

ATI Advisory



# An Evaluation Framework for Assessing Nonmedical Supplemental Benefits in Medicare Advantage

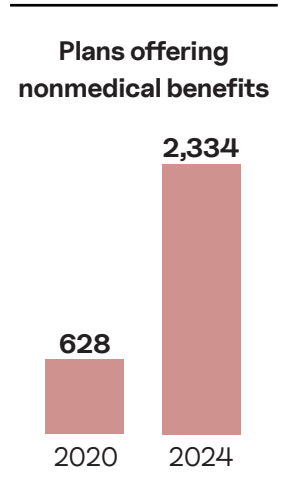
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# Context and Background

Congress and the Centers for Medicare and Medicaid Services (CMS) have made significant changes to supplemental benefit authorities, allowing Medicare Advantage (MA) plans to support nonmedical and health-related social needs (HRSNs) of Medicare beneficiaries with benefits like in-home support services, food, and transportation. These nonmedical benefits represent a departure from the long-standing history in Medicare in which the program has only addressed primarily health-related needs. In permitting these new benefits and expanding existing authorities, Congress and CMS recognized the potential value that nonmedical services would provide to individuals with complex chronic conditions and HRSNs.<sup>1</sup>

The SCAN Foundation has supported ATI Advisory (ATI) and Long-Term Quality Alliance (LTQA) to research these benefits since their implementation. Over time, these benefits have come to play an increasing role in the MA program. The number of plans offering nonmedical benefits has grown from 628 in 2020 to 2,334 in 2024.<sup>2,3</sup> Meanwhile, the Medicare Payment Advisory Commission (MedPAC) estimated plan spending on supplemental benefits (including more traditional benefits like dental, vision, and hearing) of \$50 per member per month in 2023, totaling an estimated \$18 billion in annual federal spending.<sup>4</sup> These benefits are only available in MA, not in Traditional Medicare. Given the increasing adoption of these benefits, and the taxpayer dollars supporting them, there is a need to better understand the reach, value, and impact these benefits have on the health and wellbeing of MA enrollees.



1 According to ATI analyses of the 2017 through 2020 Medicare Current Beneficiary Survey, 15% of the overall Medicare population report difficulty with 2 or more activities of daily living (ADLs), with 35% of this population reporting food insecurity and 31% living alone.

2 ATI Advisory, "Nonmedical Supplemental Benefits in Medicare Advantage in 2024." <https://atiadvisory.com/resources/wp-content/uploads/2024/01/PY2024-Nonmedical-Supplemental-Benefits-Chartbook-ATI-Advisory.pdf>

3 The authorities included in our research include CMS's expansion of the definition of "primarily health-related benefits" (PHRB); "uniformity flexibility" (UF) that allowed for more tailored supplemental benefits for "similarly situated individuals"; Special Supplemental Benefits for the Chronically Ill (SSBCI), which allowed plans to individually target nonmedical benefits to chronically ill enrollees; and the Center for Medicare and Medicaid Innovation's (CMMI) Value-Based Insurance Design (VBID) model which allowed plans to target benefits based on condition or income. **Appendix A** provides additional details on the authorities used to offer these benefits and examples of the benefits.

4 The total of \$18 billion in spending was estimated using the MedPAC estimate of \$50 per member per month spent on Parts A and B supplemental benefits, multiplied by 2023 MA enrollment (30 million), times 12 months to produce an annual figure. [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf)



# Research Findings and Gaps on the Evolving Landscape of Nonmedical Benefits

Our research over the last five years has culminated in published analyses of benefit offerings and insights on plan and provider practices based on data analysis, desktop research, and over one hundred interviews with plans, providers, policymakers, beneficiary advocates, and researchers. However, half a decade into the implementation of nonmedical supplemental benefits, we still have little data on benefit access and utilization, how well benefits are supporting MA enrollees' needs, and the extent to which these benefits are leading to the desired outcomes for MA enrollees and the Medicare program. While plans may have internal data on utilization, this data is generally not available publicly and does not answer questions of whether these benefits are leading to the desired outcomes of improved health or wellbeing.

The flexibility inherent in these newer benefit authorities results in a complex and evolving landscape as plans alter benefit structure, eligibility, and generosity to appeal to beneficiary interest and need. Changes in benefit type and structure can further complicate data collection and evaluation efforts (see the call-out box on this page). It is difficult for reporting infrastructure to evolve at the pace of benefit design.

In the absence of data, we cannot make definitive statements about benefit reach, equity in access, utilization, and value. This is leading to an increasing divide. Some stakeholders express skepticism, believing supplemental benefits are primarily a tool for plans to enroll members versus a pathway for meaningful supports to maintain or improve health. These stakeholders may view supplemental benefits as a distraction to meaningfully supporting HRSNs in Medicare. Other stakeholders see these benefits as a panacea to addressing the HRSNs of Medicare beneficiaries.

Given this divide, the risk of doing nothing is significant. Scrutiny of the MA program overall has increased, from

## Reduction in Direct Provision of Benefits, Increased Adoption of Flex Cards, and Benefit Reporting Implications

One example of the changing landscape of nonmedical benefits is the shift from direct provision of services – things like meal delivery or transportation programs – to the use of flex cards, particularly in plans specifically designed for individuals dually eligible for Medicare and Medicaid – Dual-Eligible Special Needs Plans (D-SNPs). These cards tend to include a dollar or credit amount, are able to be used across a menu of benefit categories and are spent at the discretion of the beneficiary.

This benefit evolution, and these cards in particular, raise important questions about the nature and design of Medicare benefits and how they support health and wellbeing:

- Does this benefit construct allow beneficiaries to identify their most pressing health-related social needs and address them, resulting in better health and ability to live in the community?
- Are these cards resulting in individuals switching plans more frequently, with an impact on access to and continuity of care providers?
- How do beneficiaries use and value these cards?

The use of benefit cards requires additional data and research to advance understanding about use, value – especially to the beneficiary – and impact.

The use of cards also creates another layer of complexity from a reporting and evaluation standpoint, as they can be used across multiple benefit categories and reporting capabilities on spending varies significantly across plan and vendor.

Congress, the Administration, and the general public.<sup>5</sup> These benefits represent an easy target for those interested in reining in MA – a newer part of the program, less focused on “healthcare,” with significant spending, and limited data on how they are being used and their impact.

Without information on the costs and impacts of these benefits, policymakers could scale back supplemental benefit authority and reduce the flexibility for MA plans to support the HRSNs of Medicare beneficiaries. Alternatively, they could assume that they have taken the action necessary to support beneficiaries with complex care needs when further policy change and investments may be needed. Both outcomes are counter to policymakers’ intent for these benefits.

Government agencies and policymakers are taking initial actions to collect additional information on supplemental benefits. A recent Government Accountability Office (GAO) report highlighted the lack of data on beneficiary eligibility, access, and utilization of nonmedical supplemental benefits.<sup>6</sup> This report recommended that CMS require MA plans to submit encounter data and reduce confusion around reporting requirements by ensuring there are new procedure codes or a new data submission format to report utilization of supplemental benefits.

While not directly aligned with GAO recommendations, CMS is taking several actions to increase data collection.<sup>7</sup> CMS is collecting data as part of Medical Loss Ratio (MLR) reporting from MA plans on the dollar amounts for the claims incurred for MA supplemental benefits, split between Special Supplemental Benefits for the Chronically Ill (SSBCI) and all other primarily health-related benefits.<sup>8</sup> CMS is also collecting increasingly granular data under the Value-Based Insurance Design (VBID) model, with aggregate utilization and spending data collected alongside individual-level utilization data for select benefit categories. Finally, CMS finalized a requirement (first publicized via a Paperwork Reduction Act (PRA) notice) for data reporting from plans on utilization and cost by individual benefit in the Plan Year (PY) 2024 Part C Technical Specifications.

In the contract year (CY) 2025 Medicare Advantage and Part D proposed rule, CMS recently proposed additional requirements for plans to provide a mid-year notification to enrollees letting them know about benefits that they had not yet used but were eligible for. This proposed rule also included a requirement for plans to develop a bibliography of evidence supporting the effectiveness of benefits offered using SSBCI authority. In early 2024, CMS also released a [request for information](#) (RFI) asking for data on Medicare Advantage broadly, with a specific request for cost and utilization data on benefits.



A bill introduced by Senators Warner and Blackburn would require Senators Warner and Blackburn require plans to report to CMS on enrollee-level utilization and cost of supplemental benefits, and for CMS to make that data publicly available.

5 See recent coverage of scrutiny of MA from [Congress](#), [the Administration](#), and [general media](#).

6 US GAO. “Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization.” (January 2023). <https://www.gao.gov/products/gao-23-105527>

7 See **Appendix B** for more details on each of these data collection efforts.

8 The medical loss ratio (MLR) measures the percentage of revenue that plans spend on patient care (rather than administrative expenses or profit).



We have also seen legislators engage in this issue, most recently with a proposal from Senators Warner and Blackburn to require plans to report to CMS on enrollee-level utilization and cost of supplemental benefits, and for CMS to make that data publicly available.<sup>9</sup>

While these efforts are a promising start to understanding utilization of and spending on supplemental benefits, they will still leave gaps in understanding. CMS has not indicated how much of the data it collects will be made public, and the data CMS is collecting will take time to produce meaningful insights. There is also a need to build data infrastructure and standards to streamline reporting, and plans (and benefit providers) will need to continue building their own internal capabilities to collect this data. Finally, even with data on utilization, significant gaps will remain in our knowledge of beneficiary understanding, accessibility, and perspective on the value of these benefits to their health and wellbeing and their ability to maintain independence.

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## The Opportunity

In response to the need for better data and research to understand nonmedical benefits and their impact on beneficiaries, we have developed an Evaluation Framework. The needs of Medicare beneficiaries are varied and complex. Unsurprisingly, assessing the value of benefits is not a straightforward equation. We cannot only measure utilization and spending but must also seek to understand beneficiary perspectives of value – the impact these benefits have on their health and wellbeing.

The framework includes key questions to assess how well benefits support enrollee needs and provide value to the Medicare program alongside tangible actions for plans, government, and researchers to answer these questions. The purpose of this framework is to activate stakeholders now to improve understanding of these benefits and provide more immediate insights into the value these benefits are providing, with a focus on better understanding the beneficiary perspective.

While benefits must deliver value to the Medicare program, MA plans, and beneficiaries, the focus on the beneficiary's perspective is due to an absence of data on this topic. Over the last several years, we have developed deep insights into plan and policymaker perspectives, and CMS is now collecting utilization and spending data. But there is a significant need to better understand the beneficiary's perspective, and the Evaluation Framework provides a starting point for doing so.

In developing the Evaluation Framework, we realized it was necessary to update the Guiding Principles for implementing nonmedical benefits in MA. The original Guiding Principles



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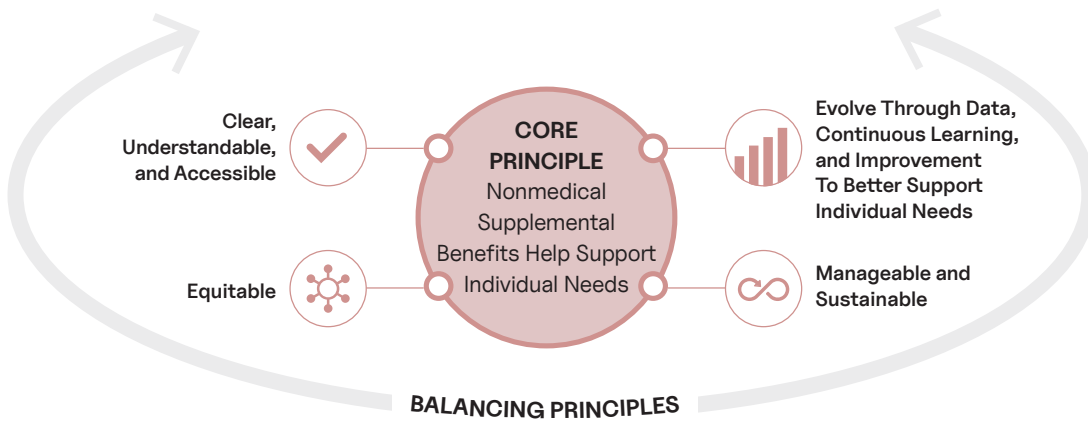
<sup>9</sup> Sen. Warner. "Medicare Advantage Supplemental Benefits Transparency Act of 2023". [https://www.warner.senate.gov/public/\\_cache/files/c/0/c09745d2-a3db-430e-88b2-841d71878807/B6ED67DDD66B3FB76A291911FF08AC7C.kel23a09.pdf](https://www.warner.senate.gov/public/_cache/files/c/0/c09745d2-a3db-430e-88b2-841d71878807/B6ED67DDD66B3FB76A291911FF08AC7C.kel23a09.pdf)

reflected a shared vision to guide a diverse array of stakeholders as they worked to develop, implement, offer, deliver, and use SSBCI. They were developed to advance benefit offerings when SSBCI were initially made available. Now that plans and providers have worked for years to design and implement nonmedical benefits, including through SSBCI authority, but also through expanded primarily health related benefit authority and VBID, the principles are needed for a different purpose. The need now is to better understand the benefits being offered, what they are and are not, and how well they are working.

The updated Guiding Principles reflect this new perspective, focused on gaining a better understanding of the benefits. These principles (seen in Figure 1) are focused on ensuring that:

- Benefits help support individual needs.
- Beneficiaries can understand and access benefits.
- The benefits are provided equitably.
- Data is collected to inform changes in the benefits over time to better support beneficiary needs.

Figure 1. Updated Guiding Principles



**The actions included in the Evaluation Framework are designed to advance these updated Guiding Principles.** If the actions are taken, stakeholders will assess the extent to which benefits help support medical and health-related social needs of individuals and are clear, understandable, and accessible in an equitable, non-discriminatory manner. The overall data and information collected through the steps in the framework will allow for continuous learning and improvement to better support individual needs, and the transparency embedded in the framework allows for more sustainable and manageable benefits.



# The Framework

In consultation with the [Leadership Circle](#) (a national group of experts on MA and long-term services and supports that has guided this work from the outset), we identified the following questions as the most critical areas of research for the field regarding nonmedical supplemental benefits:

- How do beneficiaries view and value these benefits?
- Who is accessing these benefits? Are these benefits supporting beneficiaries' needs?
- Are these benefits leading to the desired outcomes for MA enrollees and the Medicare program?

These questions are an attempt to build a holistic understanding of the impact of these benefits – prioritizing the beneficiary perspective but also ensuring that the perspectives of policymakers and plans are considered. The intersection of value for beneficiaries, policymakers, and plans is key as each stakeholder is critical to ensuring meaningful, and appropriate, use of these benefits.

The questions here will also be complementary to CMS data collection efforts. CMS has the potential to gain significant insight in the coming years into who is accessing benefits if the person-level data collection efforts in VBID are expanded. If made publicly available, this data will advance understanding of the utilization and spending on benefits for policymakers and researchers. The Evaluation Framework expands on CMS data collection efforts and identifies actors to take on key questions that will advance comprehensive data collection and evaluation- moving beyond utilization and spending.

The Evaluation Framework, and the updated Guiding Principles, are also living documents. They aim to reflect the current state of nonmedical benefit practice and policy. They are only useful to the extent that each actor takes concrete steps to carry out their respective actions and contribute to the research base on these benefits. To facilitate activity on the questions included in the Framework, the key actions and anticipated impacts are summarized below and organized by actor (CMS, MA Plans, and Researchers, Other Third-Party Entities, and/or CMS). For a more detailed list of actions, data gaps, and key questions, see **Appendix C**.



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## CMS

As the agency responsible for the MA program, CMS is uniquely able to implement data reporting infrastructure and leverage existing and forthcoming data collection efforts to inform future policy, data standardization, and data collection efforts. The actions that CMS can take would enhance standardization, increase the breadth and granularity of data collected, and provide more publicly available data on these benefits.

### *Key Actions Include:*

**1 Learn from data collection under Paperwork Reduction Act (PRA) notice requirements and Value-Based Insurance Design (VBID) demonstration to improve utilization reporting.**

Data collected in response to the finalized PRA notice requirements and VBID data collection efforts will provide CMS with information on aggregate and person-level utilization and spending on benefits. CMS can use learnings from these efforts to inform broader data collection efforts across all MA plans and for person-level data.

**2 Advance the development of data standards to enable future individual level reporting.**

Based on existing data collection efforts, CMS can identify opportunities to address disparate data collection practices and lead or initiate the development of data standardization to improve future data collection. As part of standardization, CMS can collect promising practices for data collection via debit cards or benefits offered in combination with others.

**3 Make data available to researchers and the public for evaluation and assessment.**

As CMS collects data and leverages the breadth of data being collected, CMS can create public use files (PUF) available for different research purposes on benefit utilization and spending. If/when CMS moves toward individual encounter level reporting, CMS can make encounter files available to researchers and other qualified third-party entities.

**4 Long-term, move toward individual level reporting of eligibility, utilization, and spending of benefits.**

Once data standards are established and CMS and plans have developed the infrastructure to collect and report individual-level data, CMS could require individual-level reporting of eligibility, utilization, and spending on benefits.





*Anticipated Impacts Include:*

CMS data collection efforts will enhance understanding of plan spending and the utilization of benefits at an aggregate level, and data from VBID will give some insight into beneficiary-level utilization. As CMS continues to collect data on supplemental benefits, and increases the granularity and breadth of these data collection efforts, these actions will provide transparency into benefit eligibility, utilization, and spending for research, learning, improvement, and appropriate oversight. CMS also can learn from these efforts and identify opportunities to standardize benefit data, leading to more meaningful and usable data and a reduced reporting burden for plans. The reporting structure should not inhibit plan development of innovative benefit designs to support individual needs.

For plans, increased requirements for data reporting will serve to stimulate continued development of plan infrastructure and coordination with benefit providers to collect and report data on these benefits. As additional beneficiary-level data is collected, plans and CMS should be able to conduct assessments of the equitable reach of benefits and of correlation between benefit utilization and other healthcare utilization and health outcomes.

**MA PLANS**

MA plans will need to continue to develop their capabilities to collect and report supplemental benefit data in response to CMS requirements. Plans also can learn from these efforts, informing assessments of impact that the benefits have on beneficiaries, and plans should publicly share their learnings.

*Key Actions Include:***1 Invest in data infrastructure and vendor management capacity to advance individual-level data reporting on nonmedical supplemental benefits, by unit of delivery.**

Plans are in varied stages of collecting data from vendors on benefit utilization. Plans can work with benefit providers to ensure data collection efforts and standardized reporting from vendors are part of the contracting process and that they are aligned with CMS reporting requirements and plan needs.

**2 Collect, evaluate, and publish data and findings on supplemental benefit eligibility, uptake, utilization, and other healthcare utilization/spending, as well as collecting member experience information on benefits.**

Plans will be collecting and submitting additional data on benefits to CMS in response to new requirements. Plans can also conduct their own internal analyses with this data (as some are already doing) to better understand utilization patterns and links to



demographic and HRSN data and other healthcare utilization.<sup>10</sup> As plans conduct these analyses, they can publish findings to provide information to the field on the reach, effectiveness, and impact of these benefits and to highlight lessons learned from innovative uses of benefits.

Beyond data analyses, plans can also collect information on member experience with benefits. This information has the potential to address barriers to benefit access, improve member satisfaction, and provide insights to the plan (and if published, to the broader field) of qualitative beneficiary experiences with supplemental benefits.

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**3 Advance internal capacity to: a) link benefit utilization data to retention data; b) stratify eligibility, referral, and utilization data by demographic variables; and c) link benefit utilization data with Health Risk Assessment (HRA) data.**

Plans have an opportunity to gain significant insight into the impact of benefits by advancing their ability to link benefit utilization data to other key data sources. As the infrastructure for collecting beneficiary-level data is developed, plans can structure data to enable linking utilization data with other data sources and finding meaningful insights related to retention, equitable reach, and alignment of benefits with beneficiary needs.

*Anticipated Impacts Include:*

In response to CMS requirements, MA plans will be collecting increasing amounts of data on supplemental benefits. As plans collect this data, their publication of data, lessons learned, and evaluations can support continuous learning and improvement related to the ability of supplemental benefits to support individual needs. Plan investment in internal capacity to collect beneficiary-level information can also allow for individual level benefit reporting for further research, learning, and evaluation across MA plans and benefits. We anticipate that plans will see an opportunity in beneficiary-level utilization data and begin linking this data to other data sources. These linkages will allow plans to conduct assessments related to equitable access to and utilization of supplemental benefits by demographic characteristics, including race, ethnicity, socioeconomic status, and geography. Beyond data collection activities, linking benefit eligibility and utilization data to HRA data will allow plans to assess and then support HRSNs within their membership.

Plans can also leverage their relationship with members to improve their qualitative understanding of supplemental benefits and the experiences of members in accessing and using these benefits. Alongside utilization data, information on member experience will provide plans with a more comprehensive understanding of whether the benefits are meaningfully supporting their members' health and HRSNs. The publication of qualitative research findings on member experience with benefits can also provide valuable insights to researchers and policymakers on supplemental benefits.



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<sup>10</sup> One example of this is the Elevance Health Public Policy Institute report entitled "[Medicare Advantage Supplemental Benefits Address Health-Related Social Needs](#)" in which they analyzed supplemental benefit utilization among different segments of their members.

## RESEARCHERS, OTHER THIRD-PARTY ENTITIES, AND/OR CMS

Researchers, providers, and/or CMS can conduct additional qualitative and quantitative research to provide objective insights into nonmedical benefits. This research can leverage existing data collection efforts or be initiated through complementary data collection efforts.

### *Key Actions Include:*

- 1 Conduct research, using beneficiaries and information providers (e.g. State Health Insurance Assistance Plan (or SHIP) counselors or brokers), to better understand beneficiary awareness, understanding, use, experience, and perspective on the value of nonmedical supplemental benefits.**

Researchers, other third-party entities, and/or CMS can conduct surveys, interviews, and focus groups to gain understanding of how beneficiaries view, understand, experience, and value supplemental benefits, including how benefits impact individual beneficiaries' health and ability to live in the community. Researchers external to CMS may be able to better leverage insights from both beneficiaries and additional stakeholders (e.g., SHIP counselors or brokers).

- 2 Bring together states, plans, providers, beneficiaries, and other stakeholders in learning collaboratives to share and advance meaningful and coordinated benefits.**

Researchers, other third-party entities, and/or CMS can convene states, plans, and other relevant stakeholders to promote meaningful, coordinated, and not duplicative, benefits for individuals dually eligible for Medicare and Medicaid. There is a need for better understanding of the role of nonmedical benefits for dual-eligible individuals, and the implications of certain Medicare benefits on other benefit programs. Researchers and/or CMS can also aim to advance learning on benefits by collecting diverse input from multiple perspectives on how benefits can be meaningful to beneficiaries, plans, and policymakers and to develop strategies for collaborative, multi-stakeholder research efforts.

- 3 Conduct research on the effectiveness of interventions that plans can offer using nonmedical benefits.**

Researchers, other third-party entities, and/or CMS can work with MA plans (or independently) to assess the effectiveness of interventions that are currently or could be provided using nonmedical benefits on beneficiary health and wellbeing. Additional partners in these efforts may include state agencies, community-based organizations (e.g., Area Agencies on Aging) or local and regional foundations (with close ties to the communities they serve). This research can inform plan benefit offerings, these studies should be made publicly available, and any datasets built by CMS should have a public use file available for further research.



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**4 Analyze the demographics of individuals enrolled in plans offering certain benefits.**

Researchers, other third-party entities, and/or CMS can utilize current datasets or collaborate to create new datasets to examine the characteristics of enrollees in plans offering specific supplemental benefits and examine plan switching behavior. Long-term, and as data are available, researchers can assess eligibility and utilization of benefits by demographic characteristics.

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**5 Long-term, review and publish data and research assessing beneficiary supplemental benefit utilization, medical utilization, and clinical and functional data/effects.**

As datasets are built out in the coming years, researchers and/or CMS can analyze nonmedical supplemental benefit utilization across demographic characteristics, and link data on medical utilization and other clinical and functional indicators and publish their findings.

***Anticipated Impacts Include:***

The qualitative research efforts of researchers, other third-party entities, and/or CMS can increase policymaker and plan awareness and understanding of beneficiary perspectives on the value of nonmedical benefits to their health, wellbeing, and independence. This research can also inform efforts between states and plans to coordinate benefits for dually eligible individuals and ensure MA supplemental benefits are designed to address gaps that are not met by Medicaid benefits and improve the care experience. The additional data can help policymakers, plans, and advocates assess and understand if benefits are supporting beneficiary needs and which benefits show the most potential in supporting beneficiary needs. Analysis of eligibility and utilization data can provide the ability to assess if benefits are available and accessed in an equitable manner across geographies, and by age, race, and duals-status. In the long-term, information and increased understanding about benefit utilization may be linked to medical utilization and costs and can lead to improved benefits as plans and policymakers have better information, data, and understanding.



## Conclusion

Congress and CMS provided flexibility that allows for benefits to support the individual needs of beneficiaries. However, this flexibility has created a complex landscape of benefits for beneficiaries to navigate and stakeholders to understand. This complexity both demands greater transparency and makes it more difficult to achieve. In the absence of data, policymakers are raising questions about the role of these benefits.

Action must be taken to close data gaps so that policymakers have the information necessary to assess and refine these benefits to align with their original intent to support the needs of individuals with complex chronic conditions and HRSNs. The risk of doing nothing is that policymakers take action to scale back benefits or assume they have taken all the action necessary to support beneficiaries with HRSNs in Medicare without data and research to understand their needs and benefit access, utilization, and impact.

The Evaluation Framework presented here charts a path to providing timely insights on MA enrollee needs, understanding, access, and experience of benefits; enhancing plan capabilities to collect and use data to improve benefit offerings; and building the evidence base on nonmedical benefits' effects. Combined with recent CMS data collection efforts on spending and utilization – which can eventually be captured at the individual-level – the Evaluation Framework will improve understanding by Congress and CMS of the potential for supplemental benefits to support beneficiary's HRSNs and be better prepared to develop guidance, guardrails, and flexibilities that allow plans and providers to deliver benefits of value to the beneficiary and the Medicare program.



# ATI Advisory

ATI Advisory is a healthcare research and advisory services firm dedicated to system reform that improves health outcomes and makes care easier for everyone. ATI guides public and private leaders in developing scalable solutions. Its nationally recognized experts apply the highest standards in research and advisory services along with deep expertise to generate new ideas, solve hard problems, and reduce uncertainty in a rapidly changing healthcare landscape. For more information, visit [atiadvisory.com](http://atiadvisory.com).

# ltqa

Long-Term Quality Alliance (LTQA) is a 501(c)3 membership organization aimed at improving outcomes and quality of life for persons with functional limitations, and their families. LTQA advances person- and family-centered, integrated long-term services and supports (LTSS) through research, education, and advocacy. For more information, visit [ltqa.org](http://ltqa.org).



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



# Appendices

## APPENDIX A. ADDITIONAL DETAILS ON FOUR PATHWAYS TO OFFER NONMEDICAL SUPPLEMENTAL BENEFITS IN MEDICARE ADVANTAGE

Pathway	Effective Year	Definition	Must be Primarily Health-Related?	Example of Benefits
Expanded Primarily Health-Related Benefits (EPhRB)	2019	<p>Previously, the definition of “primarily health-related” was limited to “an item or service whose primary purpose is to prevent, cure, or diminish an illness or injury.”<sup>11</sup> In 2018, CMS expanded the definition to include:</p> <ol style="list-style-type: none"> <li>1. “Must diagnose, prevent, or treat an illness or injury, compensate for physical impairments;</li> <li>2. Act to ameliorate the functional/psychological impact of injuries or health conditions; or</li> <li>3. Reduce avoidable emergency and healthcare utilization.<sup>12</sup></li> </ol> <p>These benefits must be offered uniformly, meaning similarly-situated individuals receive the same services.</p>	Yes, but under the new definition of “primarily health-related.”	<ul style="list-style-type: none"> <li>• Adult Day Health Services</li> <li>• Home-Based Palliative Care</li> <li>• In-Home Support Services</li> <li>• Support for Caregivers of Enrollees</li> <li>• Therapeutic Massage</li> </ul>
Uniformity Flexibility (UF)	2019	<p>In the same 2018 guidance in which CMS revised the definition of “primarily health-related,” CMS also waived the uniformity requirement, permitting MA plans to offer tailored supplemental benefits for “similarly situated individuals” based on disease state or condition.</p>	Yes, but under the new definition of “primarily health-related”	N/A; UF can be used to offer EPhRB benefits.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	2020	<p>SSBCI must “Have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.” A chronically ill enrollee is defined as an enrollee who:</p> <ul style="list-style-type: none"> <li>• “Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;</li> <li>• Has a high risk of hospitalization or other adverse health outcomes; and</li> <li>• Requires intensive care coordination.”</li> </ul> <p>Statute also gives plans the authority to waive uniformity requirements for these benefits, meaning that they can be targeted to each enrollee’s individualized need.</p>	No, plans have the flexibility to offer benefits that are not primarily health-related.	<ul style="list-style-type: none"> <li>• Food and Produce</li> <li>• Meals (Beyond limited basis)</li> <li>• Pest Control</li> <li>• Transportation for Non-Medical Needs</li> <li>• Indoor Air Quality Equipment and Services</li> <li>• Social Needs Benefit</li> <li>• Complementary Therapies</li> <li>• Services Supporting Self-Direction</li> <li>• Structural Home Modifications</li> <li>• General Supports for Living</li> </ul>

<sup>11</sup> The Centers for Medicare and Medicaid Services 2019 Final Rule. (April 2018). <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>

<sup>12</sup> Ibid.

Pathway	Effective Year	Definition	Must be Primarily Health-Related?	Example of Benefits
Value-Based Insurance Design (VBID)	2020 (year MAOs were allowed to offer nonmedical supplemental benefits under VBID)	<p>VBID allows MAOs to target benefits to enrollees based on:</p> <ol style="list-style-type: none"> <li>1) Chronic condition(s);</li> <li>2) Low-Income Subsidy (LIS) eligibility;</li> <li>3) Dual-eligibility status (in US territories); or a</li> <li>4) Combination of above criteria</li> </ol> <p>Participating MAOs can offer primarily and non-primarily health-related supplemental benefits.</p>	<p><b>No</b>, plans have the flexibility to offer benefits that are not primarily health-related.</p>	<p>N/A; VBID can be used to offer EPHRB and SSBCI benefits</p>



APPENDIX B. CURRENT OR UPCOMING/PROPOSED CMS SUPPLEMENTAL BENEFIT DATA COLLECTION INITIATIVES

Data Collection Initiative	First Plan Year for Data Collection	Definition	Potential Limitations
Medical-Loss Ratio (MLR) Reporting <sup>13</sup>	2023	<p>All MAOs are required to submit data to CMS annually on the dollar amounts for the claims incurred for MA supplemental benefits, for each plan they are offering (defined by individual plan benefit packages). The list for reporting includes the following two categories:</p> <ul style="list-style-type: none"> <li>• “All Other Primarily Health-Related Supplemental Benefits”</li> <li>• “Non-Primarily Health-Related SSBCI”</li> </ul> <p>Expenditure data would be aggregated at the contract level and publicly reported, except for when it would reveal plan-level expenditures for a specific benefit offered under a single plan under the contract. CMS will release the MLR data no sooner than 18 months after the end of the applicable contract year.</p>	<p>The aggregated nature of these benefit categories limit CMS’ line of sight into how much is being spent on each benefit subcategory. However, CMS maintains flexibility to modify the scope of data fields and the specific list of supplemental benefit categories required to be reported on the MLR Reporting Template.</p>
VBID Supplemental Benefit Data Reporting <sup>14,15</sup>	2023	<ul style="list-style-type: none"> <li>• Annual Summary-level Data Reporting (<b>mandatory</b>, at the PBP level) <ul style="list-style-type: none"> <li>- All primarily and non-primarily health related supplemental benefits offered through the VBID Flexibilities component, except cost sharing reductions on Medicare Parts A/B or Part D benefits.</li> </ul> </li> <li>• Biannual Beneficiary-level Data Reporting focused on three priority areas (<b>voluntary</b>) <ul style="list-style-type: none"> <li>- Focused on priority areas for advancing health equity, such as food, transportation, and general supports for living benefits to address health-related social needs, but they are not required.</li> </ul> </li> </ul>	<p>CMMI has opted to introduce different phases of enhanced data reporting as voluntary before making it mandatory the following year in order to encourage participating plans to begin developing reporting capabilities and to refine the data collection approach through the initial pilot test of voluntary data collection.</p> <p>CMMI is providing plans with significant flexibility in the units they used to report utilization, which may present significant challenges to standardizing, aggregating, and comparing the data that are collected across benefits and plans..</p>
	2024	<ul style="list-style-type: none"> <li>• Annual Summary-level Data Reporting (<b>mandatory</b>)</li> <li>• Biannual Beneficiary-level Data Reporting focused on three priority areas (<b>mandatory</b>)</li> <li>• Annual Beneficiary-level Data on Health-Related Social Needs (HRSNs) (<b>voluntary</b>) <ul style="list-style-type: none"> <li>- North Carolina HRSN Screening Tool</li> <li>- Protocol for Responding to &amp; Assessing Patients’ Assets, Risks &amp; Experiences (PRAPARE)</li> <li>- Accountable Health Communities (AHC) HRSN Screening Tool</li> </ul> </li> </ul>	<p>Individual-level reporting will only focus on benefits that address food, transportation, and housing benefits; however, this may encourage plans to start to build data reporting infrastructure for all benefits.</p> <p>HRSN screen data will only be collected once during the first month of the year, which limits the ability to observe change over time during a given year.</p>

13 The Centers for Medicare and Medicaid Services. “Medical Loss Ratio Report for Medicare Advantage Plans and Prescription Drug Plans.” (January 2022).

<https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pa-listing-items/cms%253f10476>

14 The Centers for Medicare and Medicaid Services. “VBID CY 2023 Non-Hospice Monitoring Guidelines.” <https://www.cms.gov/priorities/innovation/media/document/vbid-cy2023-non-hospice-monitoring>

15 The Centers for Medicare and Medicaid Services. “VBID CY 2024 Non-Hospice Monitoring Guidelines.” <https://www.cms.gov/files/zip/vbid-cy2024-monitoring-guidelines.zip>

Data Collection Initiative	First Plan Year for Data Collection	Definition	Potential Limitations
<p>CMS Collection of Supplemental Benefit Utilization Data (PRA Notice requirements)<sup>16</sup></p>	<p>2024</p>	<p>All MAOs will be required to submit data to CMS annually on the utilization and cost of supplemental benefits for each plan they are offering (defined by individual plan benefit packages). Data must be matched to Plan Benefit Package (PBP) reporting categories and split out by the authority under which each plan offers the benefits (mandatory, optional, mandatory-SSBCI, mandatory-UF).</p> <p>The reporting template includes a narrative field for the “unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases).</p>	<p>This requires plans to report aggregated data reporting across benefit categories, but is not requiring submission of individual-level data.</p> <p>CMS has also kept the reporting units open-ended to allow for plans to submit data however they collect it. CMS has included narrative fields for plans to provide explanatory text to support their quantitative data submissions. This will present significant challenges to standardizing, aggregating, and comparing the data that are collected across benefits and plans. CMS hopes that this more open-ended approach will help CMS to improve their understanding of data collection and to refine and standardize their approach in the following years.<sup>17</sup></p>

<sup>16</sup> The Centers for Medicare and Medicaid Services. (January 2024). “Medicare Part C Report Requirements, Effective January 1, 2024”. <https://www.cms.gov/files/document/cy2024-part-c-reporting-requirements-01092024.pdf>

<sup>17</sup> In CMS’ response to comments on the 60-Day PRA notice regarding providing more guidance on units of utilization, CMS responded, “We do not feel well positioned to establish standardized units of utilization at this time. We expect that MAOs measure benefits differently, and more analysis is needed to understand which units might best reflect service delivery. The data we receive through this collection will better position CMS to consider appropriate standardized units of utilization.” Office of Management and Budget. “Part C Reporting Requirements: Supplemental Benefit Utilization and Cost – 60-Day PRA Comments.” <https://omb.report/icr/202309-0938-012/doc/135582500.pdf>

Data Collection Initiative	First Plan Year for Data Collection	Definition	Potential Limitations
2025 MAPD Proposed Rule <sup>18</sup>	2025	<p>Two provisions are most directly relevant to data collection and building an evidence base:</p> <ol style="list-style-type: none"> <li>1) If finalized, MAOs must demonstrate with evidence that an item or service offered as SSBCI has a reasonable expectation of improving or maintaining the health of function of a chronically ill enrollee (this includes establishing a bibliography of the evidence by the date on which the MAO submits its bid to CMS, which will be made available to CMS upon request). CMS will prioritize “large, randomized controlled trials or prospective cohort studies published in peer-reviewed journals, or meta-analyses of the same studies,” but notes that case studies, Federal policies or reports, and internal analyses can be used in the absence of other evidence. This rule would codify CMS’ authority to review and deny approvals of bids based on the evidence that an MAO has for its benefits.</li> <li>2) MA plans will also be required to notify members mid-year of the unused supplemental benefits available to them. Plans will not need to notify members of benefits that they have accessed but have not exhausted.</li> </ol> <p>Other provisions to highlight:</p> <ul style="list-style-type: none"> <li>• Plans would be required to follow their written policies for determining an enrollee’s eligibility for an SSBCI when making an eligibility determination and document denials of SSBCI.</li> <li>• If SSBCI benefits are mentioned in marketing materials, then MAOs must clearly list the chronic condition(s) an enrollee must have to be eligible for the SSBCI benefits, indicate any additional eligibility requirements, and adhere to updated font size and pace of reading requirements.</li> </ul>	<ol style="list-style-type: none"> <li>1) Through CMS’ proposed requirement for the submission of a bibliography of evidence, CMS intends to encourage plans to offer evidence-based benefit offerings. Given the currently limited availability of rigorous evaluations of nonmedical supplemental benefits in the context of MA and the targeted populations, plans will likely look to more general studies on the intervention type and broader populations. In addition, this provision could potentially result in a “chilling effect” (i.e., reduction in benefit offerings and new innovations), given some offerings lack research studies that rise to the level of scientific rigor that CMS is expecting.</li> <li>2) The provision on mid-year notifications will only require plans to track which benefits plan members have begun to use, which not all plans are doing systematically across all benefits currently (as described in the next section). The provision will also not require plans to track utilization beyond a binary yes/no, which limits the scope of detailed utilization data needed for future evaluation.</li> </ol>

<sup>18</sup> The Centers for Medicare and Medicaid Services 2025 Proposed Rule. (November 2023). <https://public-inspection.federalregister.gov/2023-24118.pdf>

**APPENDIX C. FULL EVALUATION FRAMEWORK**

This appendix includes the full framework, including the data elements described in **Table 2**.

**Table 2. Outline of Key Data Elements for Evaluation Framework**

Data Element	First Plan Year for Data Collection
<b>Key Questions</b>	For each Guiding Principle, we outline several key questions to evaluate progress of the development and implementation of nonmedical supplemental benefits toward the Guiding Principles. The questions for evaluation are a combination of outcome and process measures, based on the most appropriate approach for each Guiding Principle.
<b>Relevant Data to Assess Questions</b>	Based on the key questions, we identify the relevant data needed to support conducting the desired evaluations.
<b>Currently Available Data</b>	We describe the current state of data sources that are available to support conducting the desired evaluations.
<b>Options to Fill Data Gaps</b>	We propose short-term (1-2 years) and long-term (3-5 years) actions for various actors to take to help fill the data gaps (e.g., CMS, plans, third-party entities). This includes policy recommendations that align with existing CMS efforts to collect utilization data on these benefits. This also includes options for collecting data on these benefits outside of CMS data collection efforts.



**CORE PRINCIPLE: NONMEDICAL SUPPLEMENTAL BENEFITS HELP SUPPORT INDIVIDUAL NEEDS**

*Nonmedical supplemental benefits can help support primarily health-related and non-primarily health-related needs of Medicare Advantage enrollees.*

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
1) To what extent do MA enrollees perceive the benefits as <b>helping to support their individual needs</b> ?	<ul style="list-style-type: none"> <li>Enrollee survey<sup>19</sup></li> </ul>	There is no data publicly available. Some proprietary research exists.	<ol style="list-style-type: none"> <li><b>CMS or third-party entity</b> can field a survey and focus groups of enrollees.</li> <li><b>Plans</b> can conduct survey/focus groups and submit data to CMS.</li> </ol>	3) <b>CMS</b> can add questions specific to nonmedical supplemental benefits to the Medicare Current Beneficiary Survey (MCBS).
2) To what extent are benefits influencing <b>enrollees' plan enrollment decision making</b> ?	<ul style="list-style-type: none"> <li>Enrollee survey</li> <li>Retention data</li> </ul>	Retention data	<ol style="list-style-type: none"> <li><b>Plans</b> can advance internal capacity to link benefit utilization data with retention data, analyze data internally, and submit to CMS.</li> <li><b>CMS, ACL, or third-party entity</b> can survey Medicare beneficiaries and/or SHIP counselors to understand the impact of benefits in their decision-making processes.</li> </ol>	<ol style="list-style-type: none"> <li>3) <b>CMS</b> can add questions on this topic to existing survey vehicles, such as MCBS.</li> <li>4) <b>CMS or third-party entity</b> can link benefit utilization data (once available) with retention data and analyze trends.</li> </ol>
3) For <b>dually eligible enrollees</b> , to what extent are plans and states coordinating MA benefits with Medicaid benefits to help fill gaps?	<ul style="list-style-type: none"> <li>Survey of states</li> <li>Review of SMACs</li> </ul>	Some SMACs are publicly available.	<p><b>CMS or third-party entity</b> can:</p> <ol style="list-style-type: none"> <li>1) Conduct a survey of states.</li> <li>2) Conduct a review of SMACs (MACPAC is currently reviewing all SMACs, including those not publicly available).</li> <li>3) Run a learning collaborative with states, plans, and other stakeholders to support states in collecting and leveraging data/information from MA plans operating in their states.</li> </ol>	<ol style="list-style-type: none"> <li>4) <b>CMS</b> can provide standard guidance and templates to states on collecting and leveraging data/information from MA plans operating in their states.</li> <li>5) Based on assessment of beneficiary needs and gaps in services, <b>States and CMS</b> can consider levers (e.g., SMACs) to support HRSN in a coordinated, meaningful way.</li> </ol>

<sup>19</sup> Enrollee survey data can be collected through survey tools, interviews, or focus groups. This applies to all instances of “enrollee survey.”

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
<p>4) To what extent are benefits impacting the individual need(s) that the benefit is aiming to address?</p>	<ul style="list-style-type: none"> <li>• Screening data on enrollee needs (and longitudinal tracking over time)</li> <li>• Utilization data at enrollee level</li> </ul>	<p>Through required Health Risk Assessments (HRAs), screening data on enrollee needs exists for select health-related social needs (HRSN) for Special Needs Plan (SNP) members, but this data is not submitted to CMS.</p> <p>VBID will introduce a voluntary HRSN screen starting in 2024 (mandatory in 2025).</p>	<ol style="list-style-type: none"> <li>1) <b>CMS</b> can leverage learnings from VBID’s voluntary HRSN screen in 2024.</li> <li>2) <b>CMMI</b> can link individual-level utilization data with the HRSN screen data and track over time in VBID.</li> </ol>	<ol style="list-style-type: none"> <li>3) <b>CMS</b> can request or require plans to submit with their bids the questions on individual need they will screen for.</li> <li>4) <b>CMS</b> can require standard screens (e.g., HRA or specific need screen per VBID approach).</li> <li>4) <b>CMS</b> can link individual-level utilization data with screening data on enrollee needs.</li> </ol>
<p>5) To what extent do these benefits help improve or maintain health or function (e.g., impacts on chronic conditions)?</p> <p><i>Note: While we may directionally see trends on clinical and functional data, it will be more difficult to show causal impacts given low dosage and methodological challenges.</i></p>	<ul style="list-style-type: none"> <li>• Enrollee survey</li> <li>• Self-reported data (e.g., self-reported health, quality of life)</li> <li>• Clinical data (e.g., adverse events associated w/ the chronic condition)</li> <li>• Functional assessment data</li> <li>• Utilization data at enrollee level</li> </ul>	<p>Clinical data.</p> <p>Functional assessment data for SNP enrollees.</p> <p>(Clinical and functional data exist, but are currently not linked to benefit utilization data.</p>	<ol style="list-style-type: none"> <li>1) <b>CMS or third-party entity</b> can run a learning collaborative to discuss how to standardize units of delivery, dose, desired outcomes, etc.</li> </ol>	<ol style="list-style-type: none"> <li>2) <b>Plans</b> can analyze data internally and submit to CMS and/or publicly share findings.</li> <li>3) <b>CMS</b> can collect individual-level supplemental benefit utilization data and link to claims data.</li> <li>4) <b>CMS</b> can add questions specific to nonmedical supplemental benefits to the MCBS and link to other self-reported health survey fields.</li> <li>5) <b>CMS or third-party entity</b> can conduct and publish research assessing beneficiary.</li> </ol>

**BALANCING PRINCIPLE 1: NONMEDICAL SUPPLEMENTAL BENEFITS ARE CLEAR, UNDERSTANDABLE, AND ACCESSIBLE**

*Key stakeholders—including Medicare beneficiaries and their caregivers, providers, payers, enrollment counselors, and states—understand nonmedical supplemental benefits, how to access them, and the circumstances under which they are available. Medicare Advantage enrollees can access the benefits to which they are entitled without undue burden.*

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
1) To what extent are key stakeholders (Medicare beneficiaries and their caregivers, providers, payers, SHIP counselors, brokers, and states) aware of: <ol style="list-style-type: none"> <li>The <b>existence</b> of nonmedical supplemental benefits in MA?</li> <li>How to <b>access</b> benefits?</li> <li>The <b>circumstances under which they are available</b>?</li> </ol>	<ul style="list-style-type: none"> <li>Stakeholder survey</li> <li>Review of plan marketing and enrollment package materials</li> <li>Review of plan protocols for outreach<sup>20</sup></li> </ul>	Plan marketing and enrollment package materials.	1) <b>CMS or third-party entity</b> can field a survey and focus groups of stakeholders (Medicare beneficiaries and their caregivers, providers, payers, enrollment counselors, and states). 2) <b>Plans</b> can field survey among members.	3) <b>CMS or third-party entity</b> can field stakeholder surveys annually and track over time.
2) How easily understandable and accessible do Medicare beneficiaries, caregivers, providers, and enrollment counselors find the sources of information on nonmedical supplemental benefits? (e.g., plain language, different languages, navigability)?	<ul style="list-style-type: none"> <li>Stakeholder survey</li> <li>Review of plan marketing and enrollment package materials</li> <li>Review of plan protocols for outreach</li> </ul>	Plan marketing and enrollment package materials.	1) <b>CMS or third-party entity</b> can field a survey and focus groups of stakeholders. 2) <b>Plans</b> can field survey among members.	3) <b>CMS or third-party entity</b> can field stakeholder surveys annually and track over time.

<sup>20</sup> Stakeholder survey data can be collected through survey tools, interviews, or focus groups. This applies to all instances of “stakeholder survey.”

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
3) Are Medicare enrollees <b>able to access</b> the benefits they are eligible for? What barriers to access do they face? How easily can enrollees <b>find out what benefits they are eligible for and how much they have remaining</b> ?	<ul style="list-style-type: none"> <li>• Enrollee survey</li> <li>• Review of plan protocols</li> </ul>	<p>There is no known or public data currently available. It may be challenging to identify eligible enrollees without obtaining this information from plans. Plans may be collecting some of these experience data from members or providers.</p> <p>The 2025 MAPD Proposed Rule includes a proposal that would require MA plans to send mid-year notifications to individuals on benefits they are eligible for but have not yet accessed; as well as a provision to require plans to track denials of SSBCI benefits to members.</p>	<ol style="list-style-type: none"> <li>1) <b>CMS or third-party entity</b> can field a survey and focus groups of enrollees.</li> <li>2) <b>Plans</b> can support identification of eligible members to include in CMS or third-party entity-administered surveys and focus groups.</li> </ol>	<ol style="list-style-type: none"> <li>3) <b>CMS or third-party entity</b> can review plan protocols.</li> <li>4) <b>CMS</b> can collect information included in mid-year member notification.</li> <li>5) <b>CMS or third-party entity</b> can field enrollee surveys annually and track over time.</li> </ol>
4) To what extent do plans work with enrollees to access the benefits they are eligible for and may help support individual needs?	<ul style="list-style-type: none"> <li>• Enrollee survey</li> <li>• Review of plan protocols</li> </ul>	There is no data currently available.	1) <b>CMS or third-party entity</b> can field a survey and focus groups of enrollees and review plan protocols.	n/a



**BALANCING PRINCIPLE 2: NONMEDICAL SUPPLEMENTAL BENEFITS ARE EQUITABLE**

Medicare Advantage enrollees can access nonmedical supplemental benefits in a consistent, equitable, and non-discriminatory manner that determines and supports individual need.

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
1) Are there <b>any observable differences</b> by race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, or preferred language in MA enrollees? a. <b>Ability to access</b> benefits? b. <b>Awareness</b> of benefits? c. <b>Receipt of outreach/referrals</b> about the benefits for which they are eligible? d. <b>Utilization</b> of benefits? e. <b>Ratio</b> of individuals targeted (eligible) for the benefit vs. individuals who utilized the benefit?	a. Enrollee survey; geography of offerings overlaid by demographic data b. Enrollee survey c. Plan referral data d. Plan utilization data e. Use data from c & d	a. ATI/LTQA and other researchers have published studies overlaying demographic data onto geography of benefit offerings. <sup>21,22,23</sup> b. The mid-year notification that plans would have to send to members about unused benefits, proposed in the CY 2025 MAPD Proposed Rule, would likely lead to increased awareness of benefits. c, d, e. Plans may vary in their ability to stratify referral and utilization data by demographic information.	1) <b>CMS or third-party entity</b> can analyze the demographics of individuals enrolled in plans offering certain supplemental benefits. 2) <b>CMS or third-party entity</b> can administer enrollee surveys to assess ability to access benefits and stratify by demographic information. 3) <b>Plans</b> can advance internal capacity to stratify referral and utilization data by demographic information and report findings.	4) <b>CMS</b> can require plans to report referral and utilization data stratified by demographic information. 5) <b>CMS or third-party entity</b> can stratify benefit utilization data (once available) by certain demographic characteristics (e.g., geography, gender, race, LIS status, if reason for enrollment is disability status) and report findings.
2) For <b>SNP members receiving a positive HRSN screen</b> , what percentage received benefits that addressed a corresponding HRSN?	• SNP HRA data	Data generally exists, but currently not linked to benefit utilization data.	1) Plans can advance internal capacity to link benefit utilization data with HRA data. 2) CMS can require plans to report utilization data stratified by HRSN data.	n/a

21 ATI Advisory and LTQA. “Metro and Non-Metro Medicare Advantage Plan Offerings of Nonmedical Supplemental Benefits” (September 2023). <https://atiadvisory.com/resources/wp-content/uploads/2023/09/Metro-and-Non-Metro-Medicare-Advantage-Plan-Offerings-of-Nonmedical-Supplemental-Benefits-Databook.pdf>

22 ATI Advisory and LTQA. “Delivering on the Promise of the CHRONIC Care Act: Progress in Implementing Non-Medical Supplemental Benefits” (November 2021). <https://atiadvisory.com/resources/wp-content/uploads/2022/11/Progress-in-Implementing-Non-Medical-Supplemental-Benefits.pdf>

23 Rowen, N.P., Stewart, L., and Saunders, R.S. “Evaluation of Supplemental Benefits Across Medicare Advantage Plans and Beneficiary Demographic Characteristics, 2019 to 2022.” JAMA Network Open. (September 2022). <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796648>

**BALANCING PRINCIPLE 3: NONMEDICAL SUPPLEMENTAL BENEFITS EVOLVE THROUGH DATA, CONTINUOUS LEARNING, AND IMPROVEMENT**

The federal Department of Health and Human Services (HHS) and CMS, in partnership with relevant stakeholders, work together to determine how to best advance and standardize data collection and reporting to track benefits delivered and evaluate the extent to which nonmedical supplemental benefits support the individual needs of Medicare Advantage enrollees. Key stakeholders adapt nonmedical supplemental benefits accordingly based on learnings to improve their ability to fill gaps and support individual needs.

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
1) What interventions offered by plans show the most effectiveness in supporting beneficiary needs?	<ul style="list-style-type: none"> <li>Utilization data</li> <li>Enrollee survey</li> <li>Self-reported data (e.g., self-reported health, quality of life)</li> <li>Clinical data (e.g., adverse events associated w/ the chronic condition)</li> <li>Functional assessment data</li> </ul>	Some limited published data on HRSN interventions is available.	1) <b>Researchers, other third-party entities, and/or CMS</b> can work with <b>plans</b> (or independently) to assess the links between benefit utilization and beneficiary outcomes and publish findings <b>(with key partners for data including state agencies, community-based organizations, or local/regional foundations)</b> .	2) <b>Plans</b> can use longitudinal HRA data to track self-reported beneficiary needs over time, linked to benefit utilization data.

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
2) To what extent are plans and providers tracking data by individual unit of delivery (i.e., specific touchpoint, as relevant) for each benefit? Can this information be easily reported in aggregate and at the individual level?	<ul style="list-style-type: none"> <li>Survey of plans</li> </ul>	<p>CMMI will require mandatory individual-level data on three focus areas (food, housing, transportation, in VBID only beginning in 2024.</p> <p>If finalized, the 2025 MAPD Proposed Rule includes a proposal that would require MA plans to send mid-year notifications to individuals on benefits they are eligible for but have not yet accessed, which will require plans to track utilization of each benefit.</p>	<ol style="list-style-type: none"> <li><b>CMS</b> can administer a request for information (RFI) to plans to assess readiness for reporting on individual units of delivery and potential data collection and reporting challenges.</li> <li><b>CMS or third-party entity</b> can run a learning collaborative to understand the current state of data and resources/standards needed to support plans and providers of varying business/technical acumen in this area.</li> <li><b>CMS</b> can learn from data collection under PRA and VBID to improve reporting and develop data standards for reporting individual-level nonmedical supplemental benefit utilization data.</li> <li><b>CMS</b> can gather information from plans and vendors on promising practices for data collection via debit cards or combination benefit mechanisms and develop guidance to help move towards greater standardization.</li> <li><b>Plans</b> can publish data on benefit utilization and spending.</li> </ol>	<ol style="list-style-type: none"> <li>CMS can advance the development of data standards to enable future encounter reporting.</li> <li>CMS can require plans to report individual level data.</li> <li>CMS can require plans to submit encounter data on all supplemental benefits and make the data publicly available.</li> </ol>
3) Are <b>MA plans and providers</b> using data to evaluate the extent to which benefits are supporting the individual needs of MA enrollees? To what extent are <b>MA plans and providers</b> using these data to evaluate and measure impacts? To evolve benefit design?	<ul style="list-style-type: none"> <li>Survey of plans and providers</li> </ul>	<p>Some limited data is available from plans, providers, and third-party entities who have published studies on supplemental benefits, including:</p> <ul style="list-style-type: none"> <li>Elevance Health Public Policy Institute<sup>24</sup></li> <li>Validation Institute<sup>25</sup></li> </ul> <p>CMS has recently launched an RFI to better understand the data on cost and utilization that is available and may have learnings to share from this effort.</p>	<ol style="list-style-type: none"> <li><b>A third-party entity</b> can conduct survey/focus groups with MA plans and providers to assess how plans and providers are using data to evaluate impacts and evolve benefit design.</li> <li><b>Plans/Providers/third-party entities</b> can conduct evaluations of benefits and publish findings.</li> </ol>	<ol style="list-style-type: none"> <li><b>CMS</b> can require plans to submit in their bids their plan for measuring and evaluating benefits, including data fields they will collect from vendors.</li> </ol>

24 Elevance Health Public Policy Institute. “Medicare Advantage supplemental benefits address health-related social needs”. (July 2023).

<https://www.elevancehealth.com/public-policy-institute/medicare-advantage-supplemental-benefits-can-address-hrsn>

25 Validation Institute. “2021 Validation Report: Review for Ceresti Health”. (December 2021). [https://validationinstitute.com/wp-content/uploads/2021/12/Ceresti\\_Health\\_Savings\\_2021\\_Final.pdf](https://validationinstitute.com/wp-content/uploads/2021/12/Ceresti_Health_Savings_2021_Final.pdf)

**BALANCING PRINCIPLE 4: NONMEDICAL SUPPLEMENTAL BENEFITS ARE MANAGEABLE AND SUSTAINABLE**

*To prevent drastic changes in benefit offerings year-to-year, Medicare program regulations and guidance, such as rate structures and quality measures, support Medicare Advantage plans in offering, managing, and sustaining their inclusion of nonmedical supplemental benefits offered in alignment with the Guiding Principles.*

Key Questions	Relevant Data to Assess Questions	Currently Available Data	Options to Fill Data Gaps	
			Short-Term	Long-Term
1) How much are MA plans <b>spending</b> on benefits (e.g., service vs. overhead costs)? How much did MA plans actually spend vs. expected spending?	<ul style="list-style-type: none"> <li>Plan cost data</li> </ul>	<p>CMS requires plans to submit cost data on certain supplemental benefit categories as part of the bid process, both actual and projected. However, the categories are higher level, do not match specific services, and there is a five-year lag for public data. The recently finalized PRA notice will require plans to report on how the plan determines cost of a benefit and administrative costs, but does not require reporting on the actual costs. This data will also not include expected spending.</p>	<p>1) <b>CMS</b> can require plans to disaggregate their cost data by service vs. overhead costs in their reporting to understand the true cost of the benefit.</p> <p>2) <b>Plans</b> can publish data on benefit utilization and spending.</p>	<p>3) <b>CMS</b> can require plans to report expected spending (and potentially where the dollars that were not spent due to low utilization were allocated instead).</p>
2) What are the <b>costs of the benefits</b> to members?	<ul style="list-style-type: none"> <li>Plan cost data</li> </ul>	<p>Plans will be required to submit cost data in 2024. Information on co-pays for benefits is also available in PBP files.</p>	<p>No data gaps.</p>	<p>No data gaps.</p>
3) <b>How consistent is total spending</b> on nonmedical supplemental benefits year-to-year?	<ul style="list-style-type: none"> <li>Plan cost data</li> </ul>	<p>MLR data, but aggregated into two categories: (1) “All Other Primarily Health-Related Supplemental Benefits”, and (2) “Non-Primarily Health-Related SSBCI”</p> <p>CMS requires plans to submit cost data on certain supplemental benefit categories as part of the bid process, both actual and projected.</p> <p>The recently finalized PRA notice will require plans to report on disaggregated spending by benefit type.</p>	<p>Once this data is collected, CMS will be able to assess over time</p>	<p>No data gaps.</p>
4) Are benefits <b>producing savings</b> for MA plans on other healthcare spend?	<ul style="list-style-type: none"> <li>Utilization data</li> <li>Claims data</li> </ul>	<p>Data generally exists, but currently not linked to benefit utilization data.</p> <p>Causation will not be possible to demonstrate given inability to specifically isolate the impacts of the benefit.</p>	<p>1) <b>Plans</b> can develop infrastructure to do this internally.</p> <p>2) <b>Plans</b> can send unlinked data to third-party researchers to link and evaluate.</p>	<p>3) <b>CMS and researchers</b> can evaluate on a lag if individual-level utilization data or encounter data is collected and shared.</p>

## APPENDIX D. METHODS

As an initial step, to inform the process of updating the Guiding Principles, ATI and LTQA engaged the Leadership Circle to gather their insights and suggested revisions to the Guiding Principles. After updating the Guiding Principles for Nonmedical Supplemental Benefits to reflect all authorities and plan practices on development and implementation of these benefits, we developed a draft evaluation framework to assess progress of benefit development and implementation against those updated principles. We convened a subgroup of the Leadership Circle (including representatives from government, MA plans, consumer advocacy organizations, and philanthropy and research organizations) to provide feedback on the initial framework.

To round out our understanding of key evaluation questions, existing data sources, and potential data collection challenges, we then conducted 15 interviews with representatives from federal and state government, MA plans or plan associations representing plans of varying enrollee population sizes, benefit providers, and researchers. Insights from the convenings, interviews, and desktop research were aggregated and analyzed for key themes and reflected in this report.

While our research relies on qualitative research methods with small samples, we engaged a representative group of key stakeholder organizations to gather a range of perspectives. In this framework, we sought to present a balanced and realistic perspective on the current state of supplemental benefit data collection and potential next steps for collectively advancing the development of a standardized data collection and evaluation infrastructure in a thoughtful and collaborative way.

