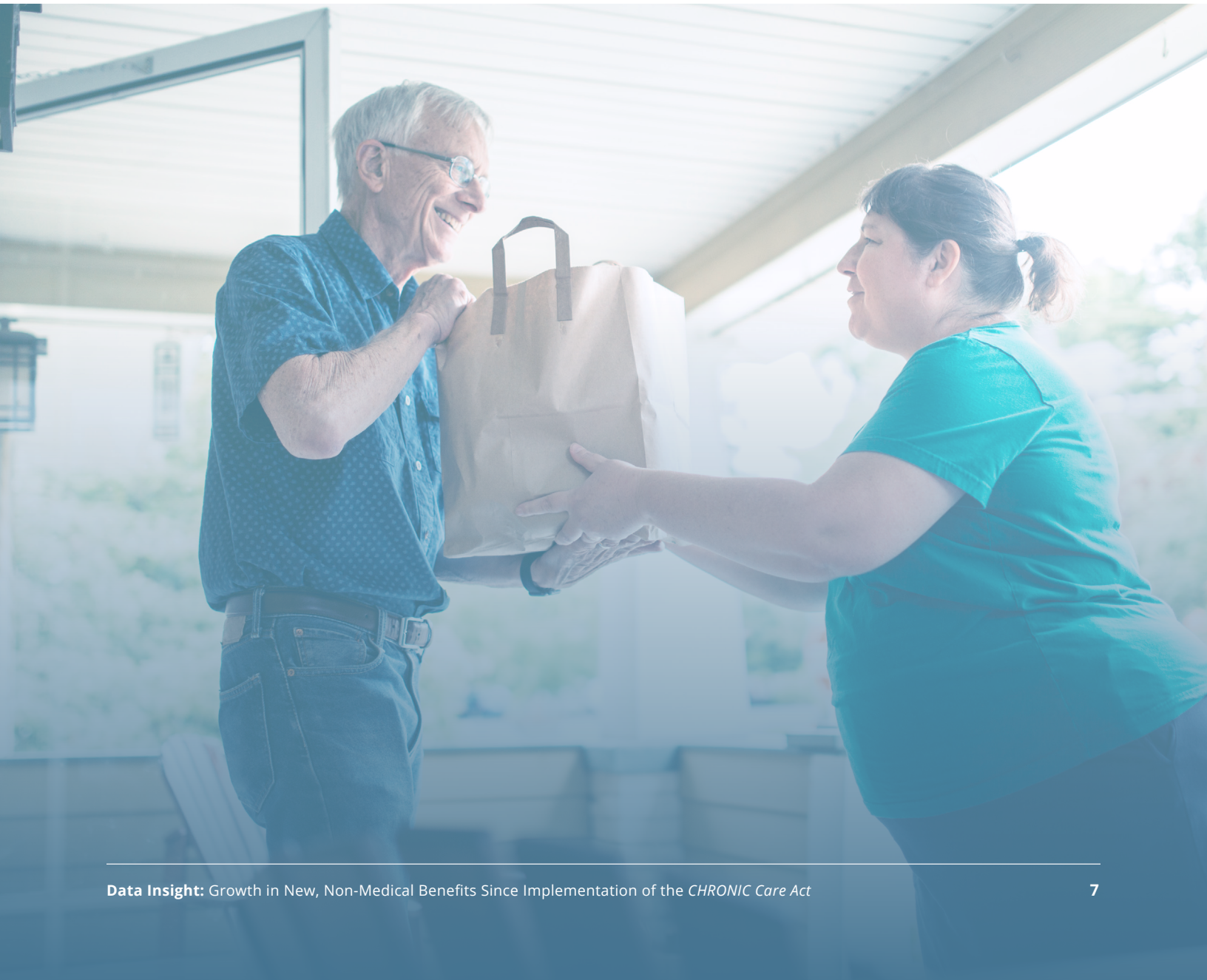
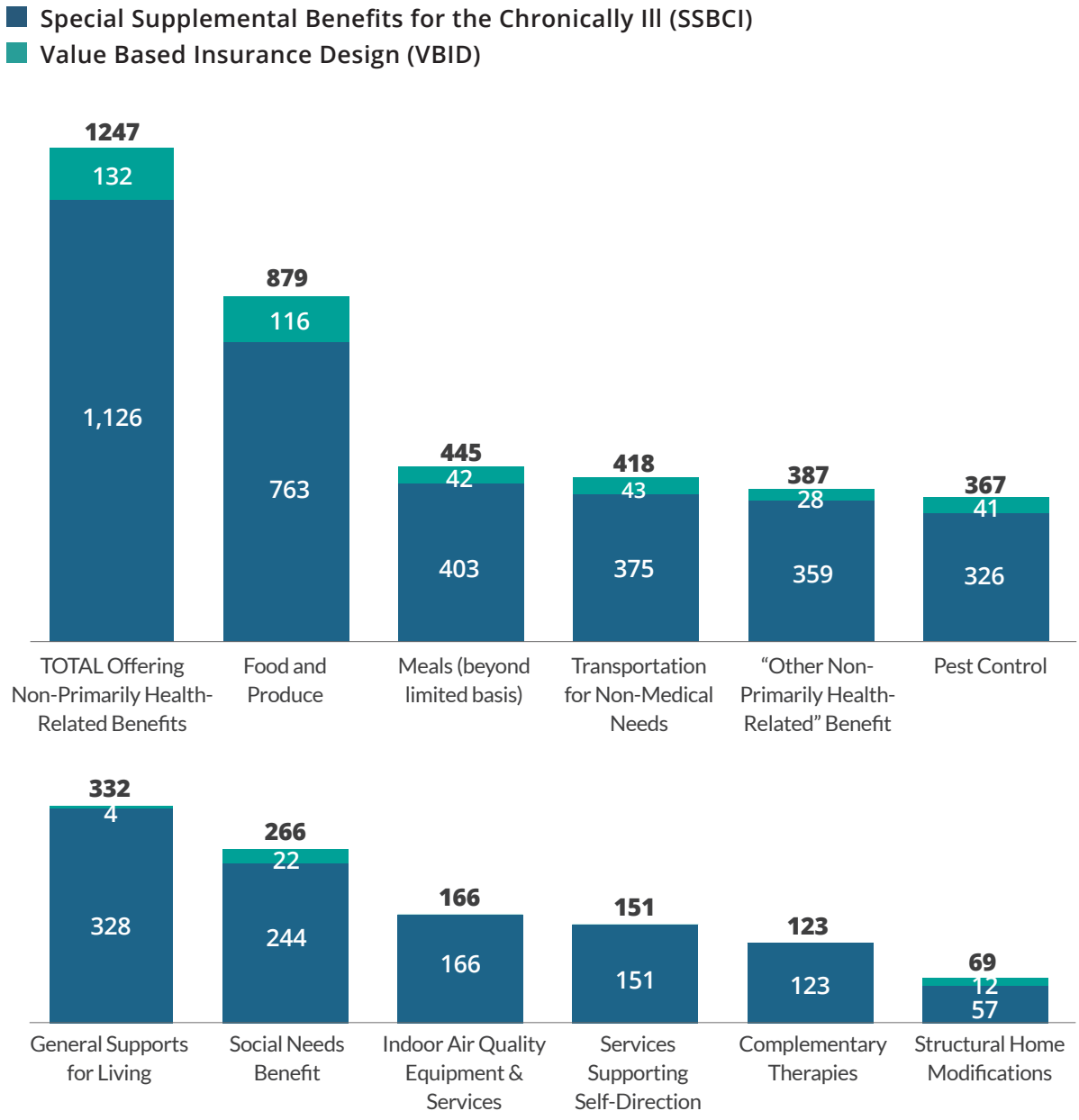
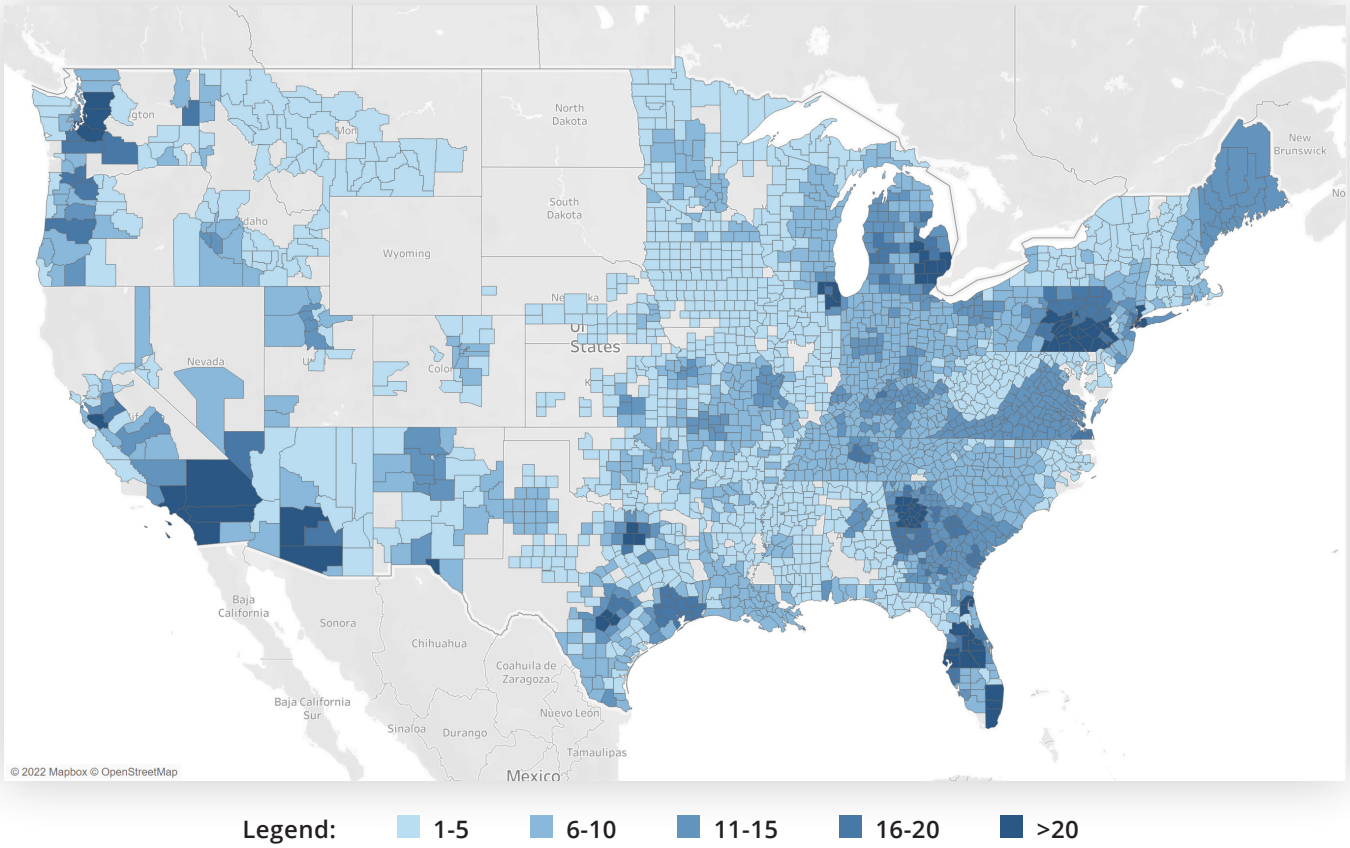


Figure 1: Authorities Used to Offer Non-Primarily Health-Related Benefits, PY 2022



In assessing the geographic availability of non-primarily health-related benefits through both SSBCI and VBID authorities, we see these benefits are available in higher frequencies along the East Coast and, alternatively, are sparse in the central part of the country (*see Figure 2)*. As one might expect, a greater number of plans per county offer these benefits in regions with significant MA penetration, including Southern California and throughout the state of Florida. Alternatively, while some plans offer these benefits in the Midwest, non-medical benefits are only offered by, on average, five or less plans per county. For PY 2022, enrollment in plans offering non-primarily health-related benefits totals over 4.5 million beneficiaries, just under a fifth of total MA enrollment (*data not shown*).

Figure 2: Number of MA Plans Offering Non-Primarily Health-Related Benefits through SSBCI or VBID, Per County, PY 2022

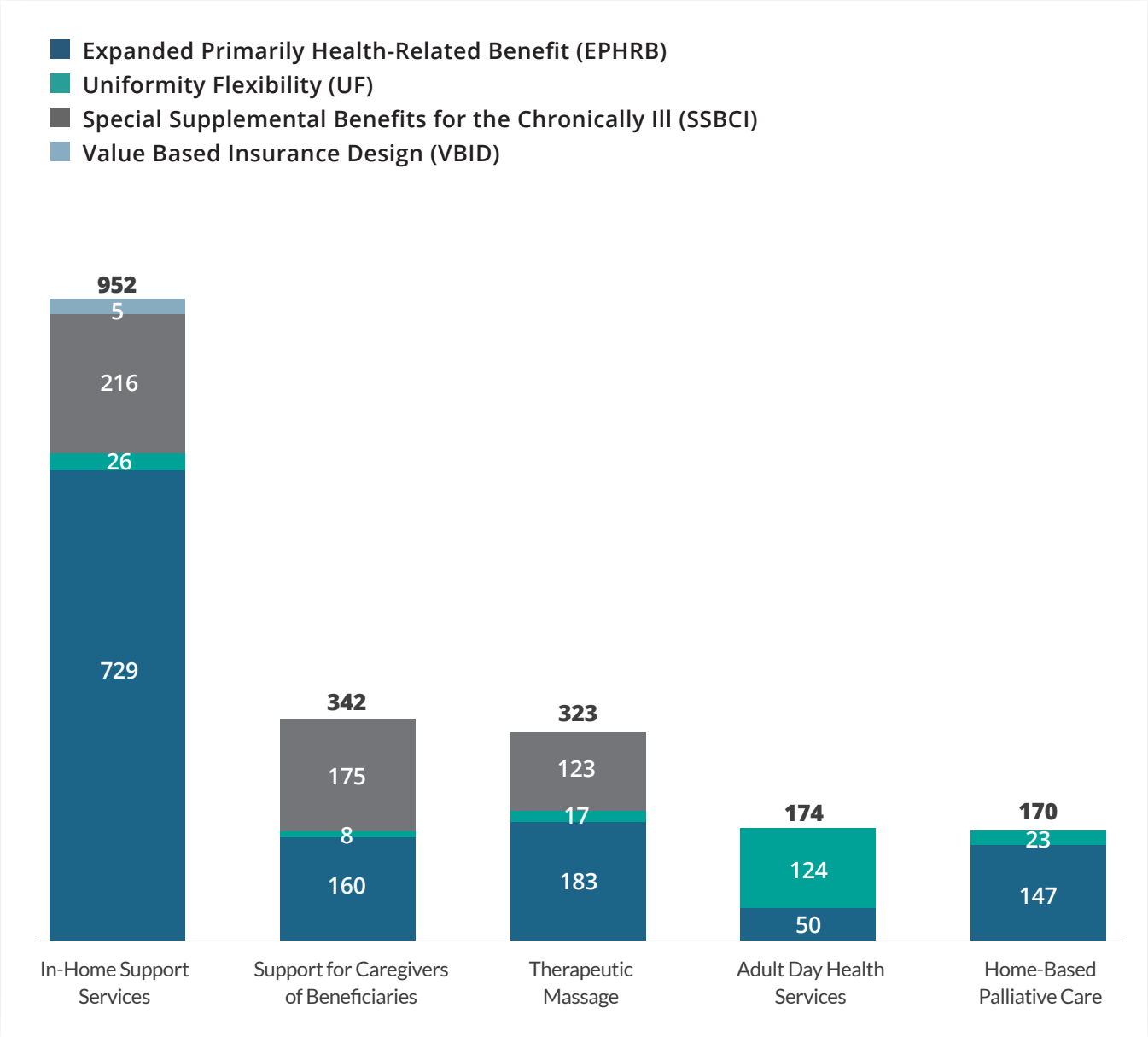


Note: Map does not include Hawaii, Alaska, or other U.S. territories (like Puerto Rico) where benefits may be offered.

Expanded Primarily Health-Related Benefits

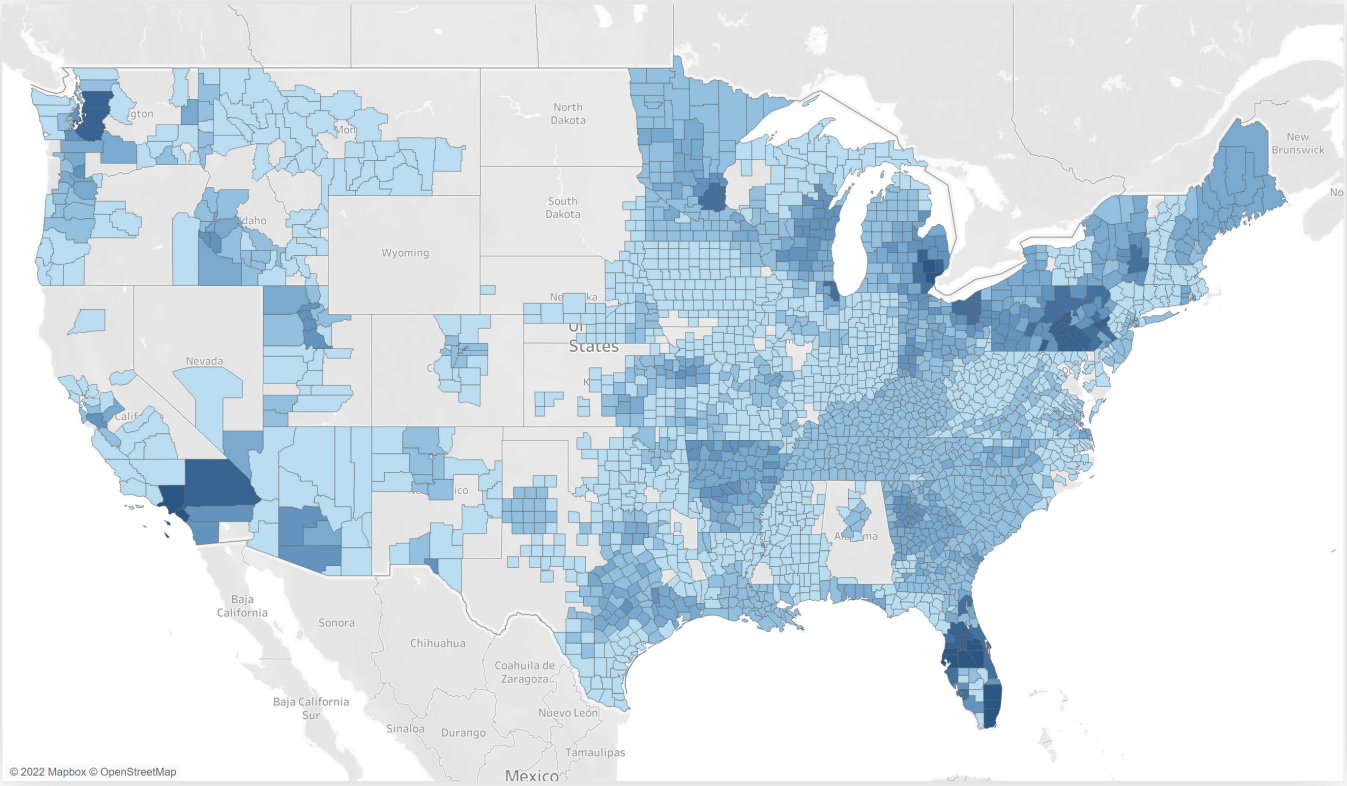
Plans also have flexibility to target EPHRB to specific plan members using additional authorities. These flexibilities, including SSBCI, UF, and VBID, allow plans to limit eligibility for EPHRB to a targeted population, rather than to the entire plan population (*see Figure 3*). Targeting benefits in this manner allows plans the opportunity to deliver high-value care to their most vulnerable populations. When including these additional authorities in this analysis, we see that 952 MA plans are providing In-Home Support Services in PY 2022, which is 223 more plans than through the traditional EPHRB authority only. Moreover, through these additional authorities, In-Home Support Services are available to over 4 million MA beneficiaries, 1 million beneficiaries greater than enrollment within plans offering In-Home Support Services through the EPHRB authority alone (*data not shown*).

Figure 3: Authorities Used to Offer Expanded Primarily Health-Related Benefits, PY 202



Once more, in viewing the geographic distribution of these five benefits through any authority (e.g., EPHRB, UF, SSBCI, VBID), benefits are predominantly concentrated along the eastern and western coasts of the country (*see Figure 4*). Overall, a greater number of plans offer these five benefits in states like Pennsylvania and Florida; this density is driven predominantly through the In-Home Support Services benefit across all available authorities. Once more, counties with the highest frequency of plans offering benefits generally represent counties with the highest density of MA beneficiaries. In total, EPHRB are available in plans enrolling over 5.5 million beneficiaries, representing 24 percent of all MA beneficiaries in PY 2022 (*data not shown*).

Figure 4: Number of MA Plans Offering Expanded Primarily Health-Related Benefits through Any Authority, Per County, PY 2022



Note: Map does not include Hawaii, Alaska, or other U.S. territories (like Puerto Rico) where benefits may be offered. Map displays any plan using EPHRB, UF, SSBCI, and/or VBID authority to offer the five benefits: In-Home Support Services, Caregiver Supports, Therapeutic Massage, Adult Day Health Services, and/or Home-Based Palliative Care.

Conclusion

While only available since 2019 and 2020, respectively, MA plans are increasingly offering EPHRB and SSBCI to MA beneficiaries across multiple markets. Over 96 percent of all Medicare beneficiaries live in a county with at least one of these new supplemental benefits available. However significant gaps remain, including availability of these benefits in rural geographies and much of the Mountain West. Although this data brief features the growth and availability of these benefits over time and for PY 2022, more work is necessary to analyze and evaluate these benefits. Furthermore, with no public data currently available on benefit utilization, little is known about member experiences with these benefits and their impact. ATI Advisory, together with Long-Term Quality Alliance and with the support of The SCAN Foundation, remain committed to filling these critical gaps in knowledge and improving the availability, and delivery of, benefits to help meet the individual needs of Medicare beneficiaries with complex conditions.

For More Information

With support from The SCAN Foundation, ATI Advisory and Long-Term Quality Alliance (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.

Methods

Analyses conducted using Plan Year 2020 through Plan Year 2022 Plan Benefit Package (PBP) data, available publicly from the Centers for Medicare and Medicaid Services. For all analyses including in this data brief, a 'plan' is defined as a Bid ID, or the combination of a Contract Number, Plan Identifier, and Segment ID. All analyses displayed in this data brief exclude the following plan types: Employer Group Health Plans (EGHPs), Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE plans. Analyses include Puerto Rico and other U.S. territories. All enrollment displayed is for February, including February 2020, February 2021, and February 2022.

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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.

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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.

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ACKNOWLEDGMENT

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