HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #2

Medicare Advantage Supplemental Benefit Flexibilities: An Early Assessment of Adoption and Policy Opportunities for Expanded Access

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January 2021

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Executive Summary

Unlike Traditional Medicare, Medicare Advantage plans, which provide coverage for 40 percent of all Medicare beneficiaries, may offer enrollees supplemental benefits which are not covered by the Medicare program. Until recently, the Medicare program has required that supplemental benefits be limited to those that are medical in nature. However, in recent years, Congress and CMS—through four different legislative and regulatory authorities— granted new flexibilities for Medicare Advantage plans to offer non-medical benefits that address social needs. Medicare Advantage plans may also now tailor supplemental benefits and make them available only to certain subpopulations based on chronic disease or health status.

Many in the policy community believe that these new flexible benefits will enable Medicare Advantage plans to better manage both the healthcare needs and social needs of medically complex and frail beneficiaries. However, only 18 percent of Medicare Advantage plans – accounting for less than 20 percent of the Medicare Advantage enrollment -- offered these new flexible benefits in 2020, raising questions regarding their perceived value by plans and beneficiaries. In addition, there is limited data to-date that demonstrates that the benefits offered under current requirements meet the specific needs of the individuals served or improve health outcomes.

HMA requested and conducted interviews with beneficiary advocates, Medicare Advantage plans, and supplemental benefit service providers to better understand the factors contributing to a Medicare Advantage plan's determination to offer (or not offer) newly available supplemental benefits as well as opportunities and challenges with the adoption and implementation of the various flexibilities. HMA also sought to understand the extent to which enrollees used the available flexible benefits, as well as their effectiveness as a tool to contain costs, improve outcomes, and address unmet health and social needs.

All Medicare Advantage organizations interviewed indicated that 2020, the first year in which all four benefit flexibilities were available, served as a period for learning, experimentation and evidence gathering; and expressed a need for more data on which flexible benefits would be most effective in improving health outcomes and reducing costs. The beneficiary advocacy organization interviewed was generally supportive of the new policies permitting Medicare Advantage plans to offer non-medical supplemental benefits but raised concerns regarding how the availability of those benefits are communicated and whether beneficiaries have meaningful access to them when eligible. All stakeholders interviewed indicated that additional time and experience is needed to understand whether the new benefit flexibilities enable plans to better serve individuals with complex health and social needs and urged CMS and Congress to promote further availability of these flexible benefits. These findings and other insights are summarized in Table A below along with corresponding considerations for future flexible benefit policies that may further facilitate plan adoption, beneficiary access, effectiveness, and relevance of the benefits.

Table A. Summary of Insights and Lessons Learned from Early Implementation of Flexible Benefits

Insights	Policy Consideration(s) to Encourage Further Adoption and Access
Limited research and data on the impacts of flexible benefits on total cost of care makes it difficult for Medicare Advantage plans to evaluate whether and how to provide them.	**Develop and Disseminate Evidence on Flexible Benefits:** CMS could conduct and share further research on the costs and benefits of flexible benefits to evaluate their impact on outcomes and support

	Medicare Advantage plan efforts and strategies to offer these benefits.
The availability of multiple pathways to offer supplemental benefit policies creates administrative burden and confusion for stakeholders.	**Simplify the Number of Flexibilities:** Congress and CMS could develop a single flexible benefit policy that permits Medicare Advantage plans to tailor flexible benefit offerings and offer non-medical benefits to eligible subpopulations
Information regarding flexible benefits is difficult for Medicare Advantage plans to communicate and for enrollees to understand which hinders enrollee awareness, access, and use. Further, variation in scope of benefit offerings across plans raises parity concerns and may make it difficult for beneficiaries to meaningfully compare benefits and options.	**Improve Communications to Enhance Access and Usage:** CMS could update Medicare Advantage communications and marketing guidelines to ensure plans convey information consistently and beneficiaries are aware of and understand the flexible benefits available to them. CMS could also standardize flexible benefit offerings to enable beneficiaries to better understand the benefits.
Current flexible benefit eligibility criteria do not enable Medicare Advantage plans to offer benefits based on socioeconomic and environmental factors, limiting availability for enrollee subpopulations that may benefit most.	**Meet the Needs of Beneficiaries Most in Need:** CMS could expand flexible benefit eligibility beyond clinical criteria to ensure that social benefits are accessible to those most in need.
Lack of familiarity with the Medicare program and Medicare Advantage plan contracting requirements presents challenges for service providers.	**Educate and Train Service Providers:** CMS could develop training materials and standardized billing processes that Medicare Advantage organizations could use to educate and contract with service providers on Medicare/Medicare Advantage program requirements.
Beneficiaries and their representatives do not currently appear to be involved in the design of flexible benefits in a substantial way.	**Involve Beneficiaries:** CMS could increase its efforts to ensure that Medicare beneficiaries and specific subpopulations of Medicare beneficiaries inform the future development, design, evaluation, refinement, and possible expansion of flexible benefits.
Supplemental benefits are not covered for individuals in Traditional Medicare, leaving the majority of Medicare beneficiaries without access to flexible benefits.	**Test Provision of Flexible Benefits in Traditional Medicare:** CMS could develop a new payment model through the Center for Medicare & Medicaid Innovation (CMMI) or modify existing CMMI models to test the availability of flexible benefit offerings on total cost of care and quality for individuals enrolled in Traditional Medicare.

This brief was produced under a grant from Arnold Ventures.

Introduction: New Medicare Advantage Supplemental Benefit Flexibilities

Today, 40 percent of all Medicare beneficiaries are enrolled in a Medicare Advantage plan[1], a rapid increase from the 24 percent enrolled in 2010. Over the past decade, the Medicare Advantage population has become increasingly diverse and complex. Although the demographic profile of Medicare Advantage enrollees is similar to that of beneficiaries in Traditional Medicare, Medicare Advantage

[1] HMA analysis of CMS Medicare Advantage enrollment files, October 2020.

enrollees are slightly more racially diverse and lower income.[2] A significant portion – 44 percent – of individuals dually eligible for Medicare and Medicaid are enrolled in a Medicare Advantage plan. Thirty-seven percent of enrollees in Medicare Advantage plans have high needs (for example, disabled or living with three or more chronic conditions and difficulty with an activity of daily living) and require a range of medical and social services.[3] Unlike Traditional Medicare, Medicare Advantage plans are required to offer a limit on the amount of out-of-pocket expenditures a beneficiary can incur for Part A and B benefits during the enrollment, often making it an attractive option for some individuals with complex health needs.

In addition to the cost-sharing protections, Medicare Advantage plans may offer enrollees supplemental benefits which are not covered by the Medicare program. The Medicare program does not provide explicit funding for supplemental benefits; they are typically funded through rebates to plans.[4] Rebate amounts vary by plan and geography, and average around $107 per member per month (PMPM) for Medicare Advantage plans that are not Special Needs Plans (SNPs).[5] Supplemental benefits generally include dental care, vision, hearing, and fitness benefits. In addition to premiums and cost-sharing for medical (Part C) and prescription drug (Part D) benefits and the expansiveness of their provider networks, Medicare Advantage plans compete for enrollees based on the availability and generosity of supplemental benefits.

Historically, the Centers for Medicare & Medicaid Services (CMS) defined supplemental benefits as those that are "primarily health-related," or benefits that are intended to prevent, cure, or diminish an illness or injury, and Medicare Advantage plans were required to provide these benefits uniformly to all of their enrollees. Many Medicare Advantage plans, providers, and some consumer advocates argued that this definition restricted plans' ability to offer innovative benefits that would prevent or delay progression of chronic disease, address social needs, and be tailored to enrollees most in need.

In recent years, Congress and CMS expanded supplemental benefit policies to grant Medicare Advantage plans more flexibility to design and target their supplemental benefit offerings through four different pathways ("flexible benefits") that enable Medicare Advantage plans to tailor benefits to select subpopulations and to offer benefits intended to address both medical and social needs. Table B below summarizes the four Medicare Advantage supplemental benefit flexibilities.

[2] Neuman P, Jacobson GA. Medicare Advantage Checkup. New England Journal of Medicine 2018;379(22):2163–72

[3] Eva H. DuGoff et al., Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs (Commonwealth Fund, Feb. 2019).

[4] Medicare Advantage plans that bid below the benchmark (the CMS target against which plans bid to provide coverage of Medicare A/B services) receive a percentage of the difference between the bid and benchmark in the form of a rebate. Rebate amounts range between 50% and 70% of the difference between the bid and the benchmark; this percentage is determined by a plan's star rating. Plans with higher star ratings receive a higher percentage of the difference as a rebate.

[5] Skopec L, Ramos C, Aarons J. Are Medicare Advantage Plans Using New Supplemental Benefit Flexibility to Address Enrollees' Health-Related Social Needs? Washington, DC: Urban Institute; September 2019.

Table B. Medicare Advantage Supplemental Benefit Flexibility Pathways

- **Value-based Insurance Design (VBID) Demonstration**: In 2017, CMS launched the VBID demonstration, which permits Medicare Advantage plans to provide reduced cost-sharing or supplemental benefits for targeted subpopulations of enrollees based on clinical criteria and/or certain socioeconomic status indicators (such as low-income subsidy eligibility or dual-eligible status). Until 2020, only plans in a limited number of states were eligible to apply, but Congress expanded the scope of the demonstration to include all 50 states through the Bipartisan Budget Act of 2018 (BBA 2018).
- **Expanded Primarily-Health Related Benefits:** In 2019, under existing authority, CMS expanded the definition of "primarily health related" to include items and services intended to:
  1. Diagnose or compensate for physical impairments;
  2. Ameliorate the functional/psychological impact of injuries or health conditions; or
  3. Reduce avoidable emergency and healthcare utilization
- **Uniform Flexibility**: In 2019, under existing authority, CMS removed the requirement that Medicare Advantage plans offer benefits uniformly and permitted plans to offer tailored supplemental benefits or cost sharing for "similarly situated individuals" based on disease state or condition.
- **Special Supplemental Benefits for the Chronically Ill (SSBCI):** In 2020**,** in response to a provision in BBA 2018, CMS implemented SSBCI, permitting plans to offer supplemental benefits that are "non-primarily health-related" for individuals with one or more of 15[6] designated chronic conditions. Beginning in 2021, Medicare Advantage plans have discretion to include additional chronic conditions that meet the CMS definition of "chronically ill."[7]

Despite the availability of these new flexibilities and anticipation regarding their impact, Medicare Advantage plan adoption of and enrollment in plans that offer newly expanded supplemental benefits is relatively low. In early 2020, 19 percent of Medicare Advantage enrollees were in a plan offering flexible benefits. This number likely increased over the year, as CMS permitted plans to provide mid-year benefit enhancements, including flexible benefits, in response to the novel coronavirus (COVID-19) pandemic. CMS recently announced growth in plan adoption and availability across all four flexibility types in 2021, but CMS' enrollment estimates suggest the majority of Medicare Advantage enrollees will continue to be in plans that do not offer flexible benefits.[8] As of publication of this paper, CMS has not yet released 2021 plan-specific data detailing offerings under all four flexibilities.

Medicare Advantage plans' adoption of flexible benefits varies significantly by flexibility type, benefit offering, Medicare Advantage parent organization, and geography.[9] Examples of popular additive flexible benefits offered in 2020 are included in Table C below.

[6] Qualifying chronic conditions include: chronic alcohol and other dependence, autoimmune disorders, cancer (excluding pre-cancer conditions), cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, end-stage liver disease, End-Stage Renal Disease (ESRD) requiring dialysis, severe hematologic disorders, HIV/AIDS, chronic lung disorders, chronic and disabling mental health conditions, neurologic disorders, stroke

[7] CMS defines a chronically ill enrollee as having one or more comorbid and medically complex chronic conditions that: 1) is life threatening or significantly limits the overall health or function of the enrollee; 2) has a high risk of hospitalization of other adverse health outcomes; and 3) requires intensive care coordination.

[8] CMS Press Release. Trump Administration Announces Historically Low Medicare Advantage Premiums and New Payment Model to Make Insulin Affordable Again for Seniors. September 24, 2020.

[9] Ipakchi, N., Blum, J., Hammelman, E. and Hsieh, M. "Medicare Advantage Supplemental Benefit Flexibilities: Adoption of and Access to Newly Expanded Supplemental Benefits in 2020." Health Management Associates, May 2020.

Table C. Examples of Flexible Benefits Offered in 2020	
Flexibility Pathway and Benefit Name	**Example of Benefit Offering**
SSBCI	
Transitional/Temporary Supports	Temporary (up to 10 days) housing upon discharge from an inpatient hospital stay or skilled nursing facility if current housing situation is deemed to be unsafe
Food and Produce	Monthly delivery of pantry staples (nonperishable items)
Meals (beyond limited basis)	2 meals per day for 90 days delivered to home
Pest Control	Quarterly preventive treatments to regulate or eliminate the intrusion of household pests that may have an adverse impact on a chronic condition
Transportation for Non-Medical Needs	Up to 28 one-way trips for non-emergency transportation accompanied by a health aide if needed
Indoor Air Quality Equipment and Services	$150 allowance every year for indoor air quality equipment and services
Social Needs Benefit	Up to 8 hours of companion care/month
Expanded Primarily-Health Related Benefits	
In-Home Support Services	Assistance with meal preparation, light housekeeping, personal care and hygiene, medication reminders, and other activities of daily living; maximum of 20 hours every 3 months
Supports for Caregivers	3 telephonic support sessions per year with a dedicated Caregiver Advisor

Source: HMA review of publicly available 2020 Medicare Advantage Evidence of Benefit documents

Methodology

HMA requested and conducted semi-structured interviews with Medicare Advantage plan representatives (including policy, product, actuarial, and clinical executives), beneficiary advocacy organizations, and social service providers to gain insight into factors contributing to the adoption, availability, and utilization of flexible benefits in 2020 as well as the extent these benefits, when implemented, meaningfully address the complex needs of the Medicare population. Interviewees were identified and selected based on their experience and knowledge of Medicare Advantage supplemental benefits and to ensure a diverse array of perspectives. Organizations contacted and interviewed included:

- Medicare Advantage organizations and Medicare Advantage plan actuaries, representing national and regional insurers, organizations that offered flexible benefits as well as those that did not, and organizations that offered different types of flexible benefits
- Advocacy organizations, including Medicare beneficiary advocates, chronic disease advocates, and minority advocates
- Supplemental benefit providers, including community-based organizations (CBOs), network aggregators, and other vendors

Some of the advocacy organizations contacted indicated that they did not have detailed knowledge or positions on flexible benefits. Several other advocacy organizations did not respond to requests for interview. One beneficiary advocacy organization was interviewed.

HMA developed and used semi-structured interview guides that elicited interviewee perspectives on the drivers and barriers to Medicare Advantage plan adoption and beneficiary access to newly available

supplemental benefits, as well as the impact of these benefits on beneficiary outcomes, satisfaction, and total cost of care. HMA also solicited input on whether policymakers should encourage further adoption of newly available supplemental benefits as well as other Medicare policy changes that could enable stakeholders to better address the Medicare population's unmet health and social needs. The following overarching research questions informed our interviews.[10]

1. What factors contributed to plan determinations to offer (or not offer) supplemental benefit offerings under newly afforded flexibilities? What are the expected/realized impacts of new supplemental benefit offerings on quality and total cost of care? On enrollee satisfaction and engagement?
2. Do eligible enrollees have meaningful access to flexible benefits in plans that offer them? To what extent are the benefits being offered appropriate and effective for addressing unmet health or social needs?
3. What policy changes and/or other mechanisms could policymakers consider to support health plan and other stakeholder efforts to address non-medical needs in order to improve overall health and contain spending?

All interviewees were guaranteed that their organizations would not be cited by name to respect confidentiality.

Research Results

Factors Contributing to Medicare Advantage Plan Adoption and Selection of Flexible Benefits in 2020

In 2020, 18 percent of all Medicare Advantage plans offered flexible benefits under one of the four new authorities (Table D). These plans represented 41 percent of Medicare Advantage organizations indicating that a significant number of organizations wanted to cautiously experiment with flexible benefits, offering them in a small number of Medicare Advantage plans and markets. Medicare Advantage organizations differed in the flexibilities chosen and specific benefits offered. Expanded primarily health-related benefits is currently the most widely adopted benefit flexibility, followed by Uniform Flexibility, SSBCI and VBID.

HMA interviewed Medicare Advantage organizations and their consulting actuaries who took varying approaches to designing and implementing new supplemental benefit flexibilities to understand the factors that contributed to a plan's decision to offer these flexible benefits. In the process, we also reviewed the type(s) of flexibility and specific benefits chosen. Of the seven Medicare Advantage organizations interviewed, five offered expanded primarily health related benefits, four offered SSBCI, three provided benefits non-uniformly, two participated in VBID, and one did not offer any flexible benefits in 2020. Interviews revealed common practices as well as notable differences in approaches across Medicare Advantage organizations.

[10] While HMA interviewed stakeholders regarding all four flexibility types, flexibilities intended to address unmet social needs typically fall under SSBCI and expanded primarily health related benefits. As such, our findings are largely focused on SSBCI and expanded primarily health related benefits.

Table D. Summary of Supplemental Benefit Flexibilities Adoption and Enrollment, 2020 (as a % of all Medicare Advantage plans)					
All Medicare Advantage Plans (Including SNP)	**Flexibility 1: Expanded Primarily Health Related Benefits**	**Flexibility 2: Uniform Flexibility**	**Flexibility 3: VBID**	**Flexibility 4: SSBCI**	**At Least One Flexibility**
Medicare Advantage Organizations	19.7%	18.1%	7.4%	16.0%	41.4%
Medicare Advantage Plans	9.2%	5.5%	2.8%	4.8%	18.0%
Enrollment as a % of Total Medicare Advantage Enrollment	10.2%	5%	5.1%	5.7%	19.1%

"There is tremendous potential in recent SSBCI and supplemental benefit flexibility for plans to innovate and improve health outcomes and overall wellbeing for Medicare beneficiaries."

– National Medicare Advantage Plan Policy Executive

With limited data of specific benefits on expected total costs of care, Medicare Advantage organizations generally evaluated value of supplemental benefits against three primary dimensions. Although there was consensus among interviewees that socioeconomic and environmental factors are important determinants of health outcomes, all interviewed Medicare Advantage organizations acknowledged that limited data and evidence regarding the short-term and long-term impacts of specific interventions made it difficult to determine which benefits to offer and at what scale (e.g., units of service offered per benefit per period). In order to gain CMS approval and meet internal business goals, Medicare Advantage organizations reported they had to work with their actuarial teams to ensure they could estimate the costs and savings to meet CMS bid submission requirements and organizational business objectives. Medicare Advantage organizations also expressed the need to assess the risks of incomplete data, indicating that misestimates regarding higher-than-anticipated utilization and/or expected savings could result in significant unanticipated costs. Given the current lack of evidence, these Medicare Advantage organizations generally evaluated flexible benefit opportunities against one or more of the following dimensions:

- <u>Perceived Member Benefit/Identified Member Need</u>
  Medicare Advantage organizations all indicated that they always look for strategies to address the needs of their members, particularly those with complex health conditions. Most Medicare Advantage organizations noted that they had been collecting, through member surveys and interactions with consumer representatives, information and data on member health status and other factors. In addition to chronic disease prevalence, Medicare Advantage organizations found that their enrollee subpopulations experienced food insecurity, social isolation, housing insecurity, and behavioral health challenges. Nearly all Medicare Advantage plans believed that the new supplemental benefit policies provided them new opportunities to address those challenges.

Interviewees also stated that they wanted to be responsive to member-identified needs and market competitive pressures to expand benefit offerings. One interviewee described a process consisting of member surveys, review of grievances and appeals, focus groups, and external research to understand not only with which current benefits members are satisfied or unsatisfied, but also to learn about additional benefits that could be made available. The one plan interviewed that did not offer flexible benefits indicated that, at the time a determination was made as to whether to offer a benefit in 2020, the organization had not identified a benefit or benefits that would be meaningfully additive for its enrolled population.

- Resources Needed and Available for Upfront Investment

  Medicare Advantage plans reported that upon evaluation, some benefits were more costly than others, either because of the nature of the benefit or the anticipated utilization. Given uncertainty regarding the impact on total cost of care, and that plans were not given additional funding to offer these benefits, Medicare Advantage plans indicated that the initial cost of the benefit informed their decision regarding which benefits to offer, if at all. In order to determine whether they could afford the cost of the flexible benefit, Medicare Advantage organizations evaluated existing financial resources to determine where and how to implement the benefit. Because supplemental benefits are typically financed through rebate dollars, all Medicare Advantage organizations indicated they were more likely to offer flexible benefits in Medicare Advantage plans and markets in which there was sufficient rebate revenue to offer these flexible benefits in addition to, rather than to supplant, existing supplemental benefits.

  No Medicare Advantage organizations interviewed were willing to reduce the availability or scope of existing supplemental benefits offered, such as premium reductions, reductions in enrollee cost-sharing, or traditional supplemental benefits (e.g., vision, hearing, dental) in order to offer flexible benefits. Some plans indicated that they had to make tradeoffs with respect to which specific flexible benefits to offer and were not able to offer all the new benefits they would have liked. For example, one Medicare Advantage organization indicated a desire to offer a social isolation benefit as well as an allowance for an array of other permissible non-medical benefits but indicated that offering both would be too costly. Another Medicare Advantage organization indicated that it scaled back the eligibility criteria for a benefit to minimize the risk of overutilization. Initially, the organization sought to offer a flexible benefit to individuals that suffered a fall. However, given the uncertainty regarding costs, impacts, and beneficiary utilization of the benefit, the organization decided to revise the criteria to experiencing two or more falls.

- Market Differentiation

  Some Medicare Advantage organizations reported that the perceived benefit of positioning their plans as market innovators through these benefits outweighed the risk of uncertainty regarding financial return on investment, and that offering these benefits provided an opportunity to demonstrate public commitment to provide additional benefits to their enrollees, especially those in need. Many of these Medicare Advantage organizations relayed that they have processes in place to monitor enrollee perception of benefits offered, including evaluations of

surveys, retention rates, and quality measures assessing member experience. Participating Medicare Advantage organizations indicated that early member feedback regarding flexible benefit offerings was positive.

Multi-region Medicare Advantage organizations that offered flexible benefits in 2020 reported that uncertainty regarding the value of newly available benefits contributed to their decisions to limit benefits to only a select number of plans and markets to test and gather data before expanding. The Medicare Advantage organization that did not offer flexible benefits in 2020 stated that the perceived costs and uncertainty were too great and preferred to observe the early experiences of competitors before offering one or more of these benefits in later years.

Benefits related to meals/food delivery, transportation, and social isolation were perceived as attractive short-term opportunities. Nearly all Medicare Advantage organizations interviewed offered or considered offering non-medical meals, non-medical transportation, and social isolation benefits in 2020. Interviewees reported that of the non-medical benefits available, food and transportation are believed to have the strongest literature base demonstrating the positive impacts on health outcomes. In addition, several Medicare Advantage plans also participate in Medicaid as Medicaid managed care organizations. These plans that have both Medicare Advantage and Medicaid offerings reported that the learnings from Medicaid participation, where many similar non-medical supplemental benefits are provided, helped to inform whether and how to implement them for their Medicare Advantage offerings. These plans reported that having existing Medicaid social service provider partnerships made for a more seamless implementation process.

Although the literature base surrounding social isolation benefits is not as robust as that of food and/or transportation, Medicare Advantage organizations that offered social isolation benefits reported that offering the benefit provided an opportunity to gather data to inform future offerings. For example, one Medicare Advantage organization indicated that its social isolation service provider was able to ask questions of the members they served that could inform the demand for other benefits in future years (e.g., asking questions about meal stability to understand whether an enrollee is food secure).

Benefit offerings varied in scope, duration, and form across Medicare Advantage organizations. Even for similar benefit offerings, the duration and frequency of the benefits varied significantly across Medicare Advantage plans. For example, one health plan that offered in-home services and supports provided up to 124 hours of home health aide services annually. In contrast, another organization offering the same benefit offered 42 hours annually. In addition, some Medicare Advantage plans offered specifically assigned benefits, while others offered allowances and/or menus of services. One Medicare Advantage plan's food and produce benefit includes monthly meal deliveries with non-perishable pantry staples, and another Medicare Advantage plan offered an allowance towards the purchase of food and produce at approved locations. Notably, one Medicare Advantage plan interviewed offers eligible enrollees a "menu" of services. For example, enrollees may select one of 10 supplemental benefits, such as in-home supports, healthy food deliveries, and pest control, and are generally committed to that supplemental benefit for the duration of the plan year. Medicare Advantage plans offering allowances and "menus" of services stated that a decision to structure their flexible benefit in this form was made to provide enrollees maximum choice and value.

The availability, presence, and scalability of trusted service providers informed selection of benefit offerings. Medicare Advantage organizations were only able to offer flexible benefits in locations in

which supplemental benefit service providers operate. One interviewee indicated an interest in offering a new flexible benefit offering in multiple areas within a state but had to limit the offering to plans in one part of the state because that is where the social service provider had a presence. Interviewees also relayed varying approaches to service provider identification and contracting as well as the factors that make an attractive vendor partner. These approaches varied by benefit type. For example, some Medicare Advantage organizations that partnered with transportation vendors did so based on a trusted brand and national presence. For food and nutrition benefits, several Medicare Advantage organizations interviewed relayed a preference for local community-based organizations with long-standing ties and relationships in the community and familiarity with the enrollee population. In areas with limited established networks of providers, Medicare Advantage plans worked with technology platforms that enabled the plan to connect and contract with local providers. However, plans reported that working with technology platform providers often added additional costs. Vendors that are not as widely recognized but have innovative offerings are also attractive to some Medicare Advantage organizations. One interviewee indicated that the Medicare Advantage plan's "innovation team" consistently meets with potential vendors throughout the year to learn about novel approaches to addressing unmet health and social needs.

> ***"The biggest risk discussed after being comfortable with costs are concerns over administering and implementing, particularly with vendors that have not operated in the Medicare Advantage world."***
>
> - *Medicare Advantage Plan Actuary*

Medicare Advantage organizations also communicated a preference for working with a limited number of providers to reduce administrative burden and contracting costs and risks. As such, all interviewees noted that it was important for service providers to have capabilities to expand offerings and presence quickly. In addition, Medicare Advantage organizations also indicated it was important for the service provider to have or quickly develop familiarity with Medicare Advantage program requirements. Several Medicare Advantage organizations and supplemental benefit providers indicated that the flexible benefit opportunities were the first time working with the Medicare program or within the healthcare space and that they did not previously have a robust understanding of Health Insurance Portability and Accountability Act (HIPAA) compliance, government audits, and the Medicare Advantage plan year cycle and calendar to submit bids, have offerings approved, and begin marketing to Medicare beneficiaries.

Insights and Lessons Learned from Early Implementation of Newly Available Supplemental Benefits: Perspectives from Beneficiary Advocates, Service Providers, and Health Plans

In addition to the factors affecting Medicare Advantage plan decisions to adopt and implement flexible benefits, interviewees representing Medicare Advantage plans, a beneficiary advocacy organization, service providers, and community-based organizations shared insights gained from early implementation of and access to flexible benefits. These insights include challenges with implementation that resulted in narrow availability of flexible benefits as well as limited beneficiary awareness and understanding of the benefits when available. We highlight seven key insights:

Insight 1: Limited research and data on the impacts of flexible benefits on total cost of care makes it difficult for Medicare Advantage plans to evaluate whether and how to provide them. All interviewees stated their belief that flexible benefits have the potential to improve outcomes, increase beneficiary satisfaction, and reduce overall cost of care for beneficiaries with complex needs. All indicated, however that limited data and evidence regarding the short-term and long-term effects of specific interventions impedes them from identifying and developing the most impactful benefits that can be adopted and made accessible on a wide scale. In addition, stakeholders do not have the information needed to evaluate the impact of new flexible benefit policies to inform future refinements, additions, or other modifications to ensure effectiveness and relevance.

Insight 2: The availability of multiple pathways to offer supplemental benefit policies creates administrative burden and confusion for stakeholders. Medicare Advantage organizations interviewed generally value having multiple pathways to innovate and implement new flexible benefits, but noted challenges navigating the varying requirements associated with each one of the different flexibility types. Most Medicare Advantage plans that offered flexible benefits indicated that they first determined the benefit they wished to offer and then evaluated the various pathways to understand which flexibility type enabled the benefit offering. For example, one Medicare Advantage organization wanted to offer a benefit to address individuals with a history of falls. Upon evaluation of the various flexible benefit pathways, the organization learned that they could offer a supplemental benefit through uniform flexibility, as this pathway permits plans to tailor benefits based on clinical criteria but does not require that the subpopulation targeted have an eligible chronic condition. Although Medicare Advantage organizations were able to identify and determine an appropriate pathway to offer desired benefits, interviewees indicated that further simplicity and streamlining of requirements could reduce administrative burden, provide more opportunities to innovate, and save time and resources.

Insight 3: Information regarding flexible benefits is difficult for Medicare Advantage plans to communicate and for enrollees to understand which hinders enrollee awareness, access, and use. Further, variation in scope of benefit offerings across plans raises parity concerns and may make it difficult for beneficiaries to meaningfully compare benefits and options. Marketing and education requirements for flexible benefits vary by flexibility type. For example, Medicare Advantage plans participating in the VBID demonstration are prohibited from highlighting VBID when marketing plans to prospective enrollees. Medicare Advantage plans offering SSBCI are permitted to market these benefits but must be careful in doing so as only select subpopulations with qualifying clinical criteria are eligible for the benefit.

Medicare Advantage plans provide updated training for agents and brokers, conduct targeted outreach calls with new members and work with their care management teams to ensure that individuals that meet the criteria for eligibility are aware of the benefits available to them. Despite these efforts, the beneficiary advocacy organization interviewed indicated that there is limited transparency regarding which specific benefits are available under which plans as well as the criteria for eligibility. The beneficiary advocacy organization also expressed concerns that the information provided through television ads and some plan materials are misleading in terms of expansiveness and availability to all enrolled members.

> ***"There is limited transparency about what benefits are available under certain plans and whether beneficiaries have access to those services."***
>
> - *Medicare Beneficiary Advocacy Organization*

Further, Medicare Advantage organizations may vary flexible benefit offerings in scope, duration, and frequency. While the beneficiary advocacy organization interviewed expressed support for Medicare Advantage plans being able to tailor their offerings to meet their specific enrollee populations, it also expressed concern that this variability results in imbalance and unfairness with some Medicare Advantage enrollees having access to richer benefits than others. The organization also stated concerns that without clear and consistent communication about these flexible benefits, beneficiaries may not be able to meaningfully compare these benefits across plans and select the best plan option.

Insight 4: Current flexible benefit eligibility criteria do not enable Medicare Advantage plans to offer benefits based on socioeconomic and environmental factors, limiting availability for enrollee subpopulations that may benefit most. Although many of the new flexible benefits available are designed to address unmet health and social needs, these benefits are limited to those individuals with select chronic conditions based solely on clinical criteria. Socioeconomic status is currently not an allowable criterion for eligibility. All stakeholders suggested flexible benefits would have greater impact if Medicare Advantage plans were able to offer them based on social and other identified needs, such as living in a rural or other under resourced area.

Insight 5: Lack of familiarity with the Medicare program and Medicare Advantage plan contracting requirements presents challenges for service providers. Many service providers offering flexible benefits have not previously worked with Medicare Advantage plans or served Medicare beneficiaries and are not familiar with the statutory and regulatory framework governing the Medicare program. In addition, many flexible benefit providers are community-based organizations with funding typically driven by grants, as opposed to service-related payments. They typically do not have systems in place to take service requests from Medicare Advantage plans, submit claims for payment, and maintain service records. Medicare Advantage organizations indicated that there is substantial variation in the level of knowledge of Medicare program requirements among service providers. These plans described challenges to qualify the service providers to ensure they follow CMS regulations and are properly licensed, trained, and insured. Service providers relayed that they had to make significant up-front investments in time and resources to educate themselves on Medicare program requirements and to ensure compliance with Medicare Advantage contract provisions.

Insight 6: Beneficiaries and their representatives do not currently appear to be involved in the design of flexible benefits in a substantial way. While the beneficiary advocacy organization interviewed generally supported the availability of benefits to address unmet health and social needs, the organization indicated it was not aware of whether and to what extent the benefits being offered met the specific needs and/or preferences of the intended populations or subpopulations. Responses to HMA's outreach to advocacy organizations representing certain groups suggest that many disease, chronic condition, disability, and minority group advocates did not have an opportunity to meaningfully inform the development of flexible benefit policies. This lack of involvement raises questions about the benefits' relevance and effectiveness for those subpopulations.

Insight 7: Supplemental benefits are not covered for individuals in Traditional Medicare, leaving the majority of Medicare beneficiaries without access to flexible benefits. The beneficiary advocacy organization, service providers, and some Medicare Advantage plans stated that, in order to benefit the most in-need beneficiaries, flexible benefits should be made available to all Medicare beneficiaries, including those enrolled in Traditional Medicare. Interviewees did not state specific views for how such an expansion would be financed or how the Traditional Medicare program would determine which beneficiaries would be eligible for the benefits.

Looking Forward: Opportunities to Better Address the Unmet Health and Social Needs of the Medicare Population

Twenty-twenty was the first year in which all four new benefit flexibilities were available. Given the variability of benefit designs, 2020 also appears to have served as a year of experimentation. Medicare Advantage organizations that offered the benefits chose to do so in a generally cautious manner and in a small number of geographies. While stakeholders see promise in the ability of flexible benefits to help improve outcomes for beneficiaries with complex needs, interviewees reported several challenges in the implementation of these new benefits that could present continued barriers to widespread adoption, access, and relevance. Interviewees also shared that those beneficiaries who used flexible benefits were satisfied with their experience, however, little, if anything, is known to date about the impact on healthcare outcomes and total costs of care.

We highlight seven near-term policy considerations based on the insights developed from this study. These policy considerations are aimed towards promoting evidence-based benefit designs; expanding Medicare Advantage organization willingness to adopt the flexible benefits; and enhancing beneficiary involvement, access, and usage of these benefits.

Policy Consideration 1: Develop and Disseminate Evidence on Flexible Benefits

To encourage more Medicare Advantage plans to offer flexible benefits, CMS could conduct definitive and ongoing research on the evidence of how specific benefits and interventions impact Medicare Advantage plans' total costs of care. Based on this research, CMS could provide guidance to Medicare Advantage plans on how to structure flexible benefits and what pricing assumptions to use to ensure that their bids are approved. Further, the research would help Medicare Advantage plans better forecast the costs of these benefits and better assess the risks and opportunities associated with offering them. To inform this research and to ensure that it takes into account the views of all stakeholders, CMS could convene panels of experts and representatives from federal, state, and local agencies as well as beneficiaries and beneficiary advocates to ensure that it is incorporating the full range of data and perspectives.

CMS could also work with a selection of early-adopter Medicare Advantage plans, on a voluntary basis, to collect data on the costs, use, and savings associated with flexible benefits. This voluntary collaborative would help to inform CMS's research and CMS could issue a de-identified public data file for health services researchers.

Concurrently, CMS could convene a learning collaborative with Medicare Advantage organizations, beneficiary advocates, and other stakeholders to generate evidence, share non-competitive best practices, and identify meaningful approaches to the design, implementation, and evaluation of flexible

benefits. Information and best practices gathered could be made available to the public to assist Medicare Advantage plans make decisions about future benefit offerings.

Policy Consideration 2: Simplify the Number of Flexibilities
Congress and CMS could combine the permissions of the four supplemental benefit flexibilities into a single policy that enables plans to offer medical as well as non-medical supplemental benefits, and to target these benefits to certain populations based on clinical and other CMS-approved criteria.

Policy Considerations 3: Improve Communications to Enhance Access and Usage
CMS could update Medicare Advantage communications and marketing guidelines to ensure plans convey information consistently and beneficiaries are aware of and understand the flexible benefits available to them. Information communicated through marketing and educational materials should include criteria for eligibility for the benefit, the scope, duration, and frequency of the benefit, and how to access services. Beneficiaries should be aware of, understand, and assess flexible benefit offerings across Medicare Advantage plans. Information should be consistent across flexibility types and communicated in an accessible format that is appropriate and tailored for the intended audience. As more evidence is developed on specific benefit offerings, CMS could also encourage Medicare Advantage plans to offer standard flexible benefit offerings to enable beneficiaries better understand and compare options.

Policy Considerations 4: Meet the Needs of Beneficiaries Most in Need
Congress and CMS could expand flexible benefit eligibility beyond clinical criteria to ensure that social benefits are accessible to those most in need. For example, Congress and CMS could consider including socioeconomic factors such as income security, food security, housing security, and reliable transportation. CMS could also consider geographic factors to enable MA plans to offer tailored benefits in underserved areas.

Policy Consideration 5: Educate and Train Service Providers
CMS could develop training materials and standard billing processes that Medicare Advantage organizations could use to educate and contract with service providers on Medicare program requirements. Training materials could include information regarding compliance requirements, HIPAA, government audits, and the Medicare Advantage plan year cycle and calendar, among other program requirements. CMS could consider making this training mandatory as they do for other entities that contract with Medicare Advantage organizations.

Policy Consideration 6: Involve Beneficiaries
CMS could increase efforts to ensure that Medicare beneficiaries and specific subpopulations of Medicare beneficiaries inform the future development, design, refinement, and possible expansion of flexible benefits. CMS could survey the needs of Medicare Advantage beneficiaries, with particular focus on individuals with complex health and social needs including those with disabilities, certain chronic conditions, behavioral health needs, as well as those experiencing food, income, and housing insecurity or lack of reliable transportation. CMS could ensure that all research and future policy making explicitly takes into account the perspectives of beneficiaries and their representatives, as described in Policy Consideration #1. Additionally, CMS could consider requiring Medicare Advantage plans that seek to offer flexible benefits to demonstrate that they have undertaken efforts to incorporate the views and preferences of their members, especially those with complex needs.

Policy Consideration 7: Test Provision of Flexible Benefits in Traditional Medicare

CMS, through the Center for Medicare and Medicaid Innovation (CMMI), could develop a payment model to test the availability of flexible benefit offerings on total cost of care and quality for individuals enrolled in Traditional Medicare. Doing so would explore the feasibility of administering a flexible benefits approach in Traditional Medicare and potentially generate evidence to inform such benefits in Traditional Medicare and Medicare Advantage. The program could test the designs of specific interventions, the best ways to deliver particular benefits to eligible beneficiaries, and the specific impact of flexible benefits on quality outcomes and total cost of care. Such payment tests could be developed and administered in partnership with other federal government agencies (e.g., housing assistance through the Department of Housing & Urban Development (HUD), nutrition assistance through the United States Department of Agriculture (USDA)) to test how best to coordinate the eligibility and delivery of benefits offered through other social programs. Such a demonstration should be carefully constructed to test how these benefits may produce overall savings, including comparing model participants to control groups.

Alternatively, CMMI could test the offering of flexible benefits through another existing or proposed demonstration program that applies to the Traditional Medicare population, especially one that places financial risk on participants. For example, CMMI recently announced the Geographic Direct Contracting model, a new payment and care delivery model that seeks to test whether selected risk-bearing entities are able to improve quality and lower costs for Traditional Medicare beneficiaries across a region. Model participants are permitted to provide enhanced benefits such as expanded telehealth services and home visits for care management. CMMI could identify specific flexible benefits and interventions to include in the list of allowable enhanced benefits to test the impact on quality, outcomes, and total cost of care.