New Supplemental Benefits in Medicare Advantage

February 26, 2020
About ATI Advisory

Research and advisory services firm changing how businesses, communities, and public programs serve frail older adults

What we do
We help organizations transform the delivery of healthcare and aging services for the nation’s highest need older adults

Why the time is right
Policymakers are shifting liability for health and long-term care spending to providers and insurers. Local delivery systems are integrating care; breaking down traditional care silos; and building new partnerships to manage the needs of high cost populations

How we do it
We stand by research and data as the foundation of quality and believe that collaboration with our clients inspires new ideas
Roadmap

- A Turning Point in Medicare Policy
- Guiding Principles for New Flexibility
- Activity to Date
- Trends and Challenges
- Considerations and Discussion
A Turning Point in Medicare Policy
## Older Adults Choose Medicare Advantage To Save Money

**Medicare Fee-For-Service**

- **Part A deductible:** $1,408
- **Part B annual deductible:** $198
- **Part B coinsurance:** 20%
- **Monthly Part B premium** *(optional, varies by income)*
- **Monthly insurance premium for Prescription Drugs (Part D)** *(optional, varies by income and plan selection)*
- **Medigap insurance premium** *(optional, covers out of pocket costs, varies by plan selection)*

**Medicare Advantage**

- **Monthly Part B premium**
- **Monthly health plan premium:** *varies by plan*
- **Deductibles and cost-sharing:** *varies by plan*

Medicare Advantage limits beneficiaries' total out-of-pocket costs (maximum currently set at $6,700, some plans are less)

They Join Medicare Advantage To Save Money on Other Health-Related Costs

- Medicare Advantage plans may cover these additional benefits
  - Preventative care*
  - Dental
  - Vision
  - Podiatry
  - Hearing exams and aides*

- New rules now allow plans to cover some types of nonmedical benefits
  - Long-term services and supports

*Always covered under MA

Source: ATI Advisory.
A Higher Proportion of Medicare Advantage Enrollees Live Below $24,523 (200% of FPL)

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

Medicare Advantage
- <100% FPL: 22.3%
- 100-199% FPL: 28.0%
- 200-399% FPL: 25.0%
- >400% FPL: 24.7%

Fee-for-Service Medicare
- <100% FPL: 19.5%
- 100-199% FPL: 20.6%
- 200-399% FPL: 25.9%
- >400% FPL: 34.0%

Notes: Data exclude nursing home residents. 200% FPL is $24,523 for those over 65 in a household size of 1.
Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.
Medicare Advantage Population As Complex as Fee-for-Service Population

*The average number of chronic conditions is higher in MA (2.81) than FFS (2.73)*

Percentage of Medicare Beneficiaries with Key Chronic Conditions in 2017

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medicare Advantage</th>
<th>Fee-for-Service Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>6.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>COPD</td>
<td>20.3%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>35.2%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Diagnosed with Dementia or Alzheimer's</td>
<td>4.1%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Notes: Data exclude nursing home residents. Beneficiaries may appear in more than one condition category, so percentages do not add up. Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.
With Similar Levels of Functional Need

Percentage of Medicare Beneficiaries by Impairment Level in 2017

Requires help with 1+ Instrumental Activities of Daily Living (IADLs)  
- Medicare Advantage: 28.1%  
- Fee-for-Service Medicare: 28.7%

3+ IADLs  
- Medicare Advantage: 8.8%  
- Fee-for-Service Medicare: 9.2%

Requires help with 1+ Activities of Daily Living (ADLs)  
- Medicare Advantage: 11.0%  
- Fee-for-Service Medicare: 10.2%

2+ ADLs  
- Medicare Advantage: 5.9%  
- Fee-for-Service Medicare: 5.7%

Note: Data exclude nursing home residents. Beneficiaries may appear in more than one condition category, so percentages do not add up. 
Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey.
Function Is Strongly Related to High Healthcare Spending

Per Capita Medicare Spending, 2015

- 0-2 Chronic Conditions:
  - No Functional Impairment: $5,467
  - Functional Impairment: $12,831

- 3+ Chronic Conditions:
  - No Functional Impairment: $11,584
  - Functional Impairment: $26,972

Note: Data are limited to fee-for-service Medicare beneficiaries living in the community. Source: ATI Advisory analysis of 2015 MCBS linked to claims.
Benefit Flexibility Is a Necessary Component of Managing Complex Care Population Going Forward

STATUS QUO

CHARACTERISTICS:
- Volume-based care
- High hospitalization and ER rates
- Shorter life span, greater use of nursing home at end of life
- Frustrated residents and families

RE-DEPLOYING HEALTHCARE $

MORE FLEXIBILITY TO FINANCE:
- Integrated primary care
- Care management
- Technology and data
- Non-medical supports and services
- Social determinants of health

POSITIVE QUALITY OUTCOMES:
- Clinical outcomes
- Patient preferences
- Social support outcomes
- Caregiver support
- Longer lives

Source: ATI Advisory.
## CMS Recognized This in New Rules for CY 2019

<table>
<thead>
<tr>
<th>Benefit Uniformity</th>
<th>Old Rules</th>
<th>New Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans must offer the same benefits to enrollees of the same plan</td>
<td>Now allowed to target benefits to groups of enrollees who have certain clinical diagnoses</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supplemental Benefits</th>
<th>Supplemental benefit must be primarily health-related, which means, in part, not for the purpose of “daily maintenance”</th>
<th>Benefits are considered “primarily health-related” under a broader definition of the term</th>
</tr>
</thead>
</table>
“Primarily Health Related” Means:

### Benefits

- Benefit must:
  - Diagnose, prevent or treat an injury
  - Compensate for physical impairments
  - Act to ameliorate the functional/psychological impacts of injuries or health conditions; OR
  - Reduce avoidable emergency or healthcare utilization
- Must be recommended by a licensed professional as part of a care plan
- NOT health-related: cosmetic, comfort, social determinant purposes

### Services

- Examples:
  - Adult Day Care Services
  - Home-Based Palliative Care
  - In-Home Support Services
  - Support for Caregivers of Enrollees

Source: Centers for Medicare & Medicaid Services. 2019 Medicare Advantage and Part D Rate Announcement and Call Letter.
Congress Also Recognized This for CY 2020...And Created “Special Supplemental Benefits”

<table>
<thead>
<tr>
<th>What Health Plans Could Cover Before New Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Traditional Medicare benefits</td>
</tr>
<tr>
<td>2) Care management</td>
</tr>
<tr>
<td>3) Health-related “supplemental” benefits like dental and vision</td>
</tr>
</tbody>
</table>

- Everyone who had the same condition had to get the same thing

<table>
<thead>
<tr>
<th>The New Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congress created a new category of benefits, called “Special supplemental benefits” just for chronically ill. These benefits do not have to be medical</td>
</tr>
</tbody>
</table>

- And they can be tailored according to individual need and include SDOHs

Source: ATI Advisory.
Examples of Allowable New Benefits

Examples of new primarily health related benefits that plans could offer beginning in 2019

• Adult day care services
• Home-based palliative care
• In-home support services
• Support for caregivers of enrollees
• Medically-approved non-opioid pain management
• Stand-alone memory fitness benefit
• Home & bathroom safety devices & modifications
• Transportation
• Over-the-counter benefits

Examples of SSBCI benefits that plans could offer beginning in 2020

• Meals beyond limited basis
• Food and produce
• Non-medical transportation
• Pest control
• Indoor air quality improvement and services
• Social needs benefits
• Complementary therapies alongside traditional medical treatments
• Services supporting self-direction
• Structural home modifications
• General supports for living, such as housing

Source: ATI Advisory.
Guiding Principles for New Flexibility
Why “Principles?”

• SSBCI represent a turning point in Medicare policy.
• For the first time, Medicare allows coverage of non-primarily health related benefits through the Medicare Advantage program, as well as significant flexibility around who is eligible for these benefits and the services they receive.
• We need foundational principles that can inform regulation development, benefit design, and form the basis of a common language for everyone, including:
  – CMS and affiliates (OMB, ACL)
  – Health plans
  – Delivery systems
  – Advocates
  – Congress and affiliates (GAO, CRS)
Who Was Involved in Designing These Principles?

ATI Advisory and the Long-Term Quality Alliance, supported by a grant from The SCAN Foundation, convened a working group comprised of a diverse array of national experts on Medicare Advantage and long-term services and supports. The working group consisted of:

Melinda Abrams  
Senior Vice President, Delivery System Reform, The Commonwealth Fund

Gretchen Alkema  
Vice President of Policy and Communications, The SCAN Foundation

Larry Atkins  
Executive Director, National MLTSS Health Plan Association

Howard Bedlin  
Vice President, Public Policy and Advocacy, National Council on Aging

Laura Chaise  
Vice President, Long Term Services and Supports and Medicare-Medicaid Plans, Centene

Henry Claypool  
Policy Director, Community Living Center, UCSF

Marc Cohen  
Co-Director, LeadingAge LTSS Center @Umass Boston and Research Director, Center for Consumer Engagement in Health Innovation

Lindsey Copeland  
Federal Policy Director, Medicare Rights Center

Nicole Fallon  
Vice President, Health Policy and Integrated Services, LeadingAge

Marty Ford  
Senior Advisor, The Arc of the United States

Wendy Fox-Grage*  
Senior Strategic Policy Advisor, AARP Public Policy Institute

Danielle Garrett  
Strategic Policy Manager, Community Catalyst

Howard Gleckman*  
Senior Fellow, Urban Institute

Jennifer Goldberg  
Deputy Director, Justice in Aging

Katherine Hayes  
Director of Health Policy, Bipartisan Policy Center

Kathy Hempstead  
Senior Policy Adviser, Robert Wood Johnson Foundation

Greg Jones  
Senior Director, Public Policy, CVS Health, Aetna

Keavney Klein  
Senior Counsel, Government Relations, Kaiser Permanente

Tom Kornfield  
Vice President, Medicare Policy, AHIP

Jennifer Kowalski  
Vice President, Public Policy Institute, Anthem

Christine Aguiar Lynch  
Vice President, Medicare and MLTSS Policy, Association for Community Affiliated Plans

Kedar Mate  
Chief Innovation and Education Officer, Institute for Healthcare Improvement

James Michel  
Director, Policy and Research, Better Medicare Alliance

Cheryl Phillips  
President and CEO, SNP Alliance

Ken Preede  
Vice President, Government Relations, Commonwealth Care Alliance

Sarah Snyder Rayel  
Director, Medicare Policy, Blue Cross Blue Shield Association

Allison Rizer  
Vice President, Policy and Strategy, UnitedHealthcare Community & State

Marisa Scala-Foley  
Director, Aging and Disability Business Institute, National Association of Area Agencies on Aging

Nora Super  
Senior Director, Center for the Future of Aging, Milken Institute

Lucy Theilheimer  
Chief Strategy and Impact Officer, Meals on Wheels America

* This member joined in her individual capacity
The Guiding Principles

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

CORE PRINCIPLE
SSBCI Reflect Individual Needs

BALANCING PRINCIPLES

- SSBCI Are Clear and Understandable
- SSBCI Are Manageable and Sustainable
- SSBCI Are Equitable
- SSBCI Evolve with Continuous Learning and Improvement

SUGGESTED NEXT STEPS
Develop Better Beneficiary Decision Tools • Build Evidence Base • Pilot and Test Ideas • Support Plan Collaboration and Learning • Develop Better Risk-Adjustment

ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

ltqa FOUNDATION
Core Principle and Balancing Principles

Core Principle: SSBCI Reflect Individual Needs

SSBCI flexibility—in benefit flexibility, types of services, and providers—allows for Medicare Advantage plans to meet the individual needs of chronically ill beneficiaries.

Balancing Principle 1: SSBCI Are Clear and Understandable

Key stakeholders, including Medicare beneficiaries and their caregivers, providers, payers, enrollment counselors, and states understand SSBCI as well as its limitations and the circumstances under which they are available.

Balancing Principle 2: SSBCI Are Equitable

Chronically ill Medicare Advantage enrollees receive SSBCI in a consistent, equitable, and nondiscriminatory manner that determines and meets individual need based on chronic illness and functional status.

Balancing Principle 3: SSBCI Are Manageable and Sustainable

Medicare program regulations and guidance, such as rate structures and quality measures, support Medicare Advantage plans in offering, managing, and sustaining their inclusion of SSBCI in MA plan benefit packages.

Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement

The federal Department of Health and Human Services (HHS) and CMS, in conjunction with Medicare Advantage plans and other stakeholders, evaluate and measure the extent to which SSBCI are contributing toward meeting the needs of chronically ill enrollees and adapt SSBCI accordingly based on learnings.
Next Steps for the Guiding Principles

Balancing Principle 1: SSBCI Are Clear and Understandable
- Develop better beneficiary decision tools and information
- Increase beneficiary and family caregiver education
- Raise awareness

Balancing Principle 2: SSBCI Are Equitable

Balancing Principle 3: SSBCI Are Manageable and Sustainable
- Develop better risk adjustment

Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement
- Support plan collaboration and learning
- Build the evidence base
- Pilot and test ideas
Perspectives from the Working Group

1. CY 2020 is a growth year for non-medical primarily health related benefits
   - Much higher offerings of ‘primarily health-related’ benefits (e.g., post-hospital meals and medical transportation)
   - Growth in expanded benefits (e.g., home care)

2. CY 2020 is a stepping-stone year for SSBCI
   - SSBCI offerings in CY 2020 will be small
   - Plans are thinking about 2021 offerings

3. Need for better beneficiary awareness over offerings
   - Supplemental benefits not a major factor in enrollment decisions in 2020
   - Potential overlap/confusion with Medicaid benefits and Medicare home health

4. Need for policymaker awareness on plan business challenges
   - Need for education to understand what SSBCI can and cannot do
Needs Going Forward

❑ Assuring the principles are being realized requires data
  – There is a continued need to build the evidence base
  – Strong interest in more data and analysis on benefit offerings – who is offering what, to whom, where; benefit details

❑ Plans and providers need a simple means of connecting and communicating with one another
  – Plans are concerned about how to provide these benefits across their full geography
  – Issues around licensing and payment

❑ Consumers and stakeholders need clear information
  – What these benefits are and what are they not
  – Lack of plan-provider alignment prevents access

Growth in adoption requires new information and connections
Activity to Date
Plans Offering New Benefits in 2020

- **500 Plans** offering expanded primarily health related supplemental benefits

- **250 Plans** offering brand new non-medical supplemental benefits

Analysis of publicly-available data from CMS indicates that **512** plans will be offering at least one of the new supplemental benefits below:

<table>
<thead>
<tr>
<th>New Supplemental Benefit</th>
<th>Number of Plans Offering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Massage</td>
<td>242</td>
</tr>
<tr>
<td>Adult Day Health Services</td>
<td>85</td>
</tr>
<tr>
<td>Home-Based Palliative Care</td>
<td>61</td>
</tr>
<tr>
<td>In-Home Support Services</td>
<td>223</td>
</tr>
<tr>
<td>Support for Caregivers of Enrollees</td>
<td>125</td>
</tr>
</tbody>
</table>

Source: ATI Advisory analysis of PBP files.
Plan Press Releases Provide Limited Details on New Benefits

AmeriGroup in Texas, Personal Home Helper, “Personal Home Helper: Up to 124 hours of in-home personal care”

SCAN Health Plan in California, In-Home Care, “In-home care visits after discharge to help with ADLs”

Anthem Blue Cross in California, In-Home Support, “4 four-hour shifts upon discharge from the hospital or SNF”

Source: ATI Advisory.
**In-Home Support Services – Snapshot**

<table>
<thead>
<tr>
<th>What are “In-Home Support Services?”</th>
<th>How many plans are offering In-Home Support Services in CY 2020?</th>
</tr>
</thead>
</table>
| “...services to assist individuals with disabilities and/or medical conditions in performing ADLs and IADLs within the home. Services must be provided by individuals licensed by the state to provide personal care services, or in a manner that is otherwise consistent with state requirements.”¹ | **223 Plans**  
Offering In-Home Support Services benefits in CY 2020 (148 plans excluding D-SNPs and MMPs) |

<table>
<thead>
<tr>
<th>Where are these benefits being offered?</th>
<th>How many enrollees are in these plans?</th>
</tr>
</thead>
</table>
| **30 states and Puerto Rico**  
Are offering In-Home Support Services in at least one county in CY 2020² | **1,126,383 Medicare Beneficiaries**  
Enrolled in these **223 Plans** in February 2020³ |

In-Home Support Services – Organizations

Which organizations are offering In-Home Support Services?
✓ Aetna Medicare
✓ AHF
✓ Amerigroup
✓ Amerigroup Community Care
✓ AMH Health
✓ Anthem Blue Cross
✓ Anthem Blue Cross and Blue Shield
✓ Anthem HealthKeepers
✓ Blue Cross & Blue Shield of Rhode Island
✓ Capital Advantage Insurance Company
✓ CarePlus Health Plans, Inc.
✓ Easy Choice Health Plan
✓ Empire BlueCross BlueShield
✓ Health First Health Plans, Inc.
✓ HealthSun Health Plans, Inc.
✓ Healthy Blue
✓ Humana
✓ Keystone Health Plan Central, Inc.
✓ Liberty Advantage
✓ Medicare y Mucho Más
✓ PMC Medicare Choice
✓ Simply Healthcare Plans, Inc.
✓ UnitedHealthcare
✓ Vibra Health Plan
✓ WellCare

Examples¹ of Benefit Details from Plans Offering In-Home Support Services:

From Anthem:
**In-Home Support**
Upon discharge from a hospital or nursing facility, receive up to 8 four-hour shifts of assistance in performing activities of daily living (ADLs). Activities include support such as light cleaning or help obtaining groceries outside the home. *(From Anthem MediBlue Value Plus for Los Angeles County, California)*

From Humana:
**Personal Home Care**
$0 copayment for a minimum of 3 hours per day, up to a maximum of 42 hours per year for certain in-home services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) within the home by a qualified aide (e.g., assistance with bathing, dressing, toileting, walking, eating, and preparing meals). *(From Humana Gold Plus for Douglas County, Kansas)*

Source: ATI Advisory analysis of PBP files. 1. Plan’s 2020 ‘Summary of Benefits’ and ‘Evidence of Coverage’ Documents
Counties Where In-Home Support Services Are Available in 2020

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

Source: ATI Advisory analysis of PBP files.
# Adult Day Health Services – Snapshot

## What are “Adult Day Health Services” or “Adult Day Care Services?”

“Services provided outside the home such as assistance with ADLs/IADLs, education to support performance of ADLs/IADLs, physical maintenance/rehabilitation activities, and social work services...the primary purpose of adult day care services must be health related and provided by staff whose qualifications and/or supervision meet state licensing requirements.”

---

## How many plans are offering Adult Day Health Services in CY 2020?

**85 Plans**

Offering Adult Day Health Services benefits in CY 2020 (63 plans excluding D-SNPs and MMPs)

---

## Where are these benefits being offered?

**16 states**

Are offering Adult Day Health Services in at least one county in CY 2020

---

## How many enrollees are in these plans?

**572,375 Medicare Beneficiaries**

Enrolled in these 85 Plans in February 2020

---

Adult Day Health Services – Organizations

Which organizations are offering Adult Day Health Services?
✓ Amerigroup
✓ Amerigroup Community Care
✓ AMH Health
✓ Anthem Blue Cross
✓ Anthem Blue Cross and Blue Shield
✓ Anthem HealthKeepers
✓ Cigna-HealthSpring
✓ Empire BlueCross BlueShield
✓ Healthy Blue
✓ Partners Health Plan
✓ UnitedHealthcare

Examples¹ of Benefit Details from Plans Offering Adult Day Health Services:

From Cigna:
**Adult Day Health Services**
Plan will reimburse adult day care services up to the maximum allowance amount on a quarterly basis. Member will be required to submit a direct member reimbursement form (DMR) and documentation for licensed adult day care services for a $150 allowance per quarter.
(From Cigna-HealthSpring Preferred Plus for Burlington County, New Jersey)

From Anthem:
**Adult Day Care Services**
You could visit a licensed adult daycare center once a week if you need help with 2 or more activities of daily living. You'll experience supervised care, physical and rehabilitation activities, and the chance to socialize.
(From Anthem MediBlue Value Plus for Los Angeles County, California)

Source: ATI Advisory analysis of PBP files. 1. Plan’s 2020 ‘Summary of Benefits’ and ‘Evidence of Coverage’ Documents
Counties Where Adult Day Health Services Are Available in 2020

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

Source: ATI Advisory analysis of PBP files.
Other Popular Benefits – Transportation and Limited Duration Meal Benefits

While previously limited, the introduction of SSBCI now allows plans to offer non-health related transportation (e.g., to the bank or grocery shopping) and meal benefits (e.g., beyond post-discharge) to chronically-ill enrollees.

Statistics below reflect available data on primarily health-related transportation and limited duration meal benefits, not SSBCI:

<table>
<thead>
<tr>
<th>Description</th>
<th>Transportation</th>
<th>Limited Duration Meal Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>For medical services (e.g., doctor’s appointment)</td>
<td>Following surgery or a hospital stay or for a chronic condition on a limited (e.g., 2-4 week) basis</td>
</tr>
<tr>
<td>Number and Percent of Plans Offering in 2020*</td>
<td>1,941 (33%)</td>
<td>2,066 (35%)</td>
</tr>
<tr>
<td>Number and Percent of Plans Offering in 2020, excluding D-SNPs and MMPs</td>
<td>1,452 (28%)</td>
<td>1,653 (32%)</td>
</tr>
</tbody>
</table>

*Note: Out of a total of 5,823 plans, excluding PACE

Source: ATI Advisory analysis of PBP files.
What Services Can Be Offered as SSBCI?

While not limited, CMS offered the following services as examples of special supplemental benefits for the chronically ill:

- Meals
- Complementary Therapies
- Food and Produce
- Services Supporting Self-Direction
- Transportation (for non-medical needs)
- Structural Home Modifications
- Pest Control
- General Supports for Living
- Indoor Air Quality Equipment and Services
- Other

*We are still awaiting CMS’ release of these data.*

Source: CMS Guidance.
Trends and Challenges
Medicare Advantage Is Growing

Medicare Trustees Report Projection of Medicare Advantage Enrollment

Plans Gearing Up with New Capabilities and Partnerships

- **Health Systems / Providers JV with Payers**
  - E.g., Banner and Aetna; Cleveland Clinic and Oscar

- **Payers Acquiring Home Health and Palliative Care Capabilities**
  - E.g., Humana and Kindred; Anthem and Aspire; Centene and Social Bridge

- **Retail Chains Acquiring Payers**
  - E.g., CVS and Aetna - $100 million to SDOH
And Starting To Recognize Value of Non-Medical Services in Managing Healthcare

<table>
<thead>
<tr>
<th>Traditional Services</th>
<th>Non-Traditional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes rehabilitation or nursing services that beneficiaries receive after, or instead of, a stay in an acute care hospital</td>
<td>Settings of care and services that get included in care management efforts and innovations</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Transportation</td>
</tr>
<tr>
<td>Outpatient clinics and physician offices</td>
<td>MD house calls</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>Palliative care</td>
</tr>
<tr>
<td>Home health care</td>
<td>Post-hospital meals</td>
</tr>
</tbody>
</table>

Source: ATI Advisory.
Non-Medical Supplemental Benefits Play Key Role in Meeting Individual Needs, Managing Healthcare

**Example 1:** I-SNPs offering transportation benefits
- 85% of all I-SNPs are offering a transportation benefit
- Reflects the needs of I-SNP members, who need help with activities of daily living

**Example 2:** CareMore meal benefit
- Offer 125 home-delivered meals (3 meals per day for 6 weeks) along with nutritional consultations from a registered dietician at no co-pay
- CareMore reports:
  - 36% reduction in readmissions
  - 5.9% reduction in average A1c levels
  - 5.8% reduction in average BMI
  - 98% of beneficiaries recommend CareMore given this experience

Source: ATI Advisory.
## Plans Are Struggling To Develop and Manage New Provider Networks

### Challenges

- Limited understanding of the impact of functional impairment on cost and on their enrollees’ long-term services and supports needs
- Conservative view of benefit design as supplemental funding is limited
- Limited understanding of how/why nonmedical services and supports are attractive to enrollees and families
- No easy way to communicate with or aggregate provider networks at regional or national level
- Noncompetitive rates
- Disconnect between new offerings and frontline employee education and knowledge
As a Result, Home Care and Other Providers Uncovering Issues

Challenges

- Consumer confusion over what is covered, differences between Medicare-covered “home health” and new “home care”
- First time, for many providers, interacting with public payer sources – lack information/IT systems
- Plan benefit designs are incompatible with home care provider business models
- Wide variability in plan requirements for certification, NPI, credentialing
- No obvious entry points to get “signed up” to provide services
How Can We Increase Dollars To Pay for Non-Medical?

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Rate</td>
<td>$800</td>
<td>$869</td>
</tr>
<tr>
<td>Rebate</td>
<td>0.5* $69 = $34.5</td>
<td>% available for rebate</td>
</tr>
<tr>
<td></td>
<td>Amount for reducing enrollee out of pocket spending &amp; offering supplemental benefits</td>
<td></td>
</tr>
</tbody>
</table>

Plan Premium = $81

MORE ENROLLMENT

Source: ATI Advisory.
Considerations and Discussion
## Considerations

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do plans need to more easily partner with service providers?</td>
<td>Does supplemental benefit flexibility make provider-led MA plans more attractive?</td>
</tr>
<tr>
<td>What are the concerns of providers and how can they be addressed?</td>
<td>What are the limits/concerns of CMS?</td>
</tr>
</tbody>
</table>

Source: ATI Advisory.
Vision: Health Hubs for Complex Care Populations*

Plan entity holds risk to align financial incentives and maximize control to deliver flexible, individualized care

Hub for Service Delivery and Coordination

Tech Enables Scale and Risk Management
Telehealth, remote patient monitoring, predictive analytics help maximize resources and scale

Focus on Primary Care and Communication
Focus on primary care and virtual team communication to best target resources onsite and in-home

Coordination and Targeting To Maximize Resources
Highly targeted, personalized medical and non-medical interventions even in absence of Medicaid funding

*Older adult population with chronic conditions and need for non-medical supports and services (e.g., risk for functional or cognitive impairment)

Source: ATI Advisory.
Thank you

info@atiadvisory.com
atiadvisory.com