



2020 FORUM

Honoring the

Journey

of Growing Older

#AsIGrowOlder

Non-Medical Benefits in Medicare: Creating the Roadmap for Change



- ATI is a DC-based research and advisory services firm changing how businesses, communities, and public programs serve frail older adults.



- LTQA is a 501(c)3 membership organization aimed at improving outcomes and quality of life for persons who are managing functional limitations, and their families through research, education, and advocacy.



Overview

- Overview of New Supplemental Benefits in Medicare Advantage
- The Guiding Principles
- Snapshot of New Supplemental Benefits
- What Comes Next and Why Should We Care?





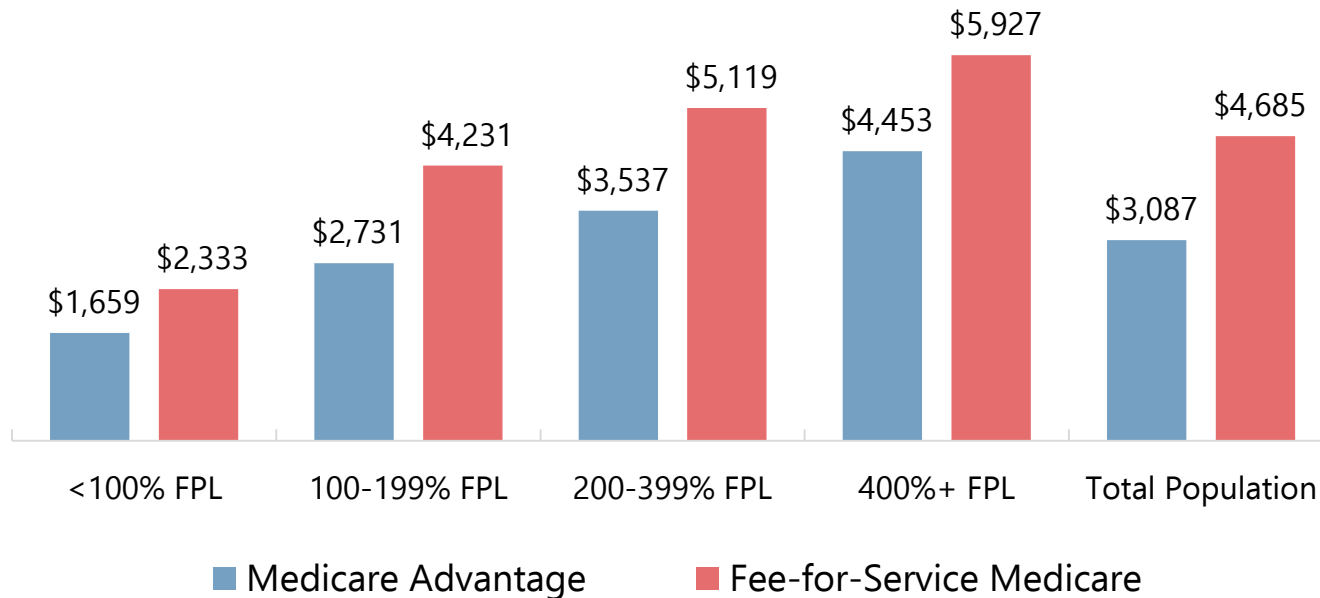
What is Medicare Advantage?

- Medicare Advantage (MA) plans are private health insurance companies that contract with the government to provide hospital and physician services and generally prescription drugs for people who enroll in their plans.



MA Beneficiaries Spend Less on Healthcare

Average Premium and Out-of-Pocket Spending,
by Federal Poverty Level (FPL) in 2017



Medicare Advantage beneficiaries pay less in premiums and out-of-pocket spending than Traditional Fee-for-Service Medicare beneficiaries.

Note: Data exclude assisted living and nursing home residents.

Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.



Beneficiaries Join Medicare Advantage to Save Money and for Additional Benefits

- Medicare Advantage plans cover benefits not found in Traditional Medicare like dental, vision, and hearing exams and aides.
- New rules now allow plans to cover new types of nonmedical benefits.



In 2019, the Centers for Medicare and Medicaid Services Changed What Benefits Can Be Offered

	Old Rules	New Rules
Benefit Uniformity	Plans must offer the same benefits to enrollees of the same plan	Now allowed to target benefits to groups of enrollees who have certain clinical diagnoses
Supplemental Benefits	Supplemental benefits must be primarily health-related, which means, in part, not for the purpose of daily maintenance	Benefits are considered “primarily health-related” under a broader definition of the term



Congress Also Recognized This and Created SSBCI or “Special Supplemental Benefits for the Chronically Ill”

Before this law,

- Medicare could only cover traditional, medical Medicare benefits.
- Everyone within a health plan had to receive the same services.



With this new law,

- SSBCI were created.
- These benefits can be non-medical, tailored to individual need, and can include Social Determinants of Health (SDOH).



Examples of Allowable, New Benefits

New Primarily Health-Related Benefits

Adult Day Care

Home Palliative Care

Therapeutic Massage

In-Home Support

Caregiver Support

SSBCI

Food and Produce

Extended Meals

Pest Control

Transportation

Air Quality Services

Social Needs

Home Modification

Self-Direction Services

Home Modification





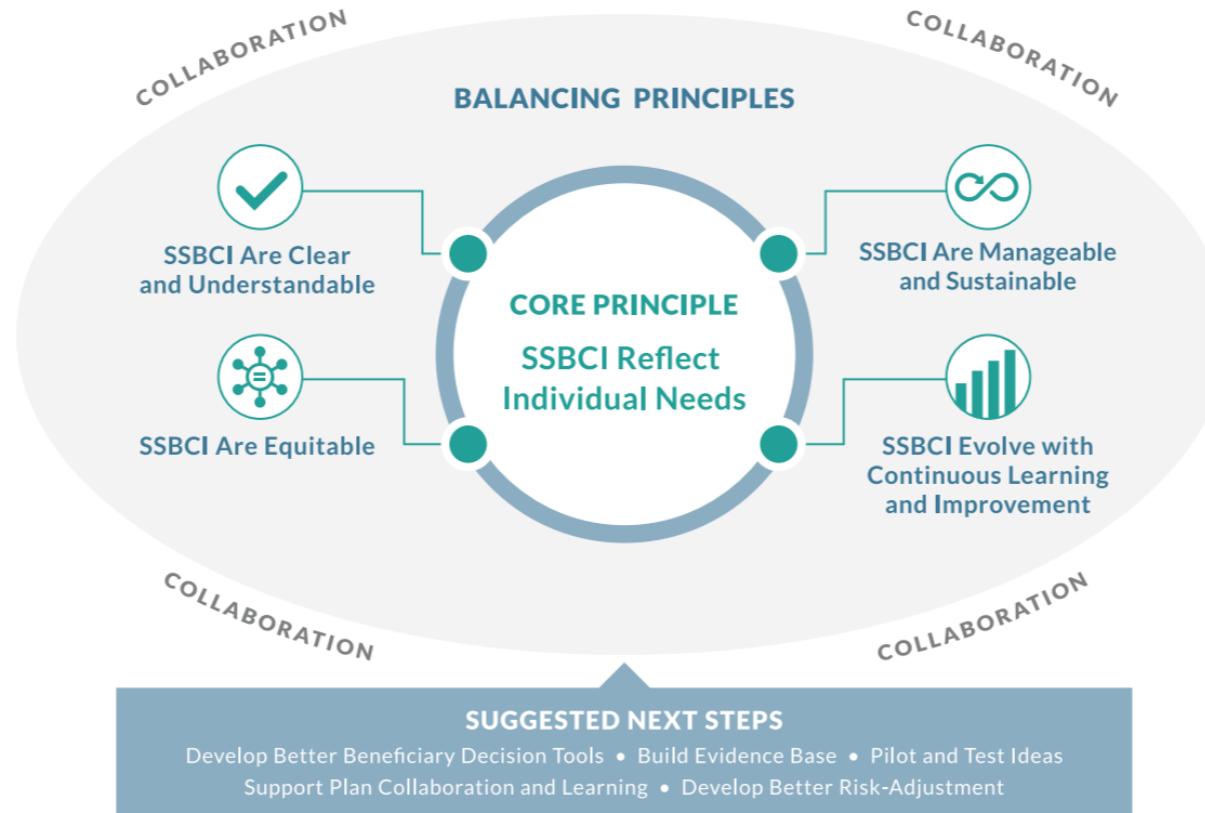
Why Principles?

- SSBCI are at a turning point.
- Non-medical benefits are now covered.
- We need principles that can:
 - Inform regulation development,
 - Inform benefit design, and
 - Form common language.



The Guiding Principles for New Flexibility Under SSBCI

A TURNING POINT IN MEDICARE POLICY:
Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill



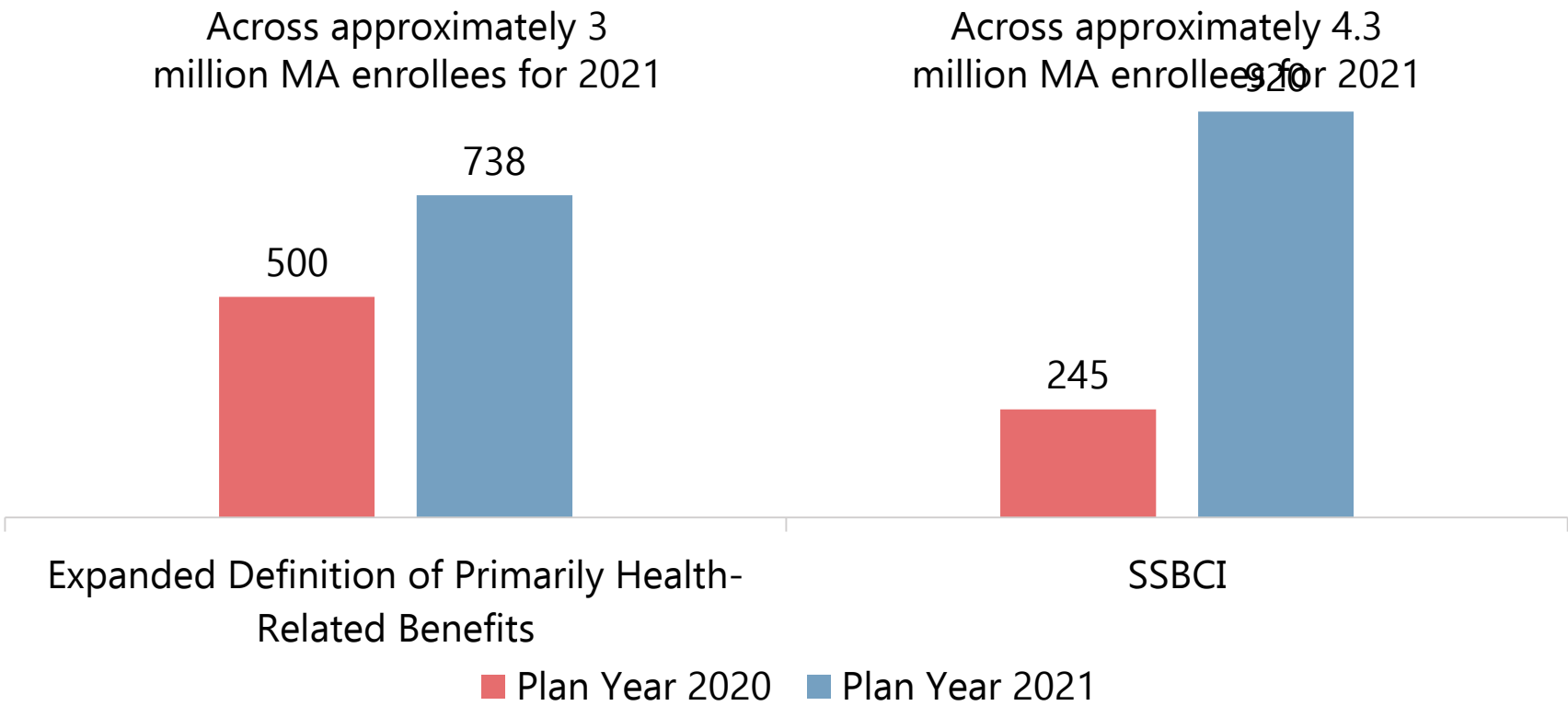
Snapshot of New Benefits

- Where are these benefits available and what plans are offering them?



Preview of Plan Year 2021 Offerings

Number of Plans Offering New Supplemental Benefits



Source: ATI Advisory Analysis of PBP Files and CMS' September 24th Press Release.



Primarily Health-Related Benefits in 2020 and 2021

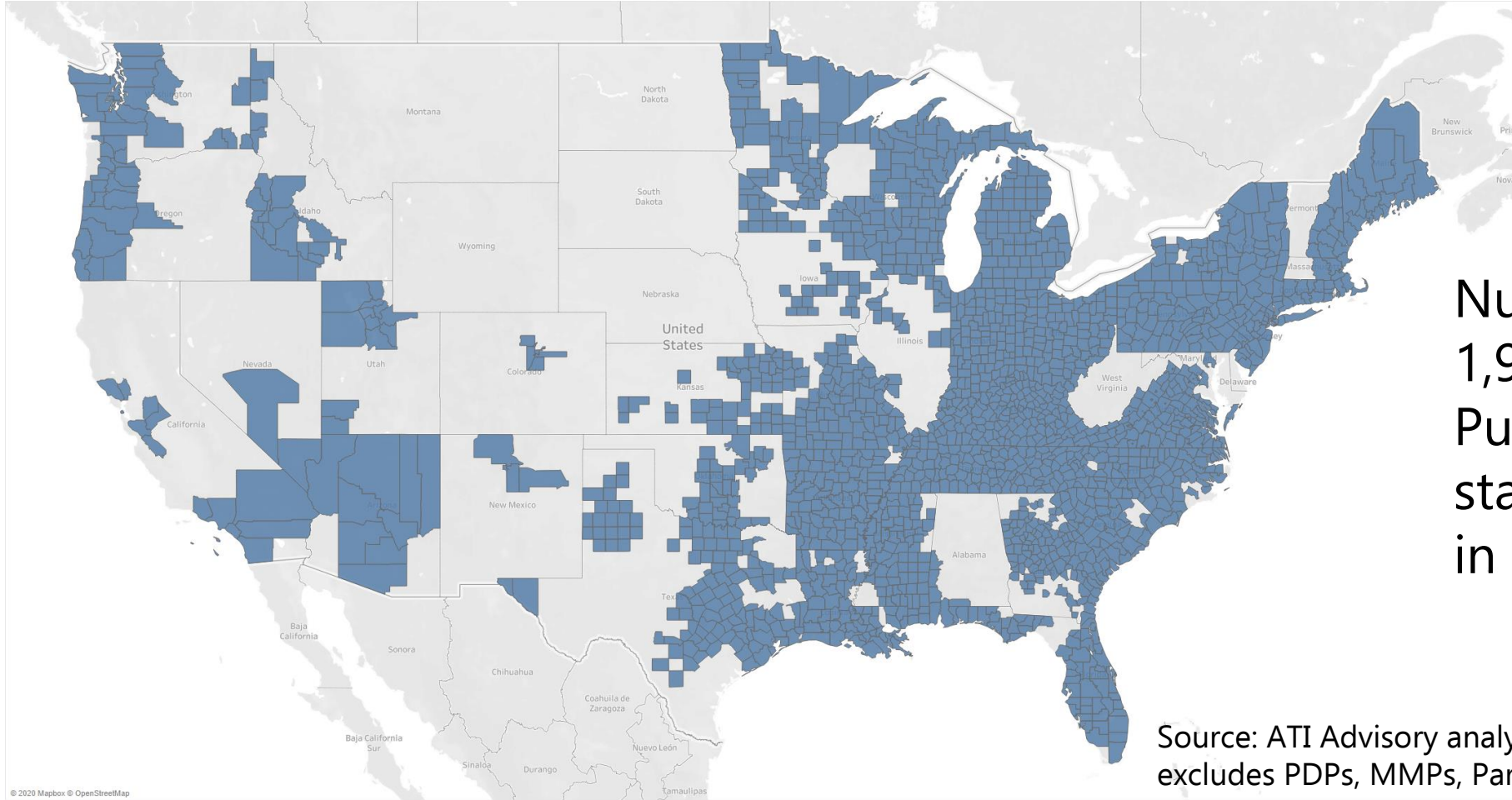
New Primarily Health-Related Benefits

Benefit	Number of Plans Offering in 2020:	Number of Plans Offering in 2021:
In-Home Support Services	223	430
Adult Day Health Services	84	127
Home-Based Palliative Care	61	134
Caregiver Support	125	95
Therapeutic Massage	230	176
Total (offering at least one of above benefits)	499	738

Source: ATI Advisory Analysis of PBP Files and CMS' September Enrollment Data.



Counties with Plans Offering New Primarily Health-Related Supplemental Benefits in 2021



Number of Counties:
1,943 (including
Puerto Rico and
states not displayed
in map)

Source: ATI Advisory analysis of CMS PBP files, includes D-SNPs, excludes PDPs, MMPs, Part B-only plans, and PACE.

SSBCI Availability in 2020

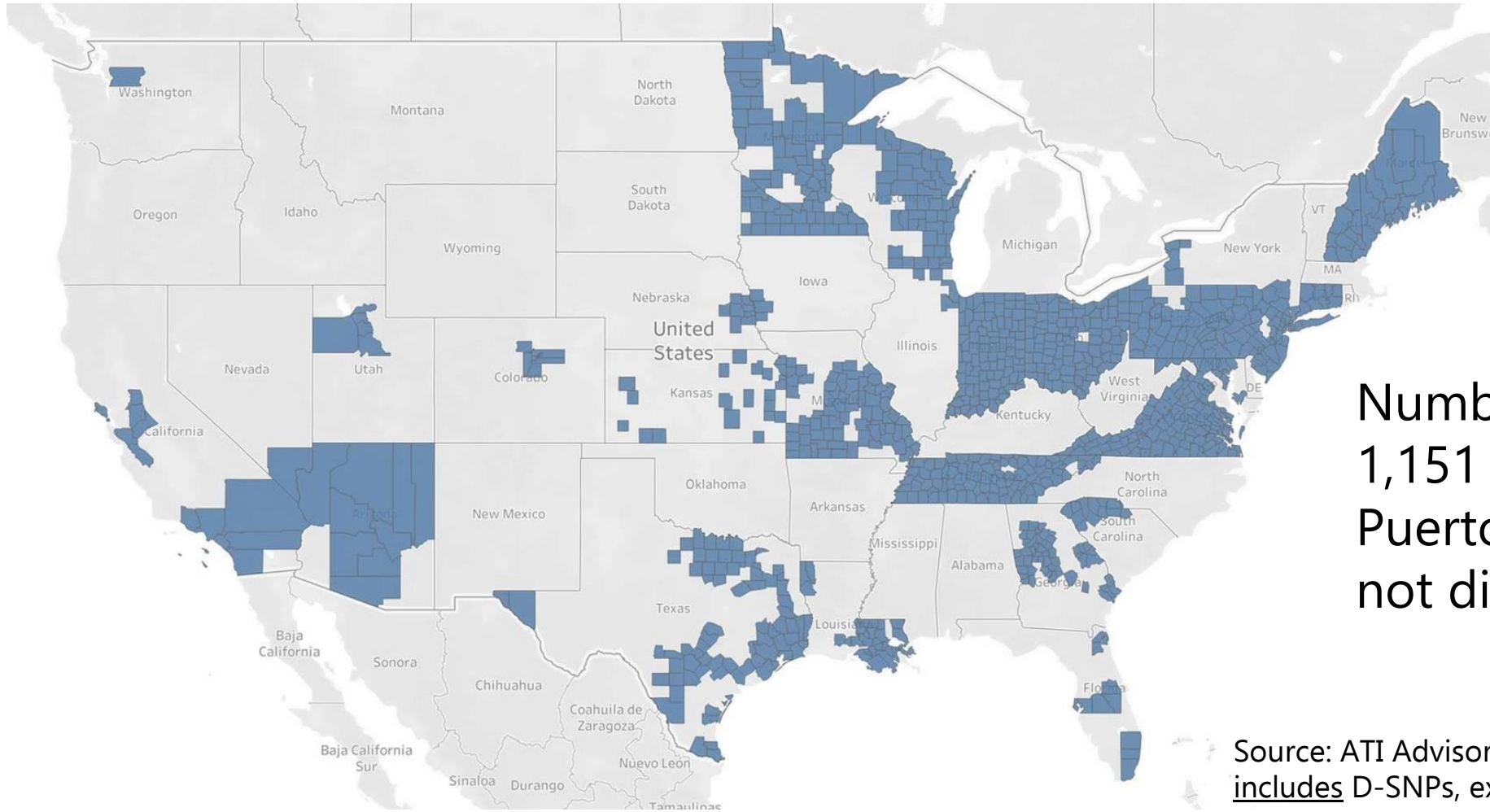
245 plans with 1.2 million
members offer at least one
of these SSBCI

SSBCI	
Benefit	Number of Plans Offering in 2020:
Food and Produce	101
Meals (beyond limited basis)	71
Pest Control	118
Non-Medical Transportation	88
Indoor Air Quality Services	52
Social Needs Benefit	34
Self-Direction Services	20
Structural Home Modifications	44
General Supports for Living	67
Complementary Therapies	1
Other: Service Dog Supports	51

Source: ATI Advisory Analysis of PBP Files and CMS' September Enrollment Data.



Counties With Plans Offering SSBCI in 2020



Number of Counties:
1,151 (including
Puerto Rico and states
not displayed in map)

Source: ATI Advisory analysis of CMS PBP files,
includes D-SNPs, excludes PDPs and PACE.

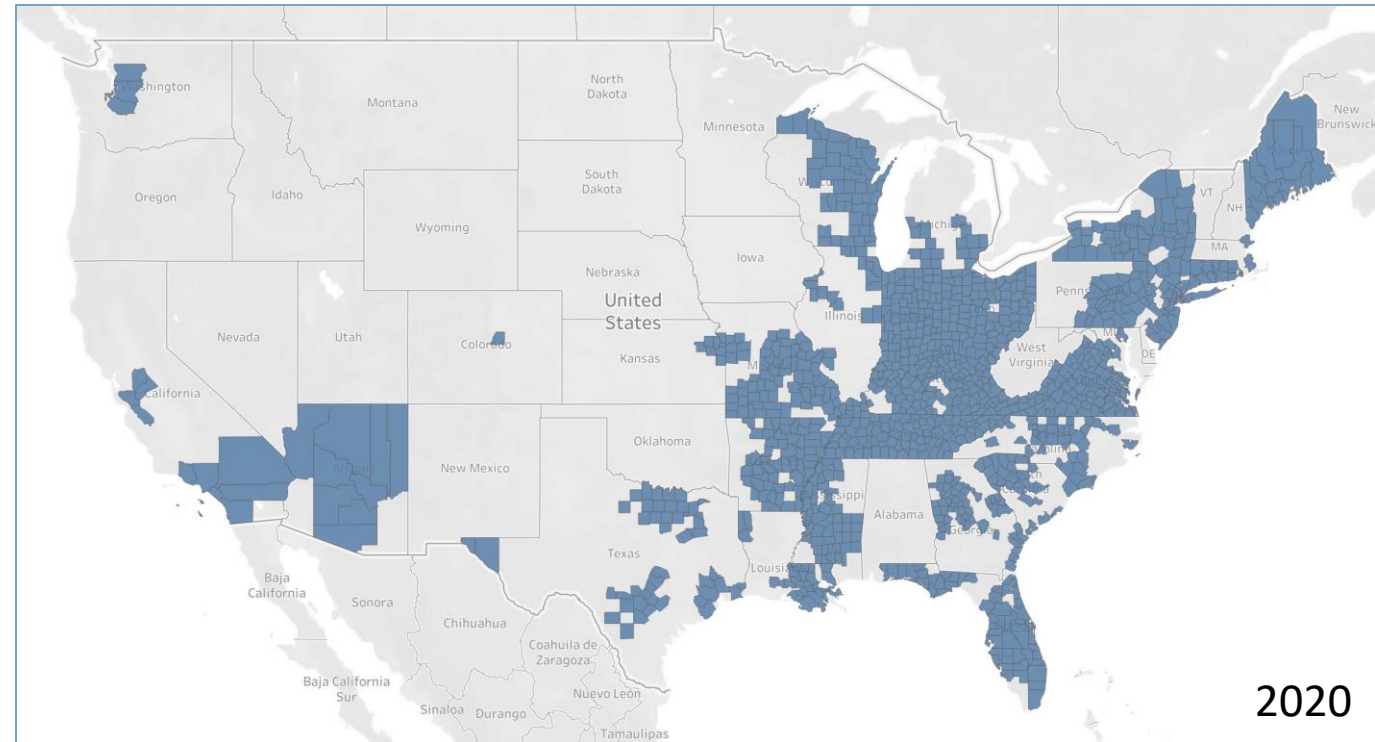


National Overview of In-Home Support Services

In 2020:

- Centene/WellCare own more than one third of the plans offering this benefit.
- A fifth tied to hospital/SNF discharge.
- Of 212 plans with clear service limits:
 - 54% limit services to **24 hours** or less a year or per discharge.
 - 30% allow between **60** to **248 hours** a year. Only **two** plans (1%) offer **248 hours** per year.

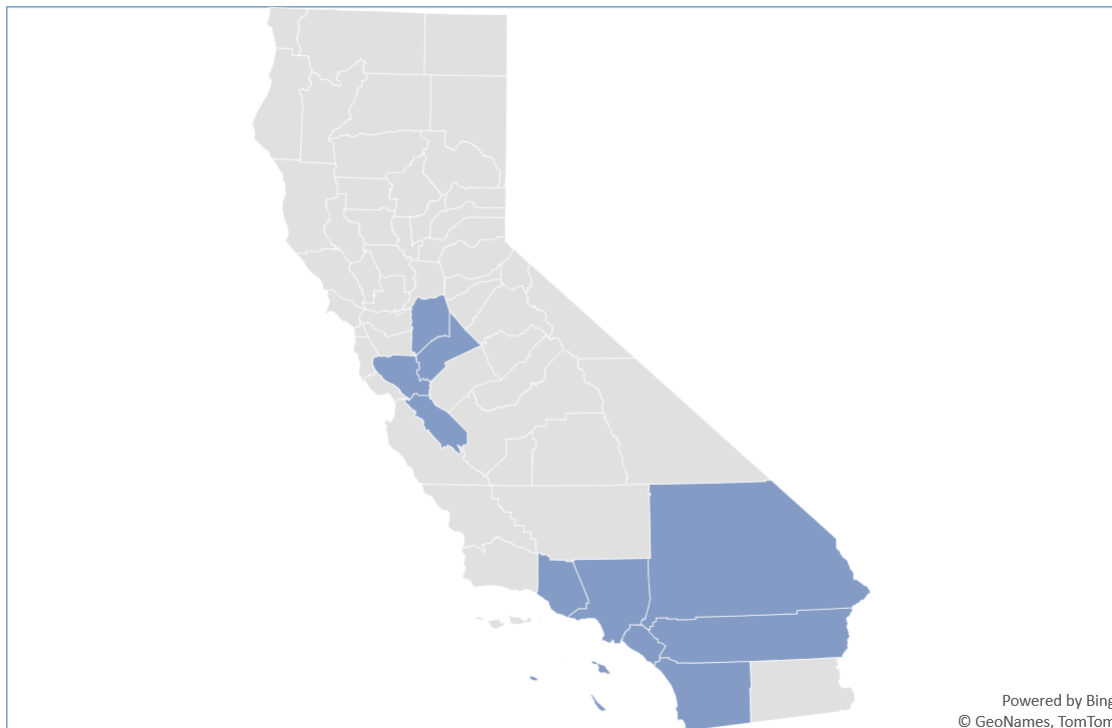
This benefit is available in **223 plans** in **30 states**, covering **1,141,186** lives in 2020. In 2021, it is in **430 plans** in **36 states and PR**.



Source: ATI Advisory Analysis of PBP Files and Plan Evidence of Coverage Documents.

In-Home Support Services in California in 2020

Counties with In-Home Support in CA



- 38 plans – with 115,985 members – offer this benefit in 10 counties.
- This benefit is primarily offered by WellCare and Anthem, as well as one plan by the AIDS Healthcare Foundation.
- These 38 plans either limit services to:
 - **16 or 32 hours** per discharge (82%) or
 - **24 or 32 hours** per year (18%).

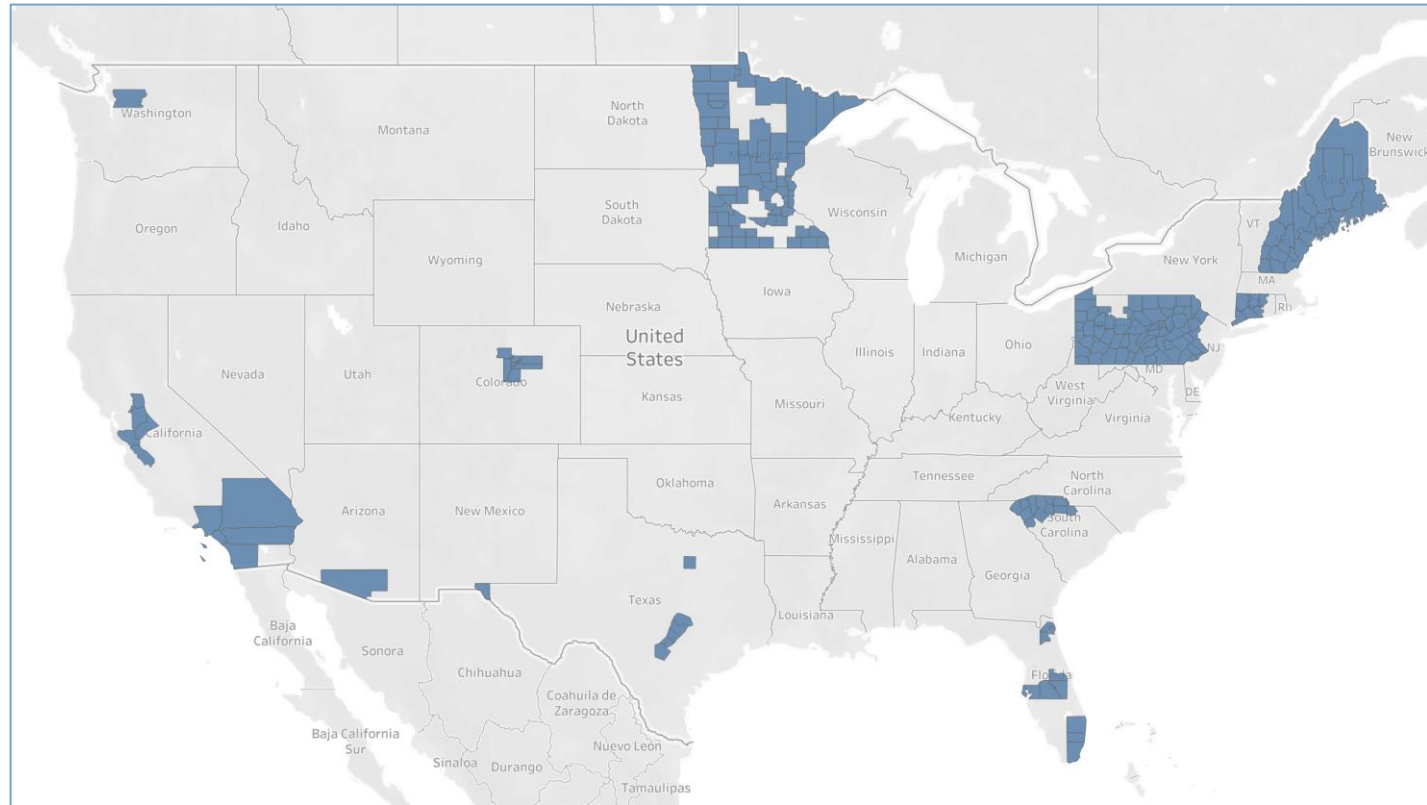
Source: ATI Advisory Analysis of PBP Files and Plan Evidence of Coverage Documents.



National Overview of Extended Meals Benefit (SSBCI) in 2020

This benefit is available in **71 plans** across **12 states**, covering **291,515** Medicare lives.

- Anthem owns 64% of plans offering this benefit. These plans allow a max of **180 meals** over 90 days.
- 2 plans (3%) allow 2 meals per day over 14 weeks for a total of **168 meals** a year. 7 plans (10%) allow 20 meals per month for a total of **240 meals** a year.
- Other plans (22%) only permit up to **20 meals** per year.

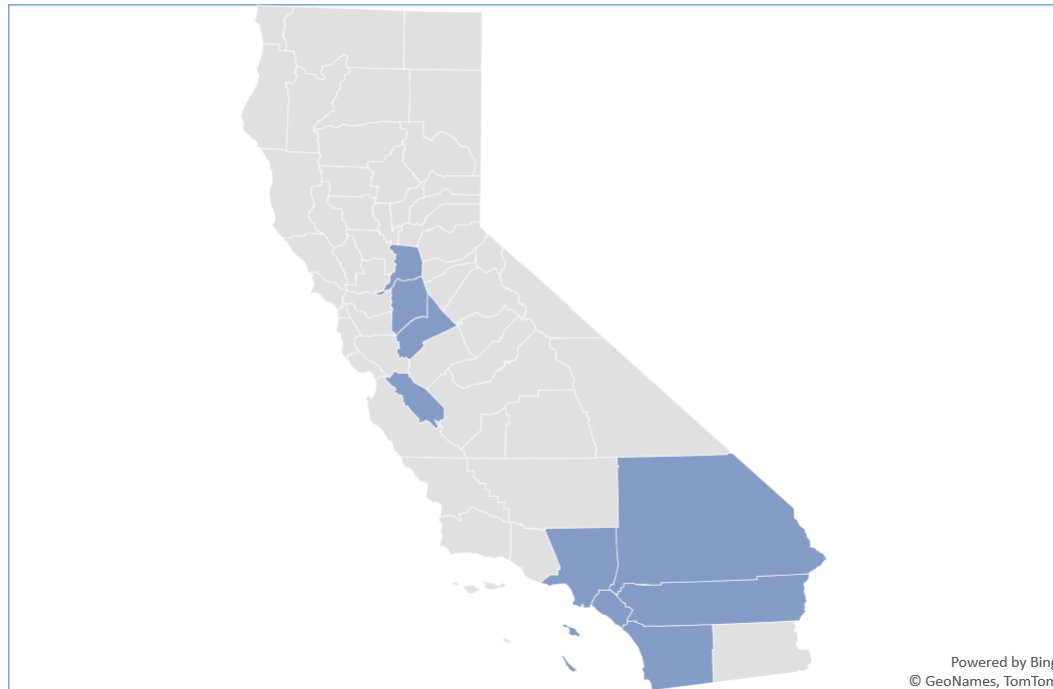


Source: ATI Advisory Analysis of PBP Files and Plan Evidence of Coverage Documents.



Extended Meals(SSBCI) in California in 2020

Counties with a Meals Benefit in CA



- In California, 32 plans – with 80,481 members – offer this benefit in 10 counties.
- In California, this benefit is offered exclusively by Anthem plans.
- This benefit is limited to 2 meals per day for up to 90 consecutive days, for a total of **180 meals**.
- Member must meet clinical criteria to qualify.

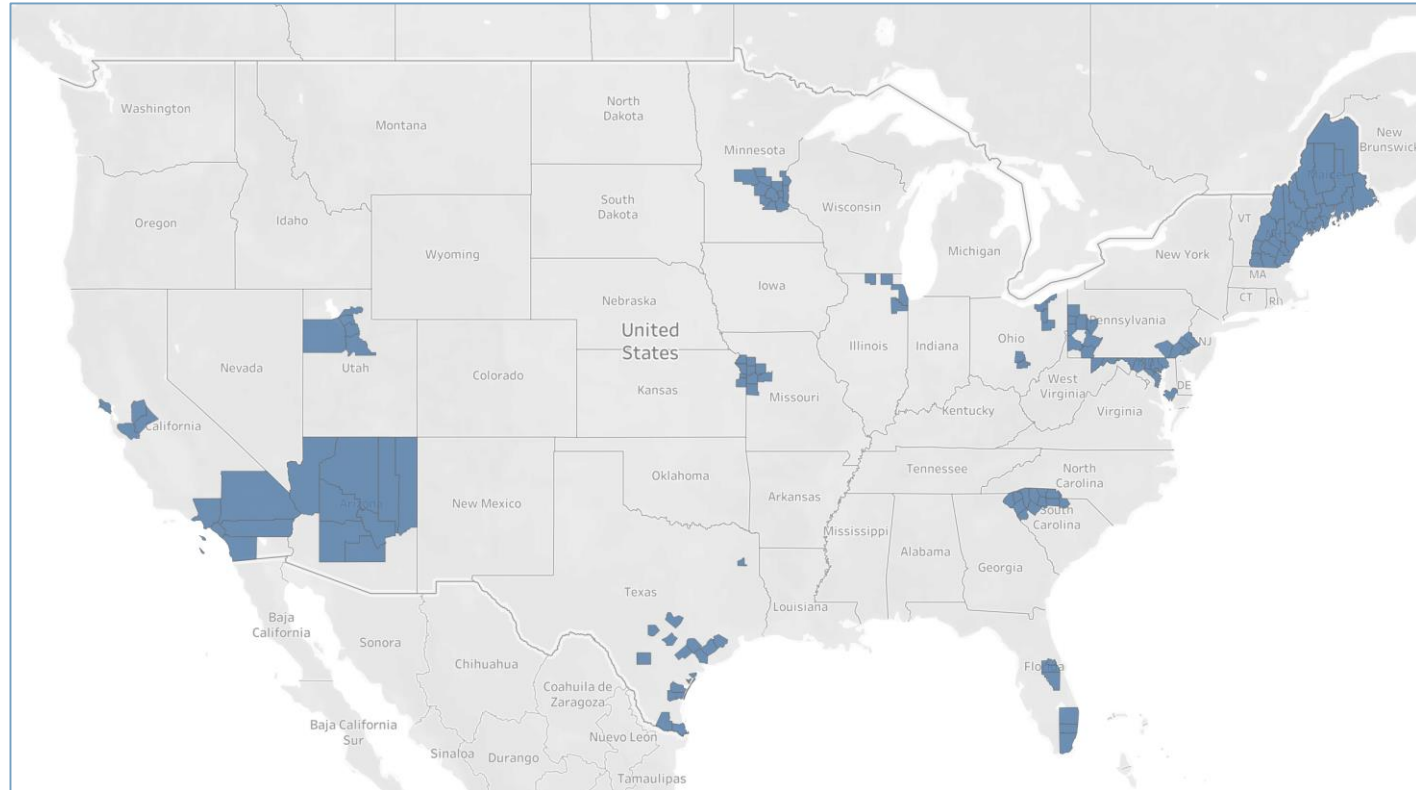
Source: ATI Advisory Analysis of PBP Files and Plan Evidence of Coverage Documents.



National Overview of Social Needs Benefit (SSBCI) in 2020

This benefit is available in **34 plans** across **15 states**, covering **159,361** Medicare lives.

- Offered by Aetna, Alignment, BCBS, Health Partners, Martin's Point, Provider Partners, Steward Health, and Texas Independence.
- One fifth of the plans partner with providers like Papa Pals or Solera Health to offer this benefit.
- 20 plans impose hourly limits. Two-thirds limit services to **48 hours** per year and one third allow up to **120 hours** per year.

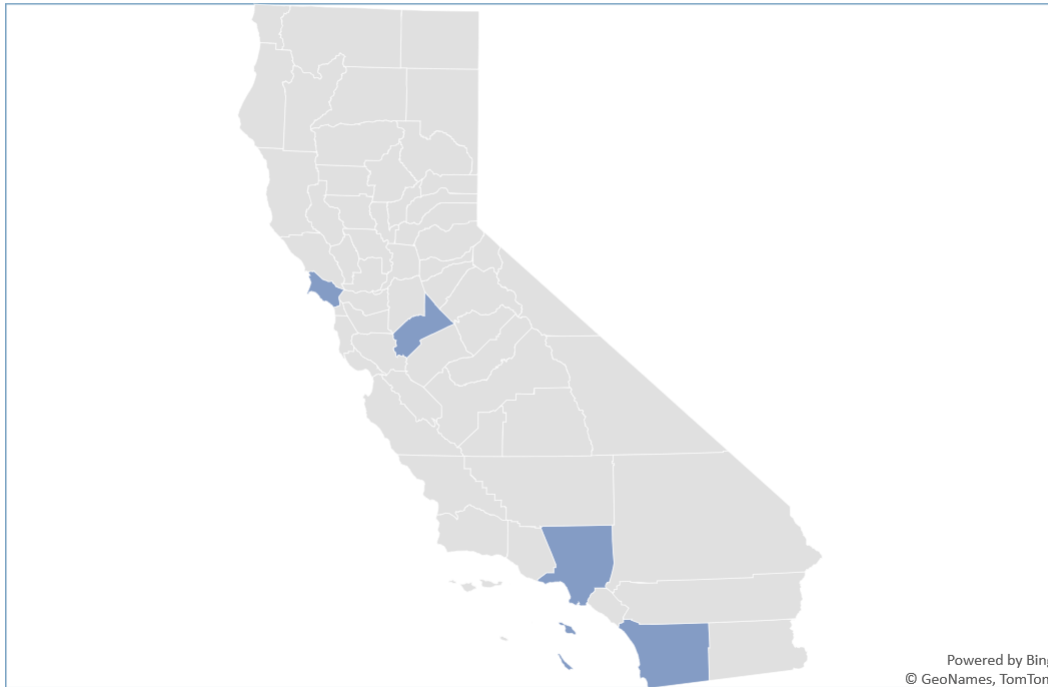


Source: ATI Advisory Analysis of PBP Files and Plan Evidence of Coverage Documents.



Social Needs Benefit (SSBCI) in California in 2020

Counties with a Social Needs Benefit in CA



- In California, 6 plans – with 35,946 members – offer this benefit in 9 counties.
- In California, this benefit is offered exclusively by Alignment Health Plan.
- Beneficiaries are eligible for up to 12 hours of companionship a quarter, for a total of **48 hours** per year.

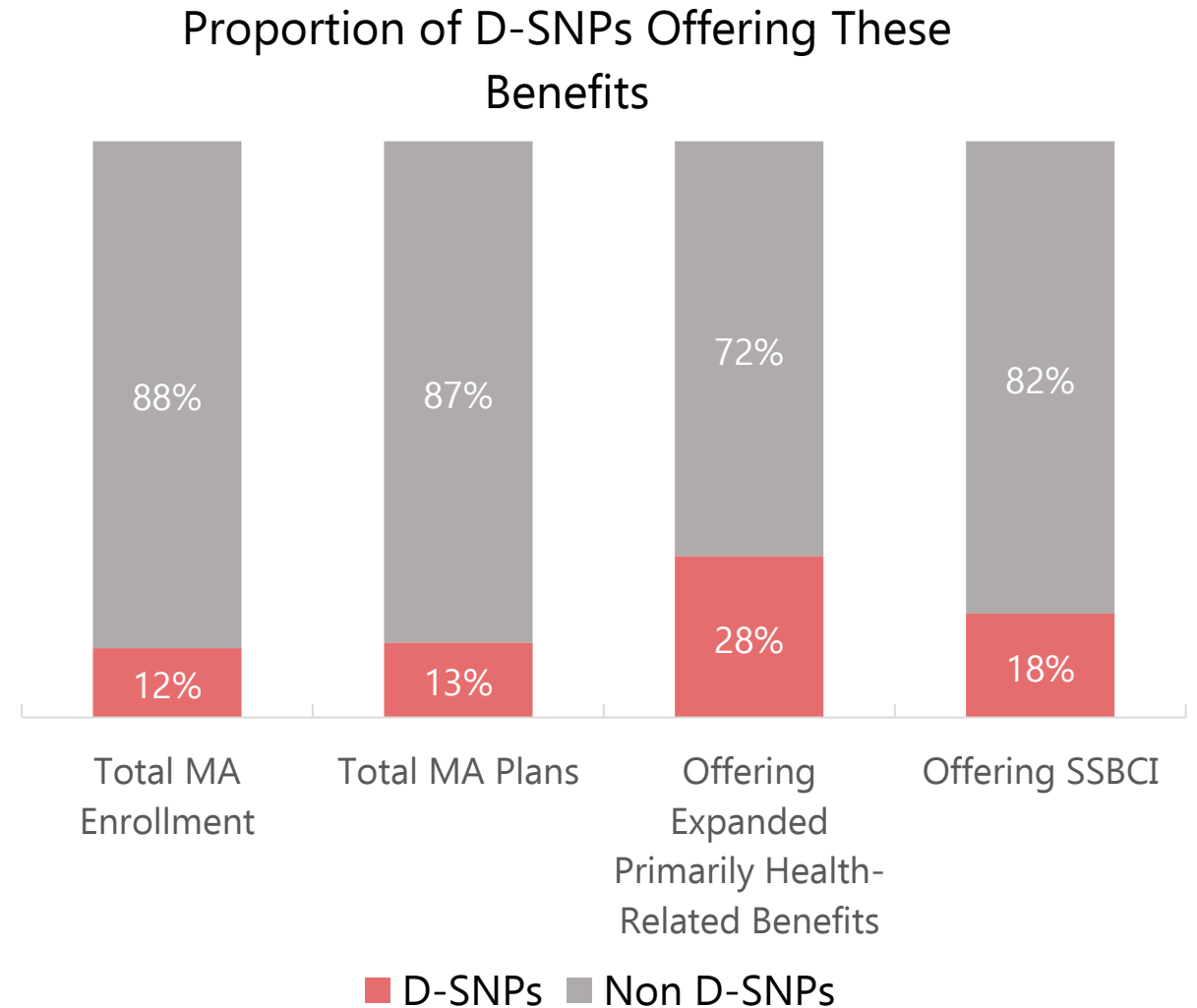
Source: ATI Advisory Analysis of PBP Files and Plan Evidence of Coverage Documents.



D-SNPs Are Offering These Benefits at a High Rate, Allowing Partnership Opportunities

States should collaborate with D-SNPs (special needs plans for individuals dually eligible for Medicare & Medicaid) to provide these benefits and supplement – not supplant – what is available in Medicaid.

Note: Analysis excludes Employer Plans, Prescription Drug Plans, and PACE.
Source: ATI Advisory Analysis of PBP Files and CMS' September Enrollment Data.



What Else Do We Know About These New Benefits?

How is Early Implementation Going?

It is early; we are learning.

- Insurance plans are often testing new benefits in smaller plans or limited markets, often through D-SNPs.

There are challenges.

- Defining benefits;
- Convincing plans to invest in these services (competing for limited dollars);
- Targeting the benefit to those eligible and likely to benefit;
- Building a network and contracting for “non-traditional” service providers;
- Getting the word out; and
- Building the evidence base.

There is hope.

- Many plans see value in services to address SDOH.
- The number of plans offering benefits is growing.
- Solutions are popping up (e.g., aggregators, back-office solutions, and technology vendors).



There Are Opportunities for Prepared CBOs and Other Local Providers

- **Our research has uncovered success factors for providers including:**
 - ✓ Plan relationships;
 - ✓ Clear definitions of benefit/service;
 - ✓ Administrative capability;
 - ✓ Technology-enabled data collection and reporting;
 - ✓ A price plans can afford;
 - ✓ **AND** the more geography you can cover, the better.
- In addition, partners and aggregators can help (examples include organizations like the Partners in Care Foundation).

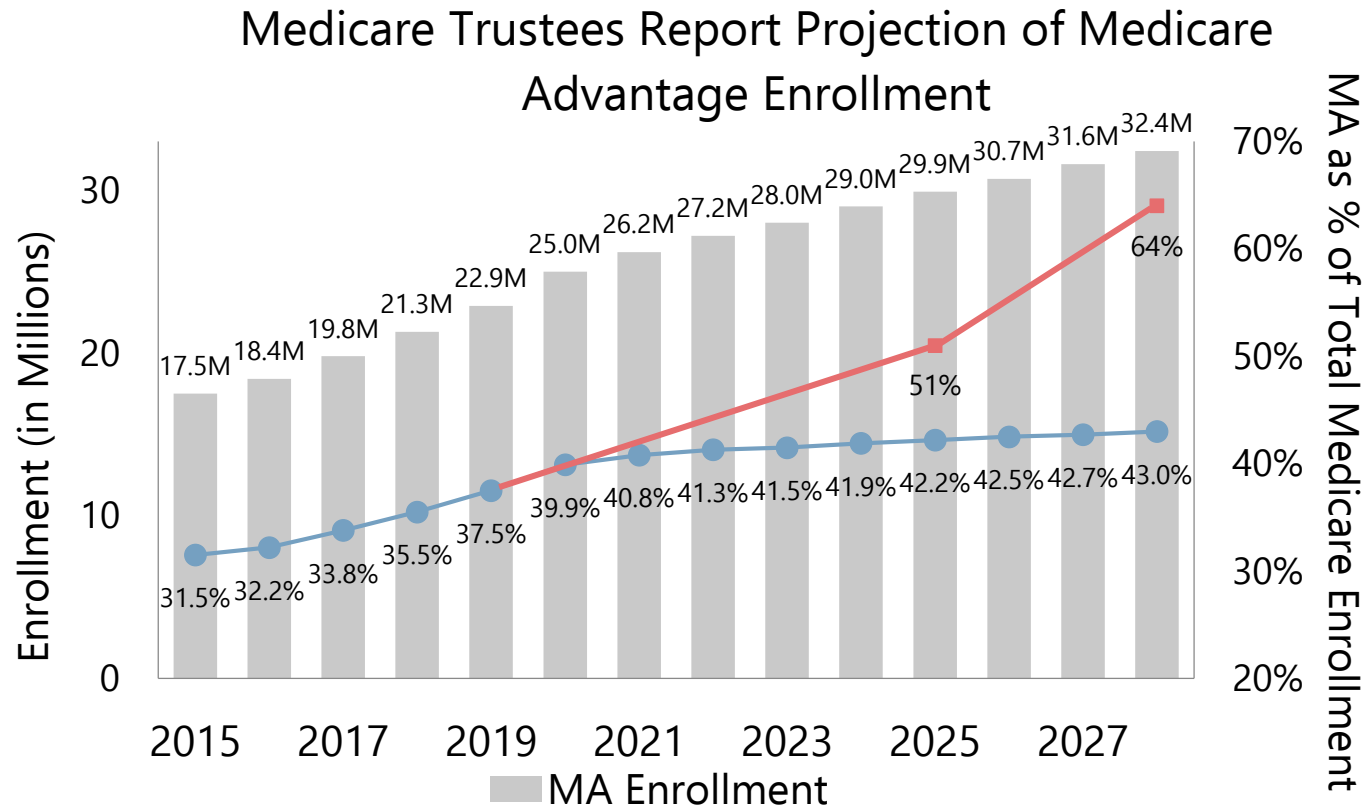


What Comes Next and Why Should We Care?

- What is the opportunity and future of these new supplemental benefits?



Medicare Advantage Enrollment Is Growing Rapidly



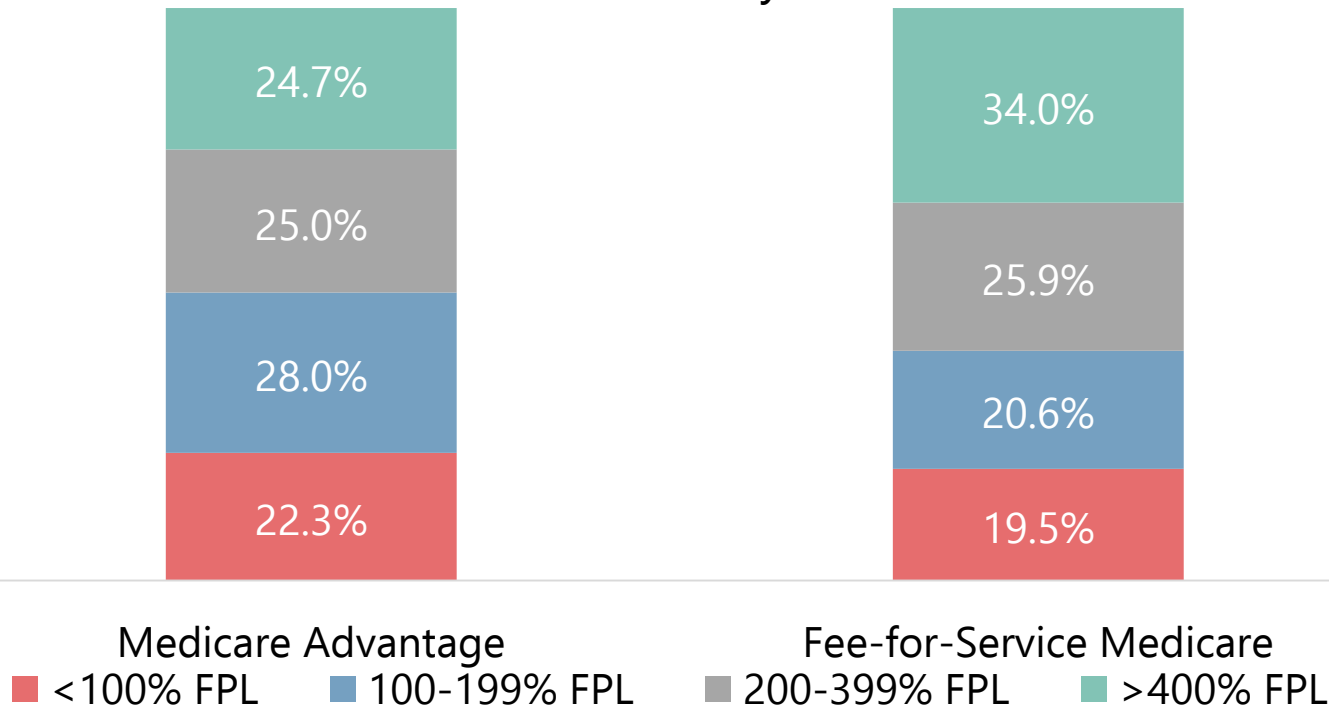
There has been steady growth of Medicare Advantage since 2015, and projections from Avalere Health and the Medicare Trustees show continued growth.

Source: Medicare Trustees Report and Avalere Health.



A Higher Proportion of Medicare Advantage Enrollees Live Below 200% of FPL

Percentage of Medicare Beneficiaries by Income as a Percent of Federal Poverty Level in 2017



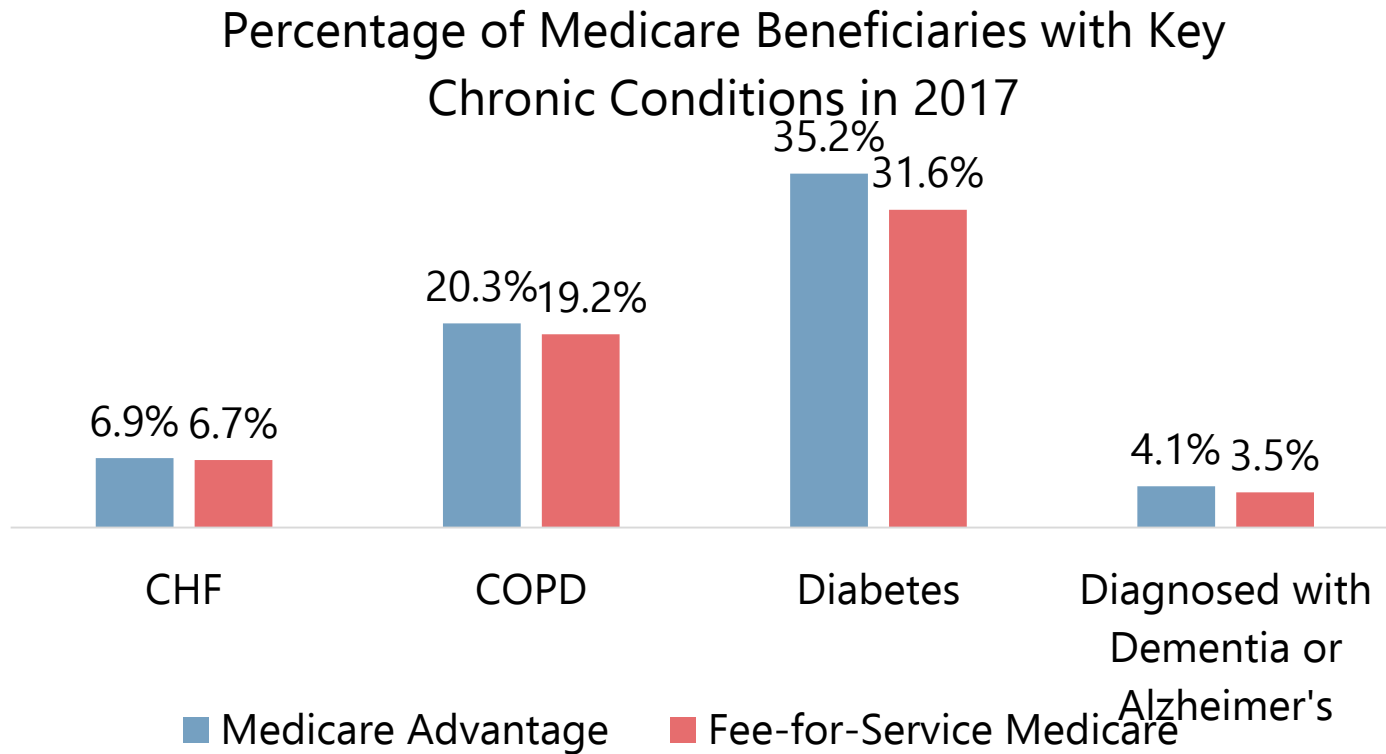
The chart to the left shows the proportion of beneficiaries in Medicare Advantage and Fee-for-Service Medicare who live in poverty. A greater percentage, 50.3%, of MA beneficiaries live below 200% of the Federal Poverty Line compared to 40.1% of Traditional Medicare.

Note: Data exclude assisted living and nursing home residents.

Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.



The Medicare Advantage Population Is As Complex as the Fee-for-Service Population



The average number of chronic conditions is higher in Medicare Advantage (2.81) than Fee-for-Service (2.73).

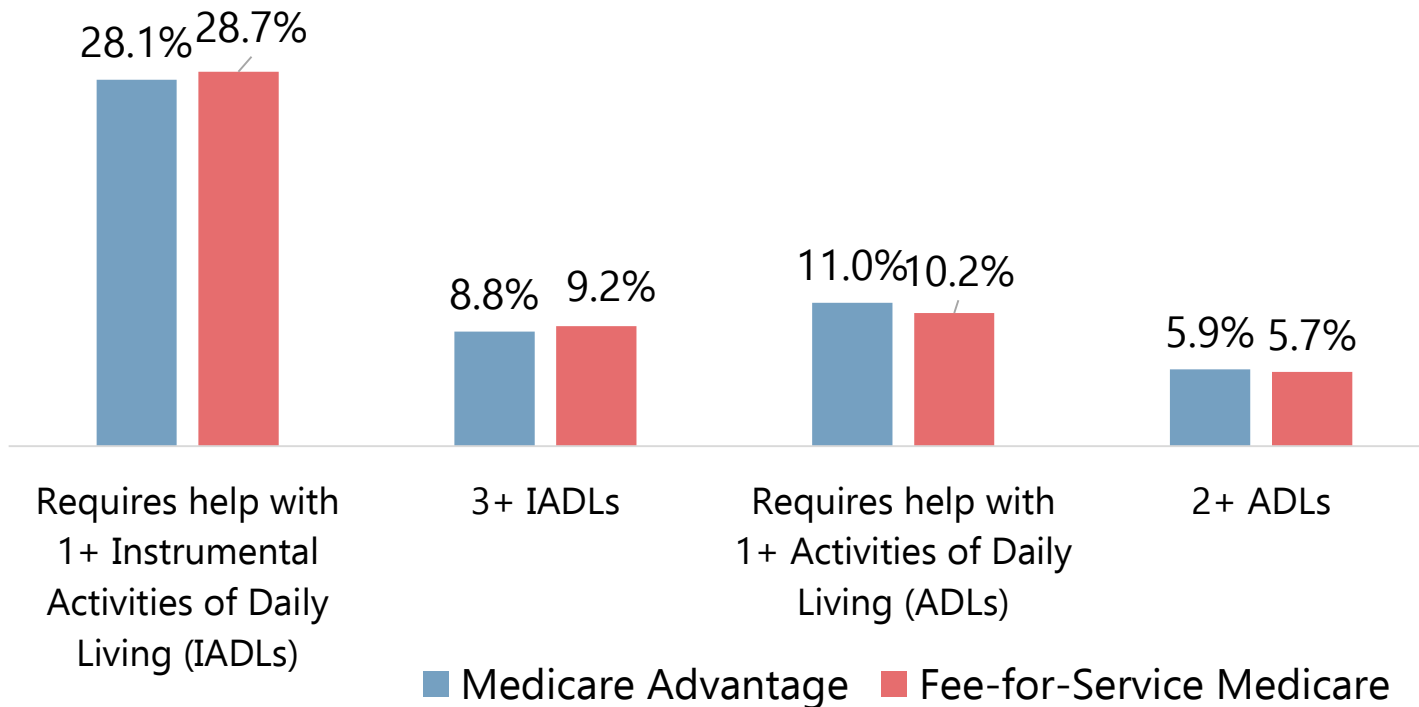
The chart to the left shows the percentage of beneficiaries from both programs who have CHF, COPD, Diabetes, or Dementia or Alzheimer's.

Note: Data exclude assisted living and nursing home residents.
Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.



Medicare Advantage Also Has Similar Levels of Functional Need

Percentage of Medicare Beneficiaries by Impairment Level in 2017



The chart to the left shows the percentage of beneficiaries from both programs who require help with Activities of Daily Living (e.g., walking, bathing, eating) or Instrumental Activities of Daily Living (e.g., cooking, shopping, cleaning).

Note: Data exclude assisted living and nursing home residents.

Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.



Certain Non-Medical Interventions Can Reduce Healthcare Costs and/or Result in Better Outcomes

Studies have found that:

- introduction of a medically-tailored **meals program** reduced ER visits and costly health care spending for dual-eligible adults.¹
- investments in **transportation** are cost-effective; decrease health care costs, particularly for chronic conditions; and improve overall quality of life.²
- individuals with strong **social bonds** are 50 percent less likely to die over a given period compared to those with fewer social connections.³

But wide-spread testing and implementation of these and many other non-medical benefits have not happened in Medicare. There is an opportunity to test non-medical benefits in MA.

Source(s): 1. Health Affairs, <https://doi.org/10.1377/hlthaff.2017.0999>. 2. National Academies, <https://doi.org/10.17226/22055>. 3. PLOS, <https://doi.org/10.1371/journal.pmed.1000316>



Plans Are Starting To Recognize the Value of Non-Medical Services in Managing Healthcare

Medical Services



Inpatient services



Outpatient clinics and physician offices



Skilled nursing facility



Home health care

Non-Medical Services



Transportation



In-Home Support Services



Social Supports



Meals and Food & Nutrition

Many of these non-medical services help people stay safe in their homes.

Source: ATI Advisory.



The New Normal for Healthcare

There is no “back to normal” for the foreseeable future.

We will be living and operating in a non-zero risk environment.



Traditional healthcare delivery turned on its head (e.g., remote patient monitoring, virtual visits)



Helping people stay at home is now an important healthcare activity (i.e., part of the “delivery” system)



Flexibility in healthcare financing is critical. Even more important in a post-COVID environment



What Comes Next? Offerings Growing Dramatically from 2020 to 2021

Big questions remain that will affect the realization of these benefits' potential and the implementation of the Guiding Principles:

- What goals will plans seek to advance and how will that affect offerings?
- Role of CBOs and other local providers?
- Will Plans/Providers share learnings?
- Can members access?
- What actions will policymakers take?



Resources

- [Guiding Principles](#) for New Flexibility Under Special Supplemental Benefits for the Chronically Ill
- [Meeting Medicare Beneficiary Needs](#) During COVID-19
- [Overview](#) of SSBCI and New Primarily Health-Related Benefits in Calendar Year 2020

ATI Advisory and LTQA, with support from The SCAN Foundation, will be publishing a paper on early plan and provider experiences with these benefits and approaches to overcome implementation challenges. **Look for the product of this work in November 2020!**



Thank You!



www.TheSCANFoundation.org