

ATI Advisory



MARCH 2023

A Deep Dive on In-Home, Caregiver, and Social Supports in Medicare Advantage:
Can These Benefits Meaningfully Meet Member Needs and Support Independence?



Contents

Executive Summary	3
Section 1: Introduction	5
Project Background	5
Section 2: Quantitative and Qualitative Impact of These Benefits	9
Literature Review Findings on Benefit Impact	9
The Impact of In-Home Support Services	9
The Impact of Caregiver Supports	10
The Impact of Social Needs Benefits	10
Interview Findings on Benefit Impact	11
Section 3: Landscape of In-Home Support Services, Caregiver Supports, and Social Needs Benefit Offerings	14
Trends in Number of Plans Offering Select Benefits	14
Geographic Trends in Benefit Offerings	17
Trends in Benefit Design: In-Home Support Services	19
Trends in Benefit Design: Caregiver Supports	22
Trends in Benefit Design: Social Needs Benefit	24
Section 4: Plan Process for Selecting These Benefits	28
Step 1: What do members need?	28
Step 2: What can plans do to meet members' needs?	29
Step 3: How can plans best deliver identified benefits?	31
Section 5: Considerations and Conclusion	37
Policy Actions	38
Plan Actions	39
Policy, Plan, and Stakeholder Actions to Improve Beneficiary Experience	40
Conclusion	41
Methods	42
Acknowledgements	43
Appendix A: Literature Review	44

Executive Summary

Since 2019, ATI Advisory (ATI) and the Long-Term Quality Alliance (LTQA), with the support of The SCAN Foundation, have convened the [SSBCI Leadership Circle](#) to guide work tracking the evolution and implementation of nonmedical supplemental benefits in Medicare Advantage (MA). This work began with the Leadership Circle establishing [Guiding Principles](#) to lay out a path for how Medicare can allow for flexibility of these benefits to support individual needs, paired with appropriate guardrails that protect beneficiaries, providers, MA plans, and the integrity of the Medicare program overall.

Four years into implementation, nearly 40% of plans are offering either expanded primarily health-related benefits (EPHRB) or Special Supplemental Benefits for the Chronically Ill (SSBCI) in 2023. The proliferation of these benefits offers new research opportunities. The question at the heart of this latest research is why benefits that help members stay in their homes- **specifically in-home support services (IHSS), caregiver supports, and social needs benefits**- have experienced significant growth and adoption despite the challenges in providing a human-powered service. Each of these benefits grew in terms of the number of plans offering them between 2020 and 2023, with a 364% increase in plans offering IHSS (from 283 plans to 1,314), a 320% increase in caregiver supports (134 to 563), and a 1215% increase in social needs benefits (34 to 447).

Through our research, we found that:

- **Plans offer these benefits because they perceive these benefits to be directly and particularly responsive to identified member needs and gaps in the care system.**
- **Plans often offer these benefits as part of a broader, flexible package of benefits to help support individual needs and overall health.**
- **Beyond addressing needs, plans view these benefits' primary impact as promoting member satisfaction and retention.**

In addition to detailed information on the benefits themselves, our research identified the following actions that policymakers, plans, and beneficiary navigators can take to improve these benefits and their impact on beneficiaries:

Policy Actions

- 1 Improve data collection on benefits to support analysis** - Comprehensive evaluations of these benefits are limited; hence, collecting beneficiary-level utilization data on the benefits is essential to developing more effective offerings for members and caregivers.
- 2 Consider clarifying benefit definitions to minimize member confusion** - IHSS and social needs benefits have significant overlap, and our research suggests that many plans use them interchangeably. However, having two plans file the same benefit differently confuses beneficiaries and those who help them navigate plans and benefits. The Centers for Medicare and Medicaid Services (CMS) will need to consider ways to further clarify benefit details as it considers updates to Medicare Plan Finder and research on beneficiary-level utilization data of these benefits.
- 3 Clarify the benefits that plans can provide to member caregivers** - Clarity on the ability of plans to target non-member caregivers with caregiver supports, as well as what benefits plans can offer to non-member caregivers, would reduce confusion and expand the ability of plans and providers to support caregivers to maintain or improve beneficiary health.

Plan Actions

- 1 Improve targeting of the IHSS benefit** - Both plans and providers struggle with offering IHSS in its current form given the cost of the benefit, and targeting the benefit (to individuals post-hospital discharge, for example) may improve the value of the benefit to plans and providers and allow for extended visit times, addressing a provider concern with staffing. Plans should also carefully consider benefit design and whether features like expiration of hours reduce the impact of the benefit for members.
- 2 Standardize identification of caregivers** - Plans and providers struggle with identifying whether members have caregivers and who those caregivers are. Standardized identification may lead to greater uptake and impact of caregiver-targeted benefits.
- 3 Collect data, evaluate results, and publish findings** - Plans should continue their efforts to date to collect beneficiary-level utilization data, aiming to evaluate the use and reach of supplemental benefits. Combined with CMS actions to collect this data, plans should advance understanding of these supplemental benefits by publishing results of evaluations.

Policy, Plan, and Stakeholder Actions to Improve Beneficiary Experience

- 1 Gather feedback directly from beneficiaries and improve the education on plan choices available to them** - Beneficiaries are the most important stakeholder in terms of evaluating the value of these benefits. CMS, plans, and State Health Insurance Assistance Programs (SHIPs) can leverage their relationships with beneficiaries to gather feedback directly from Medicare beneficiaries to inform future guidance, updates to Medicare Plan Finder, and other supports. CMS and plans should also explore additional information that can be made available to brokers and SHIP staff to support beneficiary education on plan choices.

This report outlines valuable information for plans looking to launch or expand their benefit offerings in these areas, for policymakers looking to advance meaningful supports for Medicare beneficiaries, and for stakeholders seeking to support benefits that help to address whole person health needs. We recognize additional research is needed to fully understand the current and potential impact of these benefits for beneficiaries, plans, and CMS. **We hope that this report will ultimately result in more Medicare beneficiaries having access to benefits that meaningfully meet people's needs and are delivered in alignment with the Guiding Principles.**



Section 1: Introduction

PROJECT BACKGROUND

As of February 2023, over 30 million Medicare beneficiaries are enrolled in a Medicare Advantage (MA) health plan, representing 47% of the total Medicare population.¹ As MA expands, more Medicare beneficiaries are gaining access to the supplemental benefits that MA plans can offer. MA plans traditionally emphasize dental, vision, and hearing benefits, but recent legislative and administrative actions by the Centers for Medicare and Medicaid Services (CMS) introduced broader flexibility for the benefits that MA plans can offer through expanded primarily health-related benefits (EHRB) and the Special Supplemental Benefits for the Chronically Ill (SSBCI). These benefit types are summarized below in Table 1.

Table 1. Overview of Expanded Primarily Health-Related Benefits (EHRB) and Special Supplemental Benefits for the Chronically Ill (SSBCI) Authorities

	EHRB	SSBCI
What is it?	<ul style="list-style-type: none"> • “Primarily health-related benefits” refer to supplemental benefits offered by Medicare Advantage organizations that are not covered by Original Medicare, are primarily health-related, and for which the plan must incur a non-zero direct medical cost. • CMS expanded the definition of what was considered “primarily health-related” in 2018, creating expanded primarily health-related benefits (EHRB).² This allows plans to include benefits that “diagnose, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization”. 	<ul style="list-style-type: none"> • As part of the <i>Bipartisan Budget Act of 2018</i>, the Chronic Care Act authorized the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI).³ • These benefits are not required to be primarily health-related but must “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee”, and these enrollees are defined as an individual who: <ol style="list-style-type: none"> 1. 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; 2. Has a high risk of hospitalization or other adverse health outcomes; and 3. Requires intensive care coordination.
When did it start?	Plans were first able to offer these benefits in Plan Year 2019.	Plans were first able to offer these benefits in Plan Year 2020.

1 Centers for Medicare and Medicaid Services. “Monthly Enrollment by State 2023 2” (February 2023). Includes all 50 states and Washington, DC. Excludes cost and demo plan types. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolldata/monthly/monthly-enrollment-state-2023-02>

2 Centers for Medicare and Medicaid Services. “Reinterpretation of ‘Primarily Health Related’ for Supplemental Benefits” (April 2018). https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/hpms%2520memo%2520primarily%2520health%2520related%25204-27-18_83.pdf

3 United States Congress. “Bipartisan Budget Act of 2018” (February 2018). <https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>

	EPHRB	SSBCI
What types of benefits are allowed?⁴	<ul style="list-style-type: none"> • In-Home Support Services • Caregiver Supports • Adult Day Care Services • Home-Based Palliative Care • Therapeutic Massage 	<ul style="list-style-type: none"> • Social Needs Benefit • Food and Produce • Meals (beyond limited basis) • Pest Control • Transportation for Nonmedical Needs • Complementary Therapies • Indoor Air Quality Equipment and Services • Services Supporting Self-Direction • Structural Home Modifications • General Supports for Living

As these flexibilities were introduced, The SCAN Foundation, in coordination with ATI Advisory (ATI) and the Long-Term Quality Alliance (LTQA) saw an opportunity to inform the evolution of these benefits. ATI and LTQA convened the [SSBCI Leadership Circle](#), a diverse set of experts representing health plans, providers, beneficiaries, and other stakeholders that has offered guidance and thought leadership to this work since 2019. The work began with the development of the consensus [Guiding Principles](#), which lay out a path by which Medicare can allow for flexibility of these benefits to support individual needs, paired with appropriate guardrails that protect beneficiaries, providers, MA plans, and the integrity of the Medicare program overall.

Current Research Product

Our prior research focused on defining the opportunities and challenges that plans and providers face in developing and delivering nonmedical supplemental benefits to Medicare beneficiaries. In coordination with the SSBCI Leadership Circle, we chose to conduct a deep dive on specific nonmedical supplemental benefits: in-home support services (IHSS), caregiver supports, and social needs benefits. This deep dive approach seeks to improve understanding of specific benefits, their impact, and actions that policymakers and plans can take to make these benefits more impactful and better aligned with the Guiding Principles.

We selected these three benefits, and wanted to investigate them collectively, for several reasons:

- 1 These benefits are typically human-delivered and aim to address needs that are best addressed by human-centered connection and support;
- 2 The benefits have fairly broad definitions, and we have seen providers working across each of the benefits, indicating significant overlap between them;
- 3 These benefits resemble Medicaid long-term services and supports (LTSS) and potentially address a gap in these types of services for low-income non-dually eligible individuals;⁵ and

⁴ Bolded benefits indicate the benefits of interest for this report.

⁵ While we believe that these benefits can be meaningful to the populations being served, we also recognize the disparity between services typically available as supplemental benefits and those that are provided to a dually-enrolled population as LTSS home- and community-based services (HCBS), which are significantly more generous than those offered as supplemental benefits.

4 The number of plans offering these benefits continues to grow each year, despite the challenges in offering these benefits compared to more straightforward benefits like meals.

For these benefits, we sought to understand:

- the design and generosity of each benefit offering,
- the rationale for plans to offer these three benefits, and
- the impact of these benefits on beneficiaries.

Table 2 below provides the CMS definitions and examples of these benefits.

Table 2. CMS Definitions and Examples of In-Home Support Services, Caregiver Supports, and Social Needs Benefits

Benefit	CMS Definition / Examples
In-Home Support Services⁶	In-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADL) and instrumental activities of daily living (IADL) within the home to compensate for physical impairments, ameliorate the functional/ psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. 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.
Caregiver Supports⁷	Respite care provided through a personal care attendant or the provision of short-term institutional-based care, as appropriate, to ameliorate the enrollees' injuries or health conditions, or reduce the enrollees' avoidable emergency and healthcare utilization. Respite care should be for short periods of time (e.g., a few hours each week, a two-week period, a four-week period) and may include services such as counseling and training courses for caregivers of enrollees.
Social Needs Benefit⁸	Access to community or plan-sponsored programs and events to address enrollee social needs, such as non-fitness club memberships, community or social clubs, park passes, and access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function, are non-primarily health related benefits that may be covered as SSBCI.

6 The full list of EPHRB benefits along with definitions can be found here: Centers for Medicare and Medicaid Services. "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits" (April 2018). https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/hpms%2520memo%2520primarily%2520health%2520related%25204-27-18_83.pdf

7 Ibid.

8 As opposed to IHSS and caregiver supports, CMS has only provided examples of what can be provided as social needs benefits rather than a strict definition of the benefit. The examples can be found in this CMS guidance document: Centers for Medicare and Medicaid Services. "Implementing Supplemental Benefits for Chronically Ill Employees" (April 2019). https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

Research Approach

ATI and LTQA undertook qualitative and quantitative research to develop this report, including:

- Conducting more than two dozen interviews with plans, providers, beneficiary advocacy groups, and enrollment advisors;⁹
- Reviewing the Plan Benefit Package (PBP) data that plans submit to CMS and CMS releases on an annual basis with information on the benefits plans are offering;¹⁰
- Analyzing plan Evidence of Coverage (EOC) documents, in which plans provide details on the specific benefits being offered to enrolled beneficiaries; and
- Researching existing literature on similar types of services and their impacts on physical, mental, and social health of older adults.

This research builds on our prior work, including an analysis of the development and delivery of these benefits in 2020 and 2021, as well as ongoing analyses of nonmedical supplemental benefits data released by CMS (all of which are available in our resource center).

9 See the full list of interviewees at the end of this report. Interviewees were granted anonymity to promote candid insights, and in instances in the report where an organization's name is used, the information mentioned was gleaned from publicly-available sources.

10 Centers for Medicare and Medicaid Services. "Benefits Data". <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Benefits-Data>

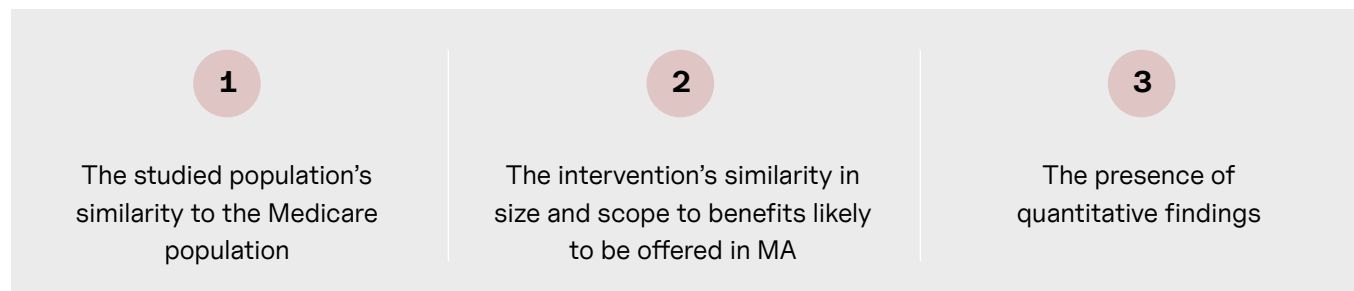
Section 2: Quantitative and Qualitative Impact of These Benefits

The impact of these benefits on member outcomes is of significant interest to plans, providers, CMS, Congress, and other stakeholders. To understand the potential impact of these benefits on members' health and plan costs, we conducted a literature review. While none of the included studies analyzed specific MA supplemental benefits offered to MA members, studies of similar interventions on frail and elderly populations point to potential impact of IHSS, caregiver supports, and social needs benefits on member outcomes.

We used this data to supplement plan interviews, in which plans shared that a perceived impact on retention and the ability for plans to use these benefits to maintain or improve member health were major drivers in offering these benefits.

LITERATURE REVIEW FINDINGS ON BENEFIT IMPACT

Below is a brief summary of findings from the literature on the impact of these benefits, with more comprehensive details on the studies available in Appendix A. Following a comprehensive literature review, we are highlighting specific studies below based upon three criteria:



THE IMPACT OF IN-HOME SUPPORT SERVICES

IHSS are designed to support ADL and IADL needs.¹¹ ADLs are tasks associated with independent living- dressing, eating, and bathing- and IADLs are more complex tasks- cooking and medication management, for example. The top three studies on IHSS-related benefits focused on populations receiving Home and Community Based Services (HCBS) through Area Agencies on Aging (AAA)/Older Americans Act (OAA)-funded activities and a Medicaid population age 65 and older.

Each of these studies found that the IHSS-related services reduced the likelihood of an individual being placed in a nursing home.

¹¹ As a reminder, the CMS definition of IHSS is "In-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADL) and instrumental activities of daily living (IADL) within the home to compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. 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".

Specific findings from these studies include:

- Personal care and homemaking services provided by an AAA reduced the likelihood of nursing home entry by over 80% after two years compared to individuals on a waitlist for the same services.¹²
- A 1% increase in the population aged 65+ receiving OAA-funded personal care services was associated with a 0.8% decrease in the proportion of residents in nursing homes needing limited supports.¹³

THE IMPACT OF CAREGIVER SUPPORTS

Caregiver supports can take numerous forms, with respite care and education / training being the primary examples. While only one of the selected studies includes respite support, each of the studies emphasizes education and training of caregivers. These studies tended to be on relatively small groups of individuals (or dyads of individuals and caregivers), and none of them focused solely on the Medicare population. However, based on age and the functional status of these populations, there is likely similarity between the groups included in these studies and Medicare enrollees receiving support from a caregiver. The studies also focused primarily on education and training programs for caregivers, which could be seen as a less intensive intervention compared to respite care.

Three of the studies included here identified potential cost reductions, with a common source of savings being reduced emergency department (ED) visits. Education provided to members and their caregivers on resources available to divert care to lower cost settings is a potential driver of savings. One key study of a health education program (HEP) targeted at spousal caregivers of frail older adults found that the program achieved total cost savings for caregivers and care recipients of \$309,461.14 (compared to a program cost of \$27,000).¹⁴ Finally, a meta-analysis of caregiver interventions found reductions in rehospitalizations at 90 and 180 days, as well as cost savings for hospitalizations.¹⁵

Notably, the Toseland study identified cost savings for the caregivers themselves. This finding may lend additional support to arguments in favor of offering this benefit, particularly in cases in which caregivers tend to be enrolled in the same plan as the care recipient. On a similar note, a separate study found that roughly 30% of caregivers in their study self-identified their personal health as either fair or poor,¹⁶ indicating that there may be significant value in considering the potential health needs of caregivers – beyond respite from caregiving– in conjunction with caregiver support interventions.

THE IMPACT OF SOCIAL NEEDS BENEFITS

Social needs benefits offered by plans were least aligned with the CMS examples of the benefit. Therefore, our analysis focused on a broad array of interventions designed to address social isolation, the need that is at the core of this benefit.

12 Area Agency on Aging 1-B "Personal Care and Homemaking Services for Older Adults and Adults with a Disability" (April 2013). <https://www.aaa1b.org/wp-content/uploads/2010/07/Personal-Care-Homemaking-Outcomes-Final-Report.pdf>

13 Thomas, Kali. "The relationship between older Americans act in-home services and low-care residents in nursing homes" (March 2014). <https://pubmed.ncbi.nlm.nih.gov/24336233/>

14 Toseland et al. "The Impact of a Caregiver Education Program on Health Care Costs" (August 2016). <https://journals.sagepub.com/doi/10.1177/1049731505276045>

15 Rodakowski et al. "Caregiver Integration during Discharge Planning of Older Adults to Reduce Resource Utilization: A Systematic Review and MetaAnalysis of Randomized Controlled Trials" (August 2017). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5555776/>

16 Center for Health Systems Effectiveness. "Medicaid Transformation Project Evaluation Interim Report" (December 2020). <https://www.hca.wa.gov/assets/program/mtp-interim-report.pdf#page=120>

Social isolation has been linked with significant negative health outcomes, including premature mortality.¹⁷ A broad variety of programs – from group fitness classes to meal delivery services – are shown to reduce social isolation. In a study of the Meals on Wheels program, numerous respondents expressed appreciation for their weekly interactions with their food delivery couriers, an unanticipated outcome of the program.¹⁸ Interventions allowing individuals to enroll in group fitness classes and various meal delivery programs showed the potential to reduce social isolation.

While some studies highlighted the positive health impacts of social isolation interventions (including fall reductions and reduced healthcare utilization), they included less detailed cost savings data compared to studies on other benefits analyzed in this report. Key findings included:

- A Meals on Wheels program that ran a randomized controlled trial of different types of delivery and engagement methods found association between daily meal deliveries and reductions in both falls and hospitalizations.¹⁹
- A pre-post study of a CareMore program providing individuals with home visits from social workers aiming to link them to social services showed reductions in outpatient ER use and acute hospital admissions.²⁰

INTERVIEW FINDINGS ON BENEFIT IMPACT

In addition to the quantitative data identified during the literature review, we asked plans why they choose to offer these benefits. Plans highlighted three driving factors:

1 **These benefits support member engagement and retention, even if they are not always at the top of the list of benefits individuals look for when shopping for a plan.**

Some of the appeal in benefits comes down to how clearly a member can translate what the benefit offers to a need that currently exists. Debit cards with a preset amount of funding available for an established list of activities, or a monthly grocery benefit, are straightforward for an individual to evaluate when shopping for a plan. Based on our interviews and research, it seems that IHSS is similarly well-understood – support with tasks around the home, for a certain number of hours – and this allows individuals to directly translate these benefits into value for themselves.

Plans also noted that while other benefits may be “flashier” and better used to attract members to the plan in the first place, IHSS, caregiver supports, and social needs benefits support member engagement and retention. The personal stories below are what plans often pointed to when noting the impact these benefits can have on their members and how it moves an individual to love the plan in which they’re enrolled, promoting member retention.

2 **Plans also find value in offering these human-centered, human-delivered benefits.**

In line with a common theme across these benefits, plans still see significant value in making human

¹⁷ Holt-Lunstad et al. “Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review” (2015). <https://journals.sagepub.com/doi/abs/10.1177/1745691614568352?journalCode=ppsa>

¹⁸ Meals on Wheels America. “More Than A Meal: Results from a pilot randomized control trial of home-delivered meal programs” (March 2015). <https://www.mealsonwheelsamerica.org/docs/default-source/News-Assets/mtam-full-report---march-2-2015.pdf?sfvrsn=6>

¹⁹ Ibid.

²⁰ Caruso, Robin. “CareMore’s Togetherness Program Addresses a Symptom of Living With Chronic Illness: Loneliness” (August 2018). <https://www.ajmc.com/view/caremores-togetherness-program-addresses-a-symptom-of-living-with-chronic-illness-loneliness>

connections. The trend towards flexible debit cards can remove the human support provided by these three benefits and may place an additional burden on the member to find service providers, vet the providers, and obtain the service. For plans, especially those with long histories of doing this work, they believe their involvement in supporting members to receive these benefits adds value and ultimately improves the member experience. Beyond just maintaining a link to members, plans described their staff using these benefits as tools to leverage existing resources and support the needs of members.

3

Lived experience of plan staff inform benefit offerings.

Similar to the impact of personal stories from members, there were numerous instances in which plan staff shared that personal experiences with caregiving led them to want to offer benefits to help support gaps in care. While unlikely an overriding reason for plans to offer these benefits, it is important to not overlook the lived experience of individuals involved in determining plan benefits. With nearly 1 in 5 Americans serving as a caregiver for individuals 50 and older, it's not surprising that some portion of plan staff are dedicating themselves to helping loved ones navigate care and a lack of LTSS options and bringing those experiences to the workplace.²¹

What is the human impact of these benefits?

One other recurring theme in our conversations with plans and providers alike was the human impact of these three benefits, shared through stories of how individuals were supported by these benefits.

Plans and providers spoke of how positive contact through these benefits has opened individuals up to more interactions and supports that were available to them:



One plan talked about a member who dealt with the passing of her husband caregiver and for whom home-delivered meals opened the door to a series of additional benefits, including direct support to her daughter now serving as her caregiver.



One provider shared multiple stories of how their companion pets allowed members to connect with family and friends by providing comfort and stability to these individuals during difficult life transitions.

21. AARP. "Caregiving in the U.S. 2020 Report" (May 2020). https://www.caregiving.org/wp-content/uploads/2020/06/AARP1316_RPT_CaregivingintheUS_WEB.pdf

Other stories emphasized the connections that these benefits enabled, either between the benefit providers and the members or between members and other individuals in their lives:



One plan talked about how a companion made available through these benefits drove the member to the airport to pick up their grandchildren, a task the member alone would not have been able to do.



Another plan talked about how a companion called a member on their birthday to wish them happy birthday and was told that no one had done that for the individual in years.



While impossible to quantify the value of these interactions, it is easy to see why plan leaders believe these types of interactions may have an impact on member retention.



Section 3: Landscape of In-Home Support Services, Caregiver Supports, and Social Needs Benefit Offerings

Our research delved into CMS PBP and EOC data to highlight the benefits that health plans are offering and how plans translate CMS requirements into benefit offerings. Below is a summary of what plans are offering under these benefits, including analysis of the benefit generosity and structure.

TRENDS IN NUMBER OF PLANS OFFERING SELECT BENEFITS

Table 3 below displays the number of plans, by authority, offering each of these benefits. Of these three, IHSS is the most popular new nonmedical supplemental benefit. While EPHRB and SSBCI authorities are the primary methods by which plans offer these new nonmedical supplemental benefits, plans can also offer these benefits under the Medicare Advantage Value-Based Insurance Design (VBID) model or Uniformity Flexibility (UF).²²

Table 3. Benefits by Authority and Number of Plans Offering the Benefit in 2023²³

Benefit	Authority	Number of Plans Offering Benefit	Percent of Total MA Plans Offering Benefit
IHSS	EPHRB	1,091	19.0%
	SSBCI	284	5.0%
	UF	7	0.1%
	VBID	5	0.1%
	TOTAL	1,314	22.9%
Caregiver Supports	EPHRB	293	5.1%
	SSBCI	263	4.6%
	UF	8	0.1%
	TOTAL	563	9.8%
Social Needs Benefits	SSBCI	360	6.3%
	VBID	78	1.4%
	TOTAL	437	7.6%

²² VBID is a Center for Medicare and Medicaid Innovation (CMMI) demonstration that began in 2017 and allows MA organizations to offer benefit packages or reduced cost sharing for members with Low-Income Subsidy or specified chronic conditions. VBID model participants can target members with primarily and non-primarily health related supplemental benefits (both EPHRB and SSBCI) and Part D benefits. CMS updated the definition of UF to allow MA organizations to offer a package of benefits or cost sharing/deductibles available to all members with a specified disease state. UF cannot be used for non-primarily health-related benefits (see the SSBCI list in Table 1) or Part D benefits.

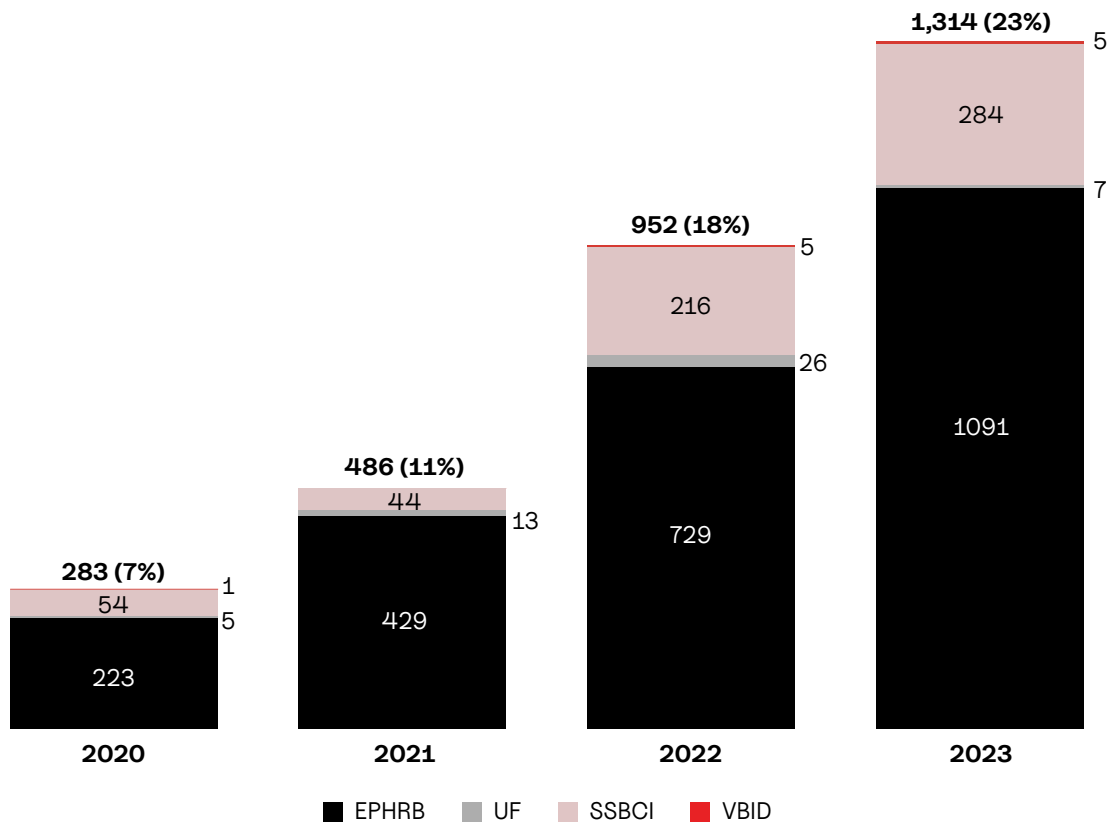
²³ Totals may not be the sum of each benefit category because plans may offer more than one benefit through different authorities. Total MA plans equals 5,730. Excludes Employer Group Health Plans (EGHPs), Part B only, Medicare-Medicaid Plans (MMPs), and Program of All-inclusive Care for the Elderly (PACE).

Since 2020, the number of plans offering the three benefits has grown significantly. Across all authorities, IHSS increased 364% from 283 plans to 1,314, caregiver supports increased 320% from 134 plans to 563, and social needs benefit increased 1215% from 34 plans to 447 (see Figures 1-3), all higher than the 203% increase in all new supplemental benefits.²⁴

IHSS is the most common nonmedical supplemental benefit offered by plans, with 23% percent of plans providing IHSS in 2023, compared to 10% and 8% of plans offering caregiver supports and social needs benefits, respectively.²⁵

Additionally, in recent years MA plans used additional authorities to offer these benefits. For example, most plans offer IHSS through EPHRB, which allows all members of the plan access to the benefit. However, over 200 plans in 2022 and 2023 offered IHSS benefits through SSBCI, which limits eligibility to certain chronic conditions. For caregiver supports, plans evenly use EPHRB and SSBCI authorities to offer their benefit.

Figure 1. Number of MA Plans Offering IHSS, by Authority, 2020-2023²⁶



²⁴ Total plans offering one of 15 new supplemental benefits were 754 in 2020 and 2,286 in 2023, including all authorities. Benefits established in the 2023 Supplemental Benefit Chartbook.

²⁵ Total MA plans in 2023 are 5,730, after excluding EGHPs, PDPs, MMPs, Part B-only plans, and PACE.

²⁶ For plan-level analysis throughout this report, a plan is the combination of a contract number, plan number, and section ID. Totals may not be the sum of each authority because plans may offer multiple benefits under different authorities. Percentage indicates percent of total MA plans offering this benefit in the given year. Excludes EGHPs, PDPs, MMPs, Part B-only plans, and PACE.

Figure 2. Number of MA Plans offering Caregiver Supports, by Authority, 2020-2023

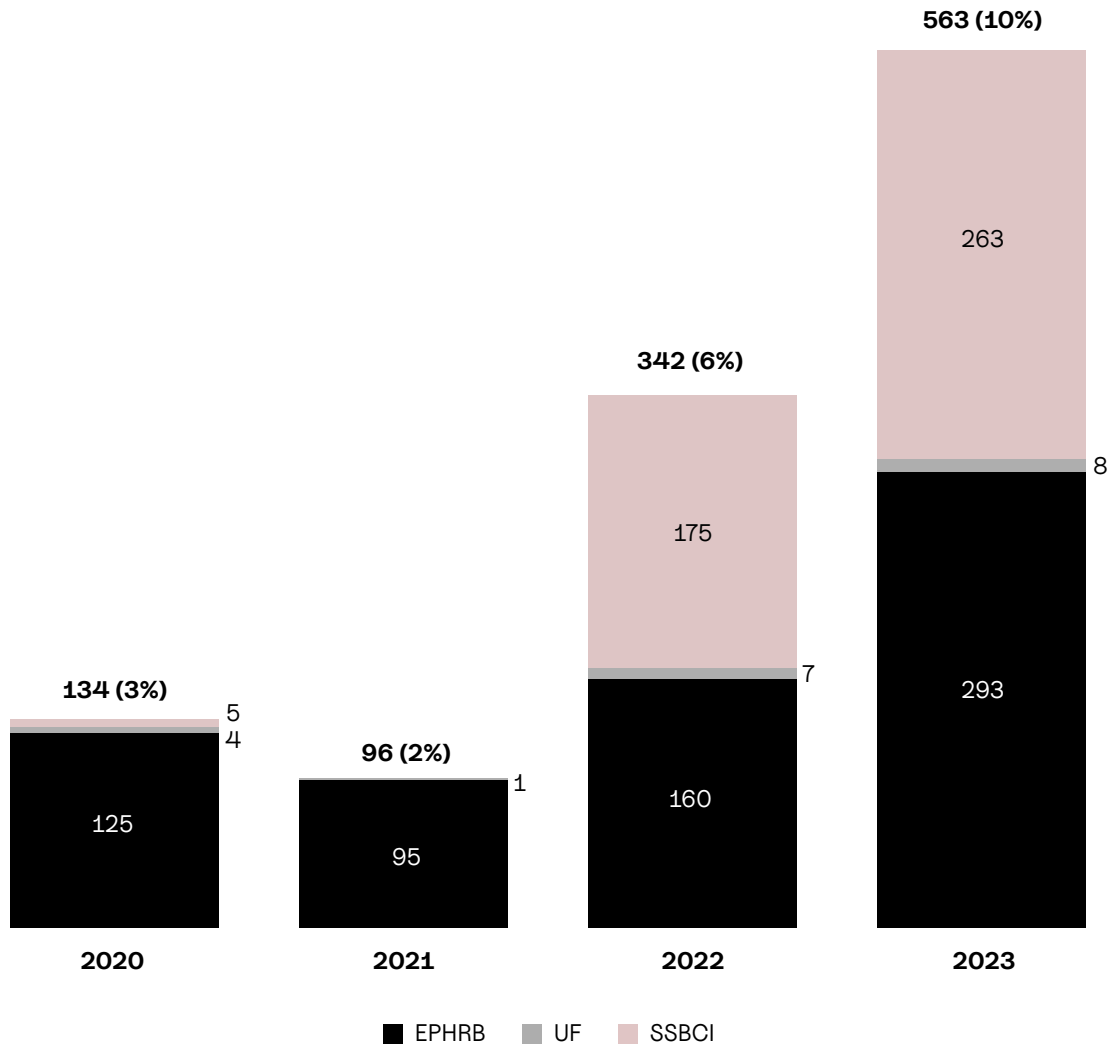
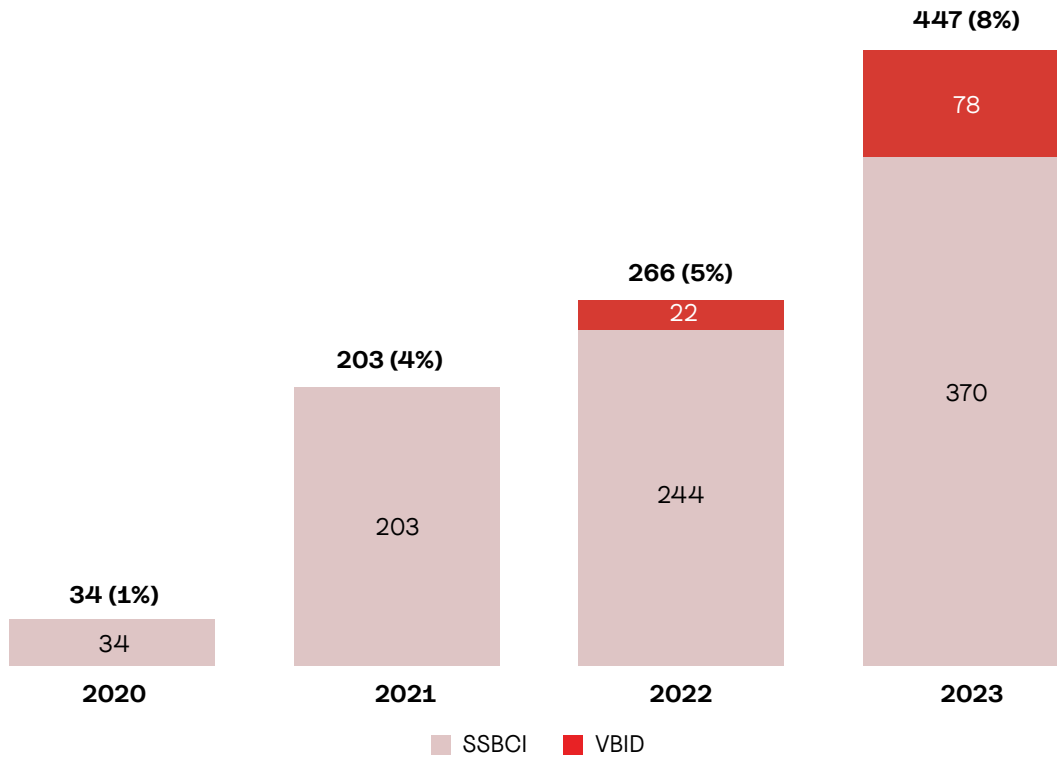


Figure 3. Number of MA Plans Offering Social Needs Benefits, by Authority, 2020-2023



GEOGRAPHIC TRENDS IN BENEFIT OFFERINGS

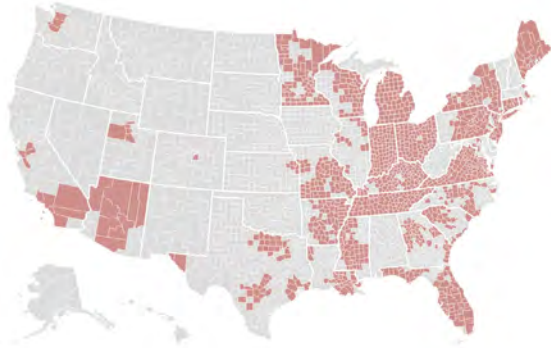
As the number of plans offering IHSS, caregiver supports, and social needs benefits has increased in the last four years, the geographic reach of these nonmedical benefits has expanded (see Figures 4-6). Our analysis reveals that plans offering these benefits grew in the following ways:

- IHSS grew from 32 states and Puerto Rico in 2020 to 46 states, Puerto Rico, and Washington D.C. in 2023;
- Caregiver supports grew from 25 states to 44 states and Puerto Rico; and
- Social needs benefits grew from 15 states to 44 states and Puerto Rico.

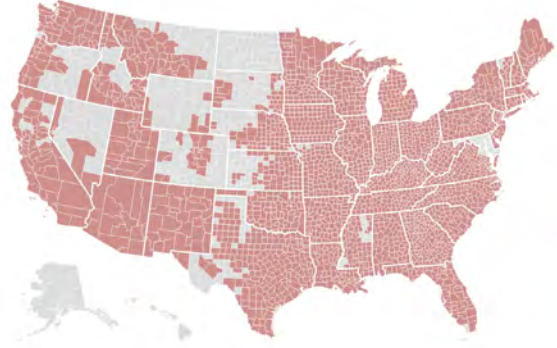
The number of plans offering each benefit *per* county has also increased. Between 2020 and 2023, the average number of plans offering IHSS in a county grew from 3.2 to 9.8, while the average expanded from 1.8 to 4.8 plans offering caregiver supports per county and 1.9 to 5.7 plans offering social needs benefits per county.



Figure 4. Expansion of IHSS, 2020 vs. 2023

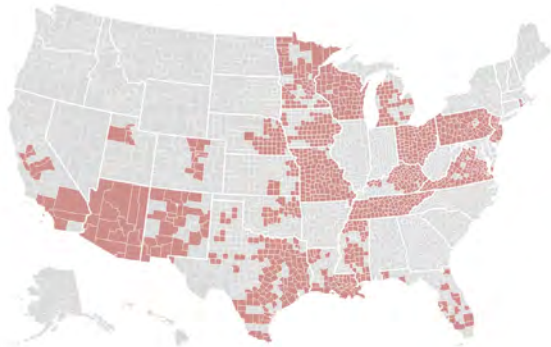


2020: 32 states & Puerto Rico; 1,397 counties

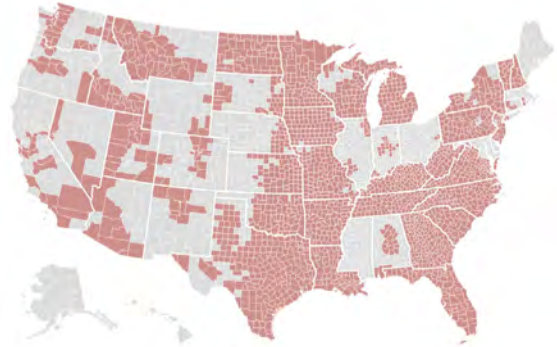


2023: 46 states, Washington, D.C., and Puerto Rico; 2,832 counties

Figure 5. Expansion of Caregiver Supports, 2020 vs. 2023

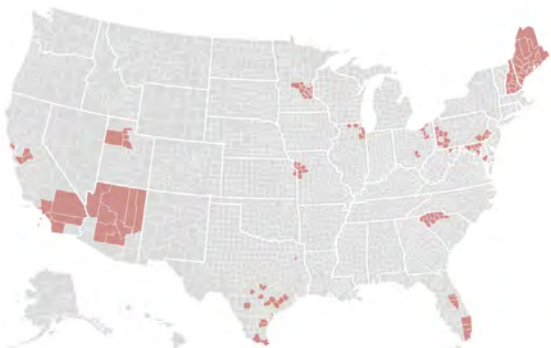


2020: 25 states; 1,212 counties

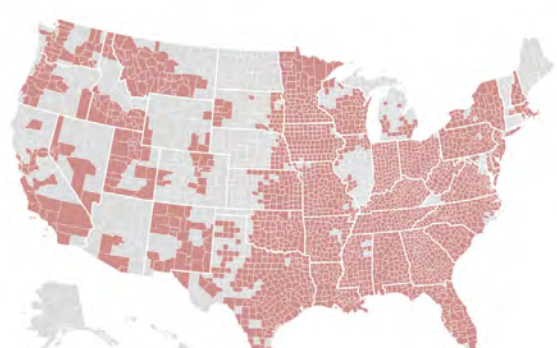


2023: 44 states & Puerto Rico; 2,224 counties

Figure 6. Expansion of Social Needs Benefits, 2020 vs. 2023



2020: 15 states; 139 counties



2023: 44 states & Puerto Rico; 2,472 counties

TRENDS IN BENEFIT DESIGN: IN-HOME SUPPORT SERVICES

As noted above, IHSS is the most commonly offered benefit among the expanded set of nonmedical supplemental benefits in 2023. Based on our analysis, it also has the most uniformity in how it is offered. Plans typically cover assistance with ADL or IADL needs (or mention homemaker or personal care services). As Table 4 illustrates, IHSS benefits are typically available in 2-4-hour increments, with a limit on the total number of hours available to members in a given year. In some cases, health plans have limited IHSS benefits to beneficiaries who have been discharged from a hospital after an inpatient stay. (The description of SCAN Affirm in Table 4 highlights how their IHSS benefit is structured as post-hospitalization support.)

The structure of the benefit also varies in terms of how members use the hours. Some plans provide hourly limits per month that expire at the end of a month, while other plans allow members to accumulate hours over the course of a year. Accumulation of hours allows individuals to “store up” the hours and potentially use them in a more strategic manner- following a procedure, for example, without explicit guidance to do this from the plan. Providers also mentioned that plans allowing members to stack visits allowed them to provide longer shifts to their staff, addressing the challenge of staffing short shifts that was voiced by several providers.



Table 4. Examples of IHSS Descriptions in Evidence of Coverage (EOC) Documents

Elevance Health Anthem MediBlue Plus (HMO) 2023 Evidence of Coverage²⁷	Molina Medicare Complete Care Select (HMO D-SNP) 2023 Evidence of Coverage²⁸	SCAN Affirm partnered with Included LGBTQ+ Health 2023 Evidence of Coverage²⁹
<p>This benefit provides companionship and assistance with independent activities of daily living such as home-based chores, help getting to appointments or getting items such as groceries, medication, and more. Help getting to appointments does not include transportation. In-home support can work in conjunction with other benefits or care plans to promote independent living, aid in reducing a member’s feeling of social isolation, and improve their overall mental outlook. You must use the plan approved provider.</p>	<p>Members have access to up to 90 hours every year. You have access to in-home support services, including cleaning, household chores, meal preparation, and assistance with other instrumental activities of daily living.</p> <p>There is no coinsurance, copayment, or deductible for these services.</p>	<p>Returning to Home is a program to help you with support and personal care services immediately following a discharge from a hospital or skilled nursing facility.</p> <p>The program covers the following services:</p> <ul style="list-style-type: none"> • Personal in-home care: Up to ten 4-hour in-home care visits (40 hours total per year) to help with activities of daily living such as bathing, dressing, laundry, bed linen changing, light housekeeping, care-giver relief, etc. • Telephonic care coordination: To aid in scheduling of follow-up care and arranging in-home support services as needed. • Home-delivered meals: Up to 4 weeks (84 meal maximum per year) of meals delivered to your home. <p>These services must be requested within 7 days of being discharged from the hospital or skilled nursing facility in order for the benefit to be authorized.</p>

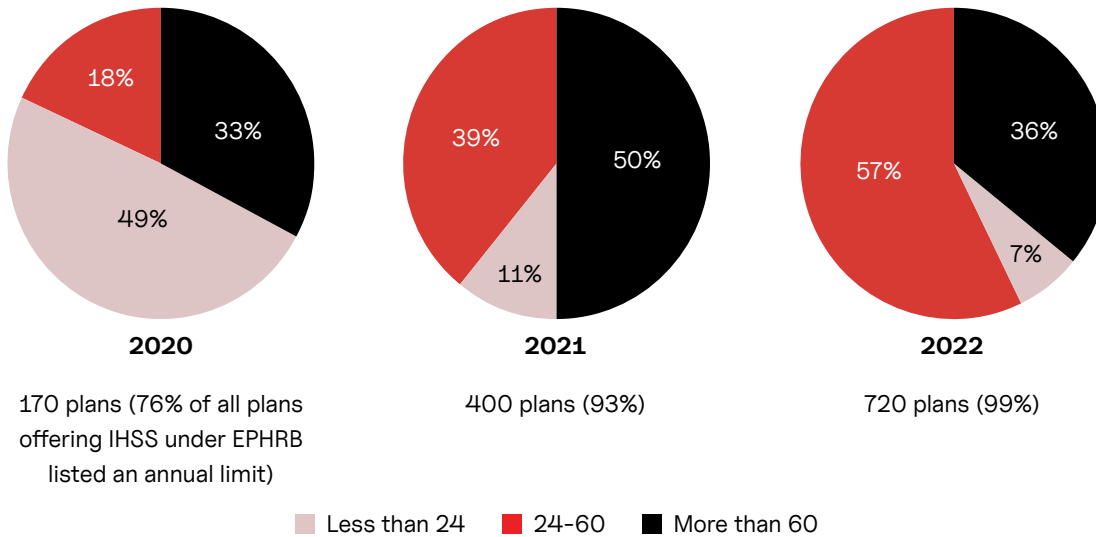
Given the labor-intensive nature of IHSS, this can be a relatively expensive benefit (paying for staff time, travel, etc.), which is magnified by workforce challenges for home care providers in the post-pandemic environment. As a result of the cost of this benefit, plans often restrict the number of hours allocated to each member. Figure 7 displays the variation in IHSS generosity from 2020-2022 through EPHRB (the primary authority used to offer this benefit). Analyses of EOC files from 2020 through 2022 show the total annual hours per plan have varied from as low as 4 hours up to 324 hours and have coalesced between 24 and 60 hours. However, while 57% of plans in 2022 offered 24 to 60 hours per year, the single annual amount most commonly offered by plans is 124 hours (22% of plans).

27 Anthem. "2023 Evidence of Coverage for Anthem MediBlue Plus (HMO)" (2022). https://file.anthem.com/MED2023/Y0114_23_3002586_U_C_0187.pdf

28 Molina Health Care. "2023 Evidence of Coverage for Molina Medicare Complete Care Select (HMO D-SNP)" (2022). <https://www.molinahealthcare.com/members/wi/en-us/mem/medicare/-/media/Molina/PublicWebsite/PDF/members/common/en-us/Medicare/2023%20Documents/Evidence%20of%20Coverage/WI005-2023-SNP-EOC-EN-508.pdf>

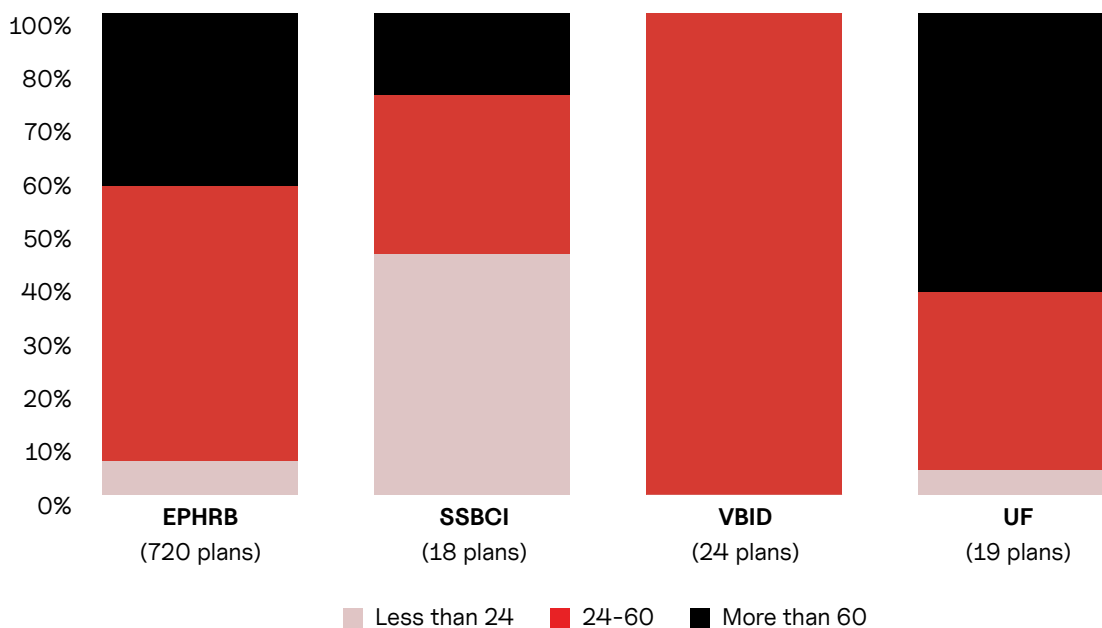
29 SCAN Health Plan. "2023 Evidence of Coverage for SCAN Affirm Partnered with Included LGBTQ+ Health" (2022). https://www.scanhealthplan.com/-/media/scan/documents/_plan_docs2023/2023-23ccaeoc0800.pdf

Figure 7. Variation in IHSS hours in EPHRB only, 2020-2022



There is also variation in annual IHSS hours based on the authority used to offer the benefit (see Figure 8). In 2022, only 8.3% of plans using SSBCI for their IHSS benefit described any annual limit, and of those, half offered less than 24 hours per year.³⁰ Additionally, all plans using VBID offered 24-60 annual hours, and a majority of plans using UF offered more than 60 annual hours. The limited data on plans offering IHSS using SSBCI seem to produce counterintuitive data, while the relatively generous annual limits for plans using VBID and UF is likely due to the ability of MA plans to target benefits to members with higher needs through these authorities.

Figure 8. Variation in IHSS Hours, by Authority, in 2022



³⁰ A significant factor to only 8.3% of plans having an annual limit is that one Medicare Advantage organization (MAO) offers over half of the plans offering IHSS under SSBCI, and this MAO offers a flex card that does not have specific information available on the number of annual hours.

The number of IHSS hours offered per year also vary among Medicare Advantage Special Needs Plans (SNPs; data not shown). SNPs tend to have members with greater care needs, including those that may benefit from support beyond traditional medical care. There are three types of SNPs:

- Dual-eligible SNP (D-SNP) for Medicaid-eligible individuals,
- Chronic condition SNPs (C-SNPs) for individuals with certain chronic conditions, and
- Institutional SNPs (I-SNPs) for individuals living in institutional settings or community-dwelling individuals who are eligible for institutional care.

Both C-SNPs and D-SNPs offer more than 60 hours per year in more than 40% of plans, compared to 33% of non-SNPs. For C-SNPs, the most common number of hours is 124 per year, offered in 45% of plans. The reason for this is that one major Medicare Advantage organization (MAO) accounts for all C-SNPs offering 124 hours per year, as well as 24% of D-SNPs and 18% of non-SNPs.

TRENDS IN BENEFIT DESIGN: CAREGIVER SUPPORTS

Caregiver supports is the next most popular benefit of the three that we examined, and it had the highest rate of growth and adoption of any EPRHB offering in 2023. This benefit has three primary forms in which plans offer it. The most common form is respite care. In instances in which respite care is provided, the services are typically delivered in-person and provide respite to caregivers by relieving them of typical duties- support with personal care or homemaker tasks (see Table 5 for sample EOC listings). This benefit can also take the form of training and educational resources for caregivers. Another common offering is counseling support, which may resemble care coordination and involve helping members with activities like setting up grocery delivery programs or scheduling medical appointments.



Table 5. Examples of Caregiver Support Descriptions in Evidence of Coverage (EOC) Documents

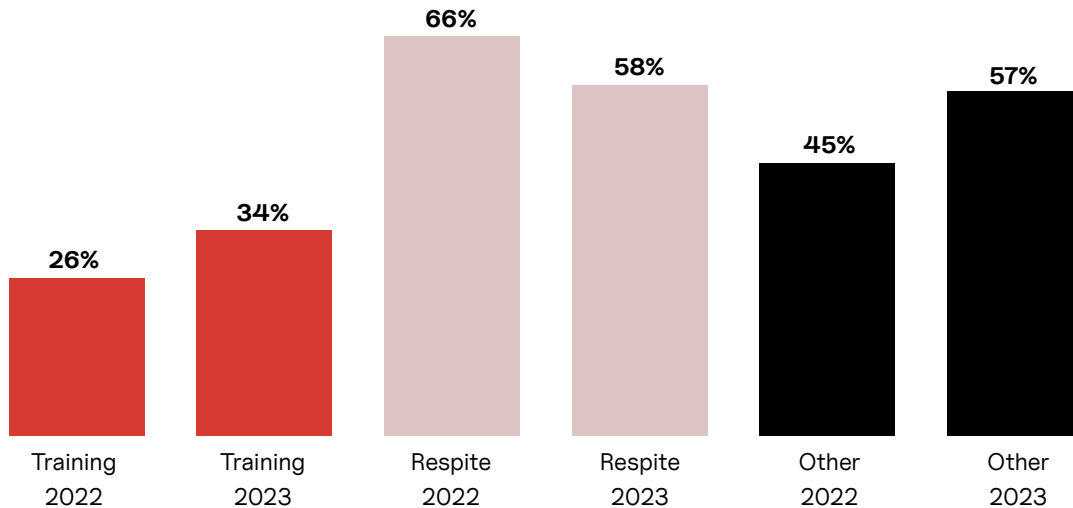
UPMC for Life HMO Premier Rx 2023 Evidence of Coverage ³¹	United Healthcare Dual Complete One (HMO-POS D-SNP) 2023 Evidence of Coverage ³²	Cigna Preferred Savings Medicare (HMO) 2023 Evidence of Coverage ³³
<p>Our plan provides tools for caregivers in support of their care for a spouse, relative, or friend who lives at home or in a nursing home. Caregivers will learn ways to help reduce stress, communicate effectively, make decisions, set goals, and solve problems.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Six counseling sessions with trained clinicians through Resources for Life. • Six-week Powerful Tools for Caregivers course designed to teach caregivers how to care for themselves while also looking after their loved one. 	<p>Members with disabilities or other qualified medical conditions may be eligible for up to 16 hours per month of respite care. Attendants provide assistance for a variety of needs including homemaking, personal care, and general supervision.</p>	<p>Services include one-on-one coaching and personalized resources for customers and caregivers.</p>

Based on interviews with plans, we found mixed interest in offering caregiver supports. Some plans highlighted caregiver supports as their primary benefit among these three, while others expressed uncertainty about how their caregiver support benefit varied from IHSS. As discussed more extensively below in the *Challenges That Plans Face* section, multiple plans expressed concerns regarding their ability to comply with guidelines while targeting a benefit towards a non-member caregiver. This concern persists despite CMS defining the benefit as one that “may include services such as counseling and training courses for caregivers of enrollees.”

Since 2022, CMS has required that MA plans identify their caregiver supports benefit in one of three descriptive categories: caregiver training (often caregiver education programs, both in-person and virtual), respite care (in-home respite care, up to a certain number of hours), or other (catch-all category that may include things like companionship, caregiver expense reimbursement, and counseling). As demonstrated in Figure 9, respite care continues to be the most popular form of this benefit while caregiver training is the least popular.

31 UPMC. “2023 Evidence of Coverage for UPMC for Life HMO Premier Rx” (2022). <https://upmc.widen.net/view/pdf/supkxehgjl/mc-eoc-2023-hmo-premier-wpa.pdf>
 32 UnitedHealthcare. “2023 Evidence of Coverage for UnitedHealthcare Dual Complete ONE (HOM-POS D-SNP)” (2022). <https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/2023/eoc/en/2023-VA-EOC-H7464-005-000-EN.pdf>
 33 Cigna. “2023 Evidence of Coverage for Cigna Preferred Savings Medicare (HMO)” (2022). <https://www.cigna.com/static/www-cigna-com/docs/medicare/plans-services/2023/eoc-h0672-005-000.pdf>

Figure 9. Proportion of Caregiver Support Categories, 2022-2023



Note. Sum of categories per year is more than 100% because plans can select more than one category to describe their caregiver support benefit.

For respite care, plans can limit the number of hours available to beneficiaries per year. In 2022, 92% of plans offered between 24 and 60 hours of respite care per year, with 40 hours per year being the most common annual limit. Only 3% of plans exceeded 60 hours per year of support. As previously noted, a significant portion of caregiver support benefits are classified as “other”, and what plans offered under this category varies. In 2022 and 2023, the most common “other” benefit was “permanent caregiver services” from Humana, available in 123 and 199 plans, respectively. This benefit type, offered under their Flex Card, is a suite of benefits a member can choose to purchase to meet their needs. Other caregiver support benefits offered by plans include caregiver reimbursement (which ranges from \$50 to \$300), personalized/educational resources, counseling services, and telephonic support.

TRENDS IN BENEFIT DESIGN: SOCIAL NEEDS BENEFIT

Of the three benefits of interest in this report, the social needs benefit is the least likely to be offered by an MA plan. It is also the only benefit of these three that is limited to the SSBCI and VBID authorities, as this benefit cannot be offered as an expanded primarily health-related benefit (EPHRB). The limiting criteria required for SSBCI (see Table 1 for more details on these criteria) may partially explain the more limited uptake of this benefit.

Our research highlighted a discrepancy between the types of social needs benefits offered by CMS as examples and the benefits actually being offered by MA plans. The CMS examples include events, club memberships, and other group interactions designed to address social isolation. Plans are offering this benefit, and the offerings have wide variability - from spiritual care to robotic pets to in-person interactions (see Table 6 for sample EOC listings). While most of these are individually targeted benefit programs, there may still be room for plans to expand their benefit offerings into group supports, similar to the examples provided by CMS. This lack of social and club membership support may also be connected to the COVID-19 pandemic, as these benefits were first available in 2020 just as many group interactions were suspended due to the pandemic.

Table 6. Examples of Social Needs Benefit Descriptions in Evidence of Coverage (EOC) Documents

Ascension Complete Michigan Access (PPO) 2023 Evidence of Coverage³⁴	Wellcare Dual Access (HMO D-SNP) 2023 Evidence of Coverage³⁵	Cigna Preferred Savings Medicare (HMO) 2023 Evidence of Coverage³⁶
<p>The health plan offers 24 hours per day, 365 days a year virtual visits and access to professionally trained chaplains through the Ascension On Demand Spiritual Care program. Chaplains are experienced in such things as spiritual assessments, care for grief and loss and stress management.</p> <p>Using the Ascension Online Care platform, members who are experiencing spiritual and emotional concerns can connect to a chaplain to help address their needs and find light in challenging times.</p>	<p>If eligible, you may receive an interactive companion cat or dog from a contracted provider. Type of pet is subject to availability. Robotic companion pets are clinically shown to improve memory and decrease the symptoms of depression by providing responsive companionship. Cats respond to physical touch with realistic purrs and motion. Dogs respond to your physical touch and voice with realistic sounds, heartbeat, and motion. For more information on the features and types of pets, please contact our plan. Benefit is limited to one pet per member per year.</p>	<p>You may be eligible for up to 96 hours (24 hours every quarter) of companionship and general assistance services every year. General assistance includes assistance with technology and light household needs.</p>

Plan executives interviewed for this report universally pointed to social isolation - the need intended to be addressed by social needs benefits - as a widespread issue. In fact, it has increased because of the pandemic and the need for social support remains high.³⁷ Plan executives acknowledged the SSBCI criteria as an unnecessary limiting factor, noting that members who do not meet the definition of having a complex chronic condition could benefit significantly from social needs benefits. Further, since many benefits can address social isolation, plans may offer benefits like fitness or IHSS as a broadly available primarily health-related benefit, or they may offer outreach or services as a quality improving activity.³⁸

Our analysis of EOC documents identified three categories of social need services: in-person, online/telephonic, and other services (e.g., robotic pets). Figure 10 indicates that in-person services accounted for 54% of plans. This benefit structure included individuals going into a member’s home to provide companionship (e.g., playing games or simply spending time with members) and homemaker services, visits by a community resource specialist after a meal delivery, or community events.

34 Centene Venture Company Michigan. "2023 Evidence of Coverage for Ascension Complete Michigan Access (PPO)" (2022). https://contentserver.destinationrx.com/ContentServer/DRxProductContent/PDFs/149_0/H7512_002_2023_MI_EOC_PPO_105804E_C.pdf

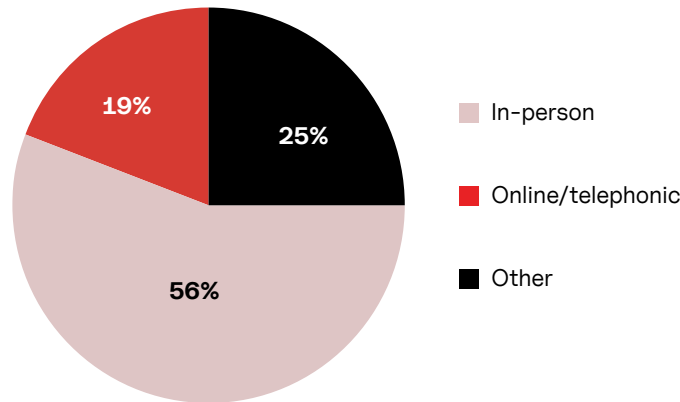
35 UnitedHealthcare. "2023 Evidence of Coverage for UnitedHealthcare Dual Complete ONE (HOM-POS D-SNP)" (2022). <https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/2023/eoc/en/2023-VA-EOC-H7464-005-000-EN.pdf>

36 Cigna. "2023 Evidence of Coverage for Cigna Preferred Savings Medicare (HMO)" (2022). <https://www.cigna.com/static/www-cigna-com/docs/medicare/plans-services/2023/eoc-h0672-005-000.pdf>

37 University of Michigan Institute for Healthcare Policy and Innovation. "National Poll on Healthy Aging: Loneliness Among Older Adults Before and During the COVID-19 Pandemic" (September 2020). <https://www.healthyagingpoll.org/reports-more/report/loneliness-among-older-adults-and-during-covid-19-pandemic>

38 In a previous report, we laid out opportunities and limitations of the various pathways available to plans to provide non-medical supports to their members. Please see page 23 of our report on "Advancing Non-Medical Supplemental Benefits in Medicare Advantage: Considerations and Opportunities for Policymakers".

Figure 10. Social Needs Benefits Categories from EOC Review, 2022



Of the 130 plans that offer companionship services in a person’s home, 129 specified the number of hours of companionship per year. The annual amount varied dramatically, ranging from 12 hours to 210 hours per year. The two most common annual limits of companionship in 2022 were 48 hours (50% of plans) and 120 hours (26%) (data not shown). Online/telephonic services (offered in 51 plans) included 24/7 spiritual care and member support, which included care coordination and supports. Additionally, other services (offered in 67 plans) included robotic pets, a pill box and wheelchair/walker safety pouch, and a bundled benefit package through a flex card. The EOCs for the flex card arrangements were typically unclear on the specific services a member could purchase. A full list of benefit types, along with the number of plans offering the benefit type, is in Table 7.

Table 7. Examples of Social Needs Benefits from EOC Review, 2022

Benefit	Number of Plans	Benefit Category
Companionship	130	In-person
Robotic Pet	51	Other
Telephonic Spiritual Care	50	Other/Telephonic
Visual Safety Checks during Meal Delivery	15	In-person
Flex Card (Service Unknown)	12	Other
Community Events	3	In-person
Unknown	3	Other

Benefit	Number of Plans	Benefit Category
Member Support	1	Other/Telephonic
Pill box & wheelchair/walker safety pouch	1	Other

TRENDS IN BENEFIT DESIGN: BUNDLED BENEFITS

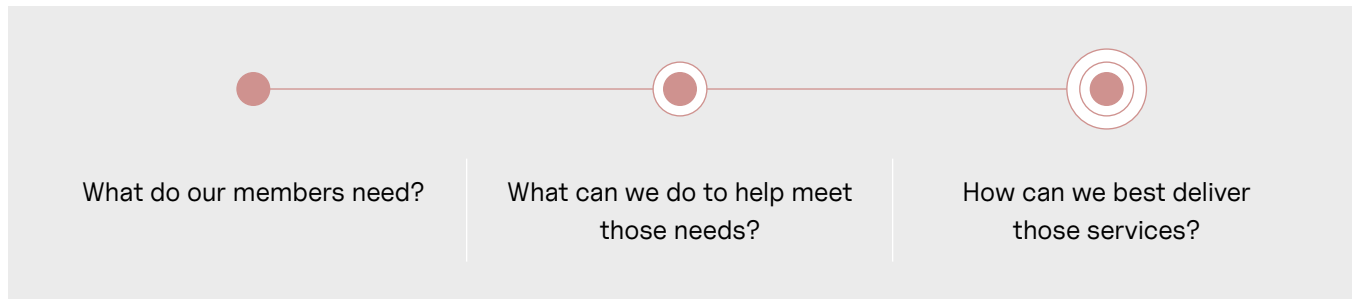
Another way MA plans offer these three benefits is through bundling benefits. Plans bundle multiple benefits under flexible spending accounts and offer a fixed dollar or credit limit, and members then choose the benefit(s) that best fit their needs. Five MAOs had this structure in 2022 in more than 170 plans, and each one used the SSBCI authority to offer their bundled benefit packages. One MAO offered a flex card for their social needs benefit, which ranged from \$20 to \$225 per month, with the larger amounts generally offered in D-SNPs and C-SNPs, and smaller offerings in non-SNP MA plans. Another MAO used a flex card (ranging from \$500 to \$1,000 per year) to offer IHSS and caregiver supports benefits. Finally, one MAO utilized a third-party aggregator that performs network management and care coordination to offer IHSS and caregiver supports benefits.



Section 4: Plan Process for Selecting These Benefits

These three benefits can help to support clear member needs and help maintain or improve their health. However, the proportion of plans offering these benefits is still only approximately 30%. Plans are still exploring nonmedical benefits in general, solutions are still evolving, and additional evidence and evaluation need to be built.

For plans considering offering these benefits, we provide insights from our interviews on a three-step process plans go through to determine how best to support member needs. The questions guiding this process are:



We provide examples of plan approaches to answer these questions below. For more information on building and delivering supplemental benefit packages, please see our [implementation roadmap](#) and [progress report](#).

STEP 1: WHAT DO MEMBERS NEED?

Plans begin by assessing what services their members need to maintain or improve their health, which may include support for living independently or for aiding a caregiver that is supporting them. They do this through a variety of methods, including outreach to various staff (care managers, customer services, sales, marketing, and clinical) who have direct interactions with members, and through feedback from members or potential members. Health plan leaders interviewed for this report noted that plan staff expectations about member needs may not always align with what members report they need.

Our analysis of data on the Medicare population indicates significant need (Table 8), and therefore opportunity, for plans to support their members by targeting these needs.

Table 8. Prevalence Rates of Needs Targeted by IHSS, Caregiver Supports, and Social Needs Benefits

Need	Prevalence of Need
ADL / IADL needs	Among community-dwelling Medicare beneficiaries ³⁹ <ul style="list-style-type: none"> • 25% have difficulty with 1+ ADL • 14% have difficulty with 2+ ADLs • 29% have difficulty with 1+ IADL • 13% have difficulty with 2+ IADLs

³⁹ ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey. Analysis excludes beneficiaries who reside in nursing homes, assisted living, and other residential facilities.

Need	Prevalence of Need
<p>Caregiver support needs</p>	<p>Research has found that:</p> <ul style="list-style-type: none"> • 42% of all Medicare beneficiaries with LTSS needs receive no help, and • 43% of Medicare beneficiaries with LTSS needs receive only unpaid help.⁴⁰ <p>When surveys have been conducted of caregivers and their needs, the caregivers indicated that:</p> <ul style="list-style-type: none"> • 38% would find respite services helpful • 21% identify their own health status as fair or poor • 23% agree that it is difficult to take care of their own health • 61% reported impacts on their employment situation, including schedule changes, reductions in hours, leave of absence, and more⁴¹
<p>Social isolation</p>	<p>While estimates have a significant range, two studies of the Medicare population identified that:</p> <ul style="list-style-type: none"> • 55.3% of the fee-for-service population reported being lonely, noting no significant difference between the FFS and MA populations • 36.7% of Medicare enrollees reported feeling less connected to friends and family in the summer of 2020 since the start of the COVID-19 outbreak

These research findings highlight the significant gaps in the infrastructure and funding available to help meet Medicare beneficiary social and LTSS-related needs.⁴² Many of the plans we spoke to reported identifying social and LTSS-related needs within their populations, gaps in the member’s ability to access services, and a desire to use the supplemental benefit authority to help address these needs.

STEP 2: WHAT CAN PLANS DO TO MEET MEMBERS’ NEEDS?

Once the health plans have identified their members’ needs, they consider the universe of solutions to support these needs. Their approaches vary depending on the organization and other assets the health plan has at its disposal. Given the relative novelty of MA plans’ ability to address these needs due to the evolution of nonmedical supplemental benefits, we found that plans are casting a wide net for solutions before trimming them down. Below, we have described several key process steps that plans take to determine how to support their members’ needs.

40 Data points are from a Commonwealth Fund report on “Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs”, and high-need older adults are defined in this report as “individuals age 65 and older who have multiple chronic conditions and no difficulty with an ADL.” Source: The Commonwealth Fund. “Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs” (February 2019). <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/targeting-high-need-beneficiaries-medicare-advantage>

41 Willink et al. The Commonwealth Fund. “Use of Paid and Unpaid Personal Help by Medicare Beneficiaries Needing Long-Term Services and Supports” (November 2017). https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_nov_willink_medicare_ltss_needs_ib_v2.pdf

42 Willink et al. The Commonwealth Fund. “The Financial Hardship Faced by Older Americans Needing Long-Term Services and Supports” (January 2019). https://www.commonwealthfund.org/sites/default/files/2019-01/Willink_financial_hardship_older_americans_LTSS_ib_0.pdf

Brainstorming Potential Solutions

The approaches shared by plans are summarized below:

→ **Gather additional information on members**

CVS/Aetna developed a Social Isolation Index in 2019 based on claims data and social determinants of health data that the company has used to estimate a member’s risk of social isolation.⁴³ This positioned the organization to have deeper insights into which members were experiencing social isolation to consider more targeted solutions.

→ **Gather additional information on existing solutions**

A few of the plans we interviewed have issued requests for proposals (RFPs) to determine the potential solutions in the marketplace. Plans used this as an information-gathering opportunity in which they could survey the market and gather ideas on the solutions that existed.

→ **Leverage internal expertise, especially from Medicaid**

Plans with Medicaid LTSS products modeled their Medicare Advantage IHSS, caregiver supports, and social needs benefits on their Medicaid offerings. Plans that have Medicaid books of business can learn from colleagues and consider best practices.

→ **Focus on small-scale pilots to test novel offerings**

Lastly, some plans shared a clear preference for minimizing risk. One plan mentioned that they considered innovative solutions, so long as those would be balanced by tried-and-true methods of supporting member needs. This approach may allow plans to think further outside the box for smaller “pilot tests” before taking on large-scale, and riskier, innovations.

Determining Plan Priorities

Plans have different priorities when it comes to the services (including supplemental benefits) that they offer. Most are focused on enrollment growth, others on retention, and still others on the impact that a service can have on members with a particular need. The formula below summarizes the different aspects that plans weigh in their calculation of the return on investment (ROI) of offering a particular service.

How Do MA Plans Calculate ROI of Services?



⁴³ Aetna News Release. “New Aetna Medicare programs help combat social isolation, improve health outcomes” (November 2019). <https://www.prnewswire.com/news-releases/new-aetna-medicare-programs-help-combat-social-isolation-improve-health-outcomes-300956925.html>

STEP 3: HOW CAN PLANS BEST DELIVER IDENTIFIED BENEFITS?

At this point in the process, plans have identified the need they are working to support, have a sense of their preferred approach (which may evolve based on vendor selection and capabilities), and are making determinations on vendor(s) and what solutions they will offer. Once a vendor is selected and implementation begins, plans collect data from providers and their claims systems to monitor and evaluate service utilization, member engagement/satisfaction, and retention. We have described these specific tasks below.

Selecting a Vendor

While a limited number of plans develop solutions to support these needs internally, many more solicit vendors to provide solutions to their members.

The primary considerations that plans have in mind when vetting vendors include the following:

→ **Vendor reputation and ability to deliver**

Plans assess the unique value that a particular vendor offers- whether demonstrated through ROI, reliability, a particular approach to providing the service to members, or other considerations. Vendor experience and reputation will also be important, particularly for vendors that have become known among MA enrollees. Given the human interactions that members have with vendors under these benefits and the risk of member abrasion via poor experience, delivering a high-quality benefit with strong customer satisfaction is critical.

→ **Meeting plan requirements**

Plans will have numerous requirements for the vendors with whom they partner. These include whether the vendor can provide coverage to the plan's entire service area, the ability to fulfill requests within certain timeframes, the technical capabilities of the vendor, and the information and claims process that will be established between plan and vendor. Meeting the geographic coverage requirements for plans can be challenging for smaller vendors, and thus vendors who can build sizable networks or aggregate providers across large geographies have a distinct advantage.

→ **Added benefits to the plan**

Going above and beyond requirements, plans will also try to determine what additional benefits they might gain from partnering with a vendor. These might include additional data and insights into the health status of their members through the in-person visits conducted by vendors or building a strong relationship with the vendor that leads to greater "stickiness" between members and their plan. Plans and providers both identified challenges in offering these benefits based on their newness, and member lack of awareness or reluctance to interact with them. Vendors able to demonstrate their ability to overcome this challenge, and engage members with direct interaction will offer significant value to plan clients.



Opportunity for Partnerships Between Plans and CBOs

Community-based organizations (CBOs), including AAAs, play a key role in meeting the needs of communities across the country. These organizations, often established as nonprofits, have in-depth knowledge of the communities for which they provide services. However, their geographic profile may be limited, and their IT infrastructure is often less mature than healthcare organizations with which they might partner.

We informally asked plans and individuals engaged with CBOs and AAAs about whether plans were working with these organizations to offer the three benefits of interest in this report. We heard that generally plans were not, and that the vast majority of vendors that plans worked with were for-profit organizations. The Western New York Integrated Care Collaborative is a counterexample to this, serving as a non-profit organization that is contracting with an MA plan to provide caregiver supports, but this is generally not common.

While geographic coverage areas and IT infrastructure may be barriers to current partnerships, there is the potential for plans to better leverage these critical stakeholders in communities across the country with the right support. If established, these partnerships may be able to support the critical CBO infrastructure in communities and may also establish a better relationship between members and providers given the community orientation of CBOs.

Overcoming Challenges to Benefit Design

Plans noted specific challenges that they face in terms of offering these benefits, and these challenges, with associated solutions, are listed in Table 9.



Table 9. Challenges and Solutions for Plans Offering IHSS, Caregiver Supports, and Social Needs Benefits

Benefit	Challenge	Solution
<p>IHSS</p>	<p>Plans shared that it's difficult to balance the level of IHSS needed by members with the cost of covering these services. Because of the cost involved in offering this benefit- and the other potential uses of a plan's rebate dollars- plans find that they have to put hourly limitations on the benefit in nearly all circumstances. As it currently stands, this benefit is not typically structured to be related to a particular episode of care (care transitions, for example), so in many cases, members use the benefit and then the hours run out. This leads to dissatisfaction on the part of members and difficulty in determining the right level of generosity and targeting on the part of plans.</p>	<p>Numerous providers noted that they would like to see this benefit migrate in the direction of support for a care transition. 60 hours of support over the course of a year may have a limited impact, but that same amount of support in a concentrated window of need could be more impactful. Plans can, and in some instances are, offering post-hospitalization targeting of the IHSS benefit and members and care managers can elect to use benefits around a specific health event, particularly if scheduled/planned (e.g., a knee replacement). Providers also noted that this, along with extended appointment times, may help mitigate some of the staffing challenges they are currently experiencing.</p> <p>For less intensive support services – support for IADL needs, for example- plans can advise members on how to make optimal use of the benefit through sharing of use cases and other information that leverages the plan insights into benefit structure and provider capabilities. This could include explicit guidance to members on using IHSS as a respite service, which would be particularly relevant for members with caregivers and may allow plans to work around existing challenges in targeting benefits to non-member caregivers (more on that below). Plans should also consider the impact of having hours expire on a monthly basis and whether members might be better served by being allowed to accumulate hours over the course of the year.</p>



Benefit	Challenge	Solution
<p>Caregiver Supports</p>	<p>The primary issue related to offering a caregiver supports benefit is that the caregivers who will be targeted with supports provided under the benefit are often not plan members and may have no direct association with the plan. Numerous plans raised this as a major challenge that they faced and noted that it raised issues, from whether or not they could in fact directly target these individuals with caregivers to the difficulty in obtaining contact information for the caregivers for the sake of connecting them with services.</p>	<p>Standardized data collection on caregivers can be a key data point that plans collect upon enrollment. Collecting this data should be paired with clear information on how this will be used and would be an opportunity to promote caregiver support benefits that are available to members.</p> <p>MA plans can collect this information at enrollment or when conducting an annual health risk assessment.</p>
<p>Social Needs Benefits</p>	<p>Plans shared that their major challenge with social needs benefits was the additional targeting criteria that must be applied because it's categorized as an SSBCI benefit. This benefit is defined as one used to target social isolation amongst members, and several plans mentioned that SSBCI was unnecessarily limiting the eligible population given the prevalence of social isolation among their member populations. This results in plans being reluctant to offer a benefit to a limited population when the need exists across a much larger proportion of the population.</p>	<p>The inclusion of social needs benefits as SSBCI likely puts unnecessary limits on plans' efforts to address social isolation. However, plans can use alternative authorities to offer benefits, particularly IHSS, that address social isolation for broader populations without the limitations of SSBCI.</p>

Evaluating and Improving Benefit Design

As numerous interviewees shared, there are significant challenges in viewing the offering of these benefits as a test- supplemental benefits are not structured as a randomized “test” to be evaluated, there are many confounding factors, it may take years to see the impact of these benefits, and beneficiary-level data collection needs to improve for researchers (and potentially plans) to conduct a meaningful analysis.

In addition, plans and providers noted that even in cases in which they are attempting to evaluate these benefits, the evaluations may take multiple years to conduct.

Nevertheless, plans and providers are taking steps to measure the success of supplemental benefits. Most organizations are in the first two stages of Figure 11, beginning to collect data on utilization and member (or caregiver) experience.



Figure 11. Data Collection Phases to Measure Success of Supplemental Benefits

<p>Benefit utilization: Collect information on how these benefits are being delivered to members, including how many people are receiving which benefits at what frequency, and demographic information</p>	<p>Member and caregiver experience: Understand how members are connecting with benefits by tracking referral sources, satisfaction with the benefit and association to the plan, member retention, and outcomes such as lower social isolation and other nonmedical needs being met</p>	<p>Health status: Track changes over time in members' management of chronic conditions, utilization of preventive services, and other indicators of improved health</p>	<p>Healthcare utilization and Medicare spending: Assess rates of emergency department use and hospital and institutional stays of members receiving supplemental benefits and those not</p>
--	--	--	--

Most plans reported collecting beneficiary-level utilization data. When asked whether they would face significant hurdles in submitting this data to CMS if requested to do so, generally the plans said that it would be feasible to submit data on utilization if CMS requested it. While there is complexity, time, and resources involved in any data collection, if CMS pursues collecting this information in alignment with our prior recommendations, it would offer additional insight into how supplemental benefit dollars are being used and lays potential groundwork for more robust efforts to determine the health and financial impact of these benefits going forward.

Providers are also attempting to collect data on these benefits, and in some cases, may be in a better position to provide insights on benefit utilization than the plans themselves. Providers also have the incentive to demonstrate their impact, whereas plans may view impact data on these benefits as information that gives them a competitive advantage. However, the shortcoming identified by providers in conducting analysis on the impact of these benefits is their lack of access to beneficiary claims data. Despite this, some of the provider-based research that is being conducted is summarized below:

- Papa Inc., a nationwide service that partners older adults with “Papa Pals” to provide companionship and assistance, conducted a study⁴⁴ with SummaCare, a Medicare Advantage organization in Ohio. The study was designed to explore changes in inpatient admission rates and high ED utilization. The study compared a member population using the Papa Pals benefit to a matched comparison group not using the benefit and found that enrollment in Papa was associated with a 1.5% to 2% decline in readmission rates and 34% fewer ED high-utilizers during the intervention year.
- The Tailored Caregiver Assessment and Referral® (TCARE®) protocol was developed as a mechanism to triage the needs of caregivers and supports them with critical information about their needs and resources to address their needs. In a randomized, controlled study, caregivers in the intervention group

44 McNamara et al. “Companion Care Associated with Reduction in Admissions and Emergency Department Use Among Older Adults” (December 2022). https://academic.oup.com/innovateage/article/6/Supplement_1/812/6939527

demonstrated reductions in measures associated with the burden of serving as a caregiver, including depression and their intention to place the individual receiving care in a nursing home.⁴⁵ This study formed the basis of TCARE, a company offering caregiver supports to health insurance plans.

- BrightStar Care, a home care provider, has assessed the impact of home care on utilization of ED visits, skilled nursing facilities, and home health care, as well as overall healthcare expenditures.⁴⁶ The study was conducted on a Medicare FFS population and compared data on two statistically similar groups, one of which received home care and another that did not. Limited results are publicly available, though the findings shared indicated a reduction in total cost of care for patients receiving the intervention who had 1 or more chronic conditions of interest.

Notably, we asked plans and providers about whether this data was being collected to determine the equitable reach and access of these benefits. While research into this was limited, at least one plan is overlaying benefit utilization data with a geographic index of need to determine whether the benefits are reaching their most vulnerable populations and how awareness of the benefits varied geographically. Plans also indicated that they were building the requisite data infrastructure to ensure accuracy and widespread collection of race and ethnicity data. Several plans have gathered feedback through focus groups and consumer advisory boards. Ensuring collection of race and ethnicity data alongside beneficiary-level utilization data can lay a strong foundation for future analyses around the equitable reach of these benefits and should be considered for future data collection requirements.

⁴⁵ Montgomery et al. "Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study" (September 2011). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202705/>

⁴⁶ Avalere. "Home Care Services Reduce Medicare Spending for 30 Chronic Conditions" (December 2021). <https://avalere.com/insights/home-care-services-reduce-medicare-spending-for-30-chronic-conditions>

Section 5: Considerations and Conclusion

As we look forward, there are several opportunities to improve the reach and effectiveness of IHSS, caregiver supports, and social needs benefits. To provide guidance on critical next steps for health plans, service providers, and CMS, we have evaluated the status of these benefits to date using the Guiding Principles, established by the SSBCI Leadership Circle and described in our report “[A Turning Point in Medicare Policy](#).”

We have detailed the key insights from our assessment of the benefits collectively in Table 10.

Table 10. Progress on Guiding Principles

Guiding Principle	Success to Date	Remaining Opportunities
Reflects Individual Needs	<p>Variety of services available allows for individual customization of the benefit</p> <p>Use of a care manager / concierge service can help further individualize these benefits</p>	<p>Additional education for members can better position them to leverage flexibility of benefits</p> <p>Providers can further coordinate with plans to gather direct insights into member lives to inform improved benefit and care offerings</p>
Clear and Understandable	<p>Clear limitations on hours / availability and how to access benefits are helpful to members in informing them of what is available</p>	<p>Particularly for caregiver supports, plans need more clarity on whether non-member caregivers can be targeted with the benefit</p> <p>Members need better education on the benefit(s) to increase utilization</p>
Equitable	<p>Creative benefit design, including in-person and virtual offerings, can promote equitable access</p>	<p>SSBCI limitations for social needs benefits may limit access to or discourage plans from offering this benefit</p> <p>Staffing challenges persist, limiting IHSS and respite services, especially in rural/hard-to-serve areas</p> <p>The absence of utilization data on these benefits makes assessing equity difficult</p>
Manageable and Sustainable	<p>Variability in benefit design (in-person or virtual, number of hours available) allows plans to determine feasible benefits within financial constraints</p>	<p>In-person provision of these benefits drives up cost, requiring plans to limit benefit offerings to ensure sustainability</p>

Evolves with Continuous Learning and Improvement

Plans are continuously iterating on benefit design— explicitly testing providers against one another, targeting benefits in different ways, reviewing uptake of benefits, and getting feedback from members and plan staff

Plans and providers must continue to collect data to evaluate impacts and inform future decision-making on benefit offerings

Public reporting of utilization data can inform improvement initiatives

Building on the assessments above, we continue to look for opportunities to improve these benefits. To that end, we offer these recommendations in the spirit of the Guiding Principles that have led this work from the outset—ensuring that more beneficiaries have access to benefits that reflect their individual needs, are understandable, equitable, sustainable, and that improve over time.

POLICY ACTIONS

1

Improve data collection on these benefits

In order to ensure these benefits are living up to their potential as well as to the Guiding Principles, more information on the benefits and their utilization is needed. In our 2021 and 2022 policy reports, we recommended that Congress and/or CMS implement requirements and incentives for plans to report on utilization of all supplemental benefits. In recent requests for information (RFIs) released in the past year, policymakers have indicated an interest in the potential impacts of these benefits on Medicaid spenddown; this will not be possible to estimate without first improving data reporting on utilization of these benefits.^{47,48} Over time, there is a potential opportunity to build the evidence base on the association between specific benefits and healthcare utilization and outcomes, and eventually examine benefit structure and dosage (e.g., for IHSS, 2-hour vs 4-hour shifts, providing care during a care transition vs. more sporadically throughout the course of a year based on general need).

2

Clearly define benefit offerings to minimize member confusion

Plans have noted that these three benefit categories are not clearly distinguishable and are often interchangeable – for instance, in-home care could fall under either IHSS or caregiver supports as respite care. There are even instances in which different plans have filed the same benefit under each of these three benefit categories.

This fluidity between benefit categories has implications for research and evaluation, as well as beneficiary education. Disaggregating plan benefit offerings by benefit category may be limited in what it tells us if the offerings under the different categories are not always distinct. CMS should consider potential implications this may have on data reporting, if it starts requiring utilization data reporting for supplemental benefits.

Furthermore, we have recommended that these benefits be added to Medicare Plan Finder. If the benefits are listed by category only, this may present potential challenges to beneficiaries having a clear understanding of what exactly is offered under each of these three benefit categories, and therefore

47 Centers for Medicare and Medicaid Services. “Medicare Program, Request for Information on Medicare” (August 2022). <https://www.federalregister.gov/documents/2022/08/01/2022-16463/medicare-program-request-for-information-on-medicare>

48 US Senate. “Dual-Eligible RFI” (November 2022). <https://www.cassidy.senate.gov/imo/media/doc/2022.11.22%20Dual%20Eligible%20RFI%20Signed%20v1%5b3%5d.pdf>

additional detail on benefits being offered or further distinction between these three benefits may be useful in potential future education efforts. As CMS considers including more detail on these benefits in Plan Finder and collecting beneficiary-level utilization data, it needs to include clear information for beneficiaries and researchers (through links to EOC documents, sharing of additional details, or other means).

3 **Clarify the benefits plans can provide to member caregivers**

As mentioned previously in this report, some plans expressed confusion around who exactly plans can target for the caregiver support benefit. This lack of clarity is preventing some plans from pursuing this benefit offering, in spite of its potential to help their members in a more holistic manner. CMS could address this challenge by providing guidance clarifying that plans can provide benefits to caregivers of members even when the caregivers themselves are not members of the plan, and clarifying what benefits can be provided to non-member caregivers. Given the logistical challenges of identifying and connecting with the caregivers of members, CMS could also consider providing suggestions for how plans can collect this information, and potentially support collection of caregiver information and sharing of these data with MA plans in the future.

PLAN ACTIONS

1 **Improve targeting of IHSS**

Based on feedback from both plans and providers, and notwithstanding the popularity of the IHSS benefit, it seems that further targeting of this benefit may be beneficial. Plans shared the challenge they have with offering a robust IHSS benefit over the course of the entire year, given the significant cost associated with offering this benefit. This leads to the plan limitations on benefits. Targeting this benefit to groups who would find it particularly valuable—those transitioning back home after a hospitalization, for example, and in need of respite care or support around the home—may prove more meaningful to members in directly addressing a need and more valuable to plans by avoiding potential member frustration when hours run out. Plans should also consider the implications of benefit structure, including expiration of hours, and whether allowing members to accumulate hours over the course of a year may provide useful flexibility to members in customizing the benefit to meet their needs.

This change may also benefit providers if it results in a change in perspective on the number of hours of service a member can receive at one time. As noted above, providers often struggle with staffing 2-hour visits, and it is likely that individuals in the process of a care transition may benefit from extended visits.

2 **Standardize identification of caregivers, in coordination with beneficiaries**

Several plans and providers involved in offering caregiver supports cited the challenge of identifying caregivers as a significant barrier in providing this benefit. Plans should develop standard approaches to identifying caregivers to members. This could occur at enrollment ideally, and could be updated or included in health risk assessments. In addition to potentially increasing utilization of these benefits, standardizing collection of this data could have the added benefit of providing plans with insight on the breadth of caregiver arrangements across their populations that can inform care approaches and future benefit offerings.

3 **Collect data, evaluate results, and publish findings**

Plans generally shared that they are collecting beneficiary-level utilization data, with varied goals including analyzing the equitable reach of benefits and determining how widely the benefits are being used. In conjunction with efforts for CMS to increase data collection on these benefits above, plans

should continue to enhance their data collection efforts on these benefits. As plans begin to better understand the reach and potential impact of these benefits, they should publish results of their findings and work in conjunction with CMS to increase a broad understanding of how these benefits are being used and any potential impact that they are having.

POLICY, PLAN, AND STAKEHOLDER ACTIONS TO IMPROVE BENEFICIARY EXPERIENCE

1

Gather feedback directly from beneficiaries and improve the education on plan choices available to them

Beneficiaries are the most important stakeholder when it comes to evaluating the effectiveness and value of these benefits. We are unable to determine causality in looking at these benefits and health and financial outcomes for beneficiaries, but there is additional information that can be collected- on beneficiary perception, understanding, how these benefits influence beneficiary plan choices, and more. One potential way to gather this information would be for CMS, plans, and brokers / State Health Insurance Assistance Programs (SHIPs) to directly engage beneficiaries by holding focus groups and through other means. CMS, plans, and stakeholders can use beneficiary feedback and insights to clarify existing guidance, Medicare Plan Finder, and other communications.

In addition to soliciting input from beneficiaries on these benefits, CMS should explore opportunities to improve Plan Finder, and CMS and plans should look for opportunities to improve the information they make available to brokers and SHIPs. SHIPs are often supplementing Medicare Plan Finder with homemade supplemental materials, created on a county-by-county basis. As noted in this report, beneficiaries struggle with a lack of information about the plan options available to them, including the supplemental benefits available and the associated eligibility criteria. Improved education on supplemental benefits, as well as vital plan information like provider networks, out-of-pocket costs, premiums, and drug coverage should support improved choice by beneficiaries.



Conclusion

Medicare Advantage plans have a unique opportunity to support their members' nonmedical needs. In-home support services, caregiver supports, and social needs benefits have the potential to help individuals maintain independence and live in the community beyond what might otherwise be achieved. If implemented in a meaningful, person-centered way, they can also promote quality – and potentially cost – objectives of the healthcare system. Policymakers, policy analysts, academics, practitioners, and taxpayers share a common interest in ensuring that Medicare beneficiaries' needs are met in the most effective, cost-efficient manner possible.

Despite the opportunity that these benefits present to support beneficiaries' needs, we also recognize the challenges associated with these benefits. They tend to require hands-on, in-person delivery of services, which drives up the cost and complexity of the benefits within limited dollars. Caregiver supports in particular may be most impactful if non-member caregivers are targeted for the benefit, but these individuals are more difficult to identify and target than members. The quantitative effects of these benefits can be hard to measure, and the evidence base is emerging. Continued research is needed to fully understand the potential impact and value these benefits provide.

In order to enhance the impact of these benefits, and in addition to the actions listed above, we see opportunities for further analysis of nonmedical supplemental benefits. This includes research to assess whether these benefits are being offered to and used by individuals who need them, if access to benefits is equitable, whether beneficiaries perceive these benefits to be “meaningful,” and how these benefits are interacting with other available supports, including Medicaid LTSS.

It will take a concerted effort by several stakeholders to assure these benefits support member needs. Supporting member needs will require benefits being offered in a sustainable, equitable, and clear way, with continuous improvement efforts. This report provides valuable information for plans looking to launch or expand their benefit offerings in these areas, for policymakers looking to evaluate and advance supports for Medicare beneficiaries, and for stakeholders seeking to support benefits that help to address whole person health needs. We look forward to supporting the continued advancement of these benefits and the Guiding Principles with our ongoing data and policy analyses.

Methods

Quantitative and qualitative data used to inform this Progress Report were gathered using a number of sources. The first data source for supplemental benefit information was taken using the PBP Data, made available publicly by CMS, from Plan Year 2020 to Plan Year 2023. This data source provides information on which plans are offering each benefit and which authority is used to offer the benefits, as well as information on the counties where these plans are offering these benefits. ATI Advisory analysis of the PBP files excludes the following plan types: Employer Group Health Plans (EGHPs), Prescription Drug Plans (PDPs), Medicare–Medicaid Plans (MMPs),

Part B–only plans, and Program of All-inclusive Care for the Elderly (PACE). For more detailed information on how plans offered these services to their beneficiaries, ATI Advisory reviewed plans’ Evidence of Coverage documents, available on plan websites. Finally, interviews were completed with numerous stakeholders, totaling more than two dozen interviews, to learn about their experiences with these non-medical benefits. Findings were further supplemented through conversations and guidance, from the SSBCI Leadership Circle, as well as other presentations and discussions with stakeholder groups.

Acknowledgements

We'd like to thank the many individuals and organizations who, in the spirit of collaborating for improvement, contributed to this report through sharing their experiences and insights.

- Addus HomeCare
- Administration for Community Living
- Blue Cross and Blue Shield of Kansas
- BrightStar Care
- Centene
- Cigna
- CVS Health, Aetna
- Element3 Health
- FirstLight Home Care
- healthAlign, a subsidiary of The Helper Bees
- Health Innovation Inc.
- Home Instead
- Home Thrive
- Humana
- Ageless Innovation / Joy for All
- Medicare Rights Center
- Molina Healthcare
- NationsBenefits
- Papa Inc.
- SCAN Health Plan
- State Health Insurance Assistance Program (SHIP) Counselors
- TCARE
- UnitedHealthcare
- UPMC Health Plan

Appendix A: Literature Review

Below are detailed summaries of a subset of the studies used to analyze the potential impact of the benefits analyzed for this report. These studies were selected based on the similarity of both the populations and interventions analyzed in the studies, as well as the presence of quantitative findings in the research.

SUMMARY OF IN-HOME SUPPORT SERVICES RESEARCH

Below are a series of tables summarizing key research in this area.

Study Title	Personal Care and Homemaking Services for Older Adults and Adults with a Disability ⁴⁹
Author(s)	Area Agency on Aging 1-B: Melody Bryant, Lisa Ellens, Ann Langford, Jim McGuire, Andrea Mulheisen
Size and Description of Population	2,757 AAA 1-B participants through non-Medicaid, MI Choice, and VA Home and Community Based Services program
Intervention	<p>The Area Agency on Aging purchases services for participants, including personal care and homemaking aides (who helped in eating, bathing, dressing, personal hygiene, housekeeping chores, laundry, shopping for necessities).</p> <p>No detailed information on intensity of services- only reference is that phone calls to inquire about cost of services asked about 4 hours of care per day for 3 days each week.</p>
Findings	<p>The study compared outcomes of individuals who received in-home services to those who were on a wait list but did not receive the services. Findings included:</p> <ul style="list-style-type: none"> • individuals who remained on the waitlist were five times more likely to enter a nursing home within 2 years; • Mortality rate of service recipients was 352 per 1000 vs those without service 477 per 1000; • After 2 years, 76% of those who received services were still on their own in the home, vs 56% of those who did not receive services; and • 75% of caregivers for those without services had caregiving interfere with work vs 25% of caregivers whose loved ones received services.
Limitations	The study did not explicitly focus on a Medicare population, and the interventions were not bound by the requirements placed on those services provided by MA plans as supplemental benefits. The study is also dated, having taken place in 2013.

⁴⁹ Area Agency on Aging 1-B. "Personal Care and Homemaking Services for Older Adults and Adults with a Disability" (April 2013). <https://www.aaa1b.org/wp-content/uploads/2010/07/Personal-Care-Homemaking-Outcomes-Final-Report.pdf>

Study Title	Volume of Home- and Community-Based Services and Time to Nursing-Home Placement ⁵⁰
Author(s)	Laura P. Sands, Huiping Xu, Joseph Thomas III, Sudeshna Paul, Bruce A. Craig, Marc Rosenman, Caroline C. Doebbeling, Michael Weiner
Size and Description of Population	1354 Medicaid HCBS recipients in Indiana, 65+ years old
Intervention	<p>The study analyzed whether the volume of home- and community-based services (HCBS) targeted at ADL needs (attendant care, homemaking services, and home-delivered meals) impacted relevant health outcomes for the population studied.</p> <p>No detailed information on intensity of services, though the article notes that the median monthly hours for attendant care was 26.2 hours and the median monthly hours for homemaking was 0 hours.</p>
Findings	<p>The study indicated that:</p> <ul style="list-style-type: none"> • Each additional 5 hours of attendant care services per month was associated with a 5% lower risk of nursing home placement • Each additional 5 hours of homemaking services per month was associated with a 13% lower risk of nursing home placement
Limitations	The study is dated, with follow-up on enrolled individuals ending in 2004. The authors also noted their inability to control for other community-provided services (e.g., meals from churches) or factors influencing the case management of these individuals. Authors noted that low volume of services could have been due to various reasons, including needs being met elsewhere or concerns about having service providers in the home.
Study Title	The Relationship between Older Americans Act In-Home Services and Low-Care Residents in Nursing Homes ⁵¹
Author(s)	Kali S. Thomas
Size and Description of Population	91,516 individuals received OAA-financed personal care services (with data based on 71,984 facility-year observations from 15,034 free-standing certified nursing homes (not hospital-based) in continuous 48 states)
Intervention	<p>The study analyzed the impact on individuals receiving in-home supportive services (personal care, homemaker, and chore services) designed to assist individuals who are unable to perform at least two ADLs without substantial assistance.</p> <p>No detailed information on intensity of services, though the study notes that average spending on OAA-financed personal care services was \$1,700.</p>
Findings	The study examined the relationship between the proportion of adults in a state who receive in-home services funded by OAA. Findings indicated that a 1% increase in population aged 65+ receiving personal care services is associated with a 0.8% decrease in the proportion of low-care residents in nursing homes.

50 Sands et al. "Volume of Home- and Community-Based Services and Time to Nursing-Home Placement" (August 2012). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006382/>

51 Thomas, Kali. "The relationship between older Americans act in-home services and low-care residents in nursing homes" (March 2014). <https://pubmed.ncbi.nlm.nih.gov/24336233/>

Limitations The study included limited descriptions of the state-specific calculations. It also only showed a significant effect for personal care services (not homemaker or chore services). The services provided are also state specific so results may be limited in generalizability. The services also were not provided by MA plans with the restrictions that exist in MA, and participants were not limited to Medicare beneficiaries.

SUMMARY OF CAREGIVER SUPPORT RESEARCH

Below are a series of tables summarizing key research in this area.

Study Title	Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study ⁵²
Author(s)	Rhonda J. V. Montgomery, Jung Kwak, Karl Kosloski, and Katherine O’Connell Valuch
Size and Description of Population	266 family caregivers
Intervention	Care managers supporting family caregivers in the intervention group used the TCARE protocol to assess caregiver needs and create a tailored care plan
Findings	Significant differences were found between intervention and control groups on all key measures except for objective burden. The measures with significant differences included identity discrepancy (disparity between care responsibilities and an individual’s identity standard), relationship burden, stress burden, depressive symptoms, and intention to place care receiver in a nursing home.
Limitations	The study did not focus on a population enrolled in Medicare, and similarity between the study population and the Medicare population is difficult to determine. The attrition rate was relatively high for participating caregivers (though the study surveyed them over the course of 9 months). The study included limited racial/ethnic diversity among caregivers. The study was also unable to look at actual placement in nursing homes due to the relatively short observation window.

Study Title	The Impact of a Caregiver Health Education Program on Health Care Costs ⁵³
Author(s)	Ronald W. Toseland and Tamara L. Smith
Size and Description of Population	105 spouses who are caregivers of frail older adults, who both had to be 55 or older, enrolled in the same health plan, and care recipients had to have chronic illness and at least 2 ADL/IADL impairments
Intervention	The intervention was a health education program (HEP) that served as a social work intervention for spouse caregivers of frail older adults and randomly assigned caregivers and care recipients to a usual care or intervention group.

52 Montgomery et al. “Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study” (September 2011). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202705/>

53 Toseland et al. “The Impact of a Caregiver Education Program on Health Care Costs” (August 2016). <https://journals.sagepub.com/doi/10.1177/1049731505276045>

Findings	<p>This study examined the impact of the HEP on health care cost outcomes. After following the participants for two years, the findings include:</p> <ul style="list-style-type: none"> • <i>Caregivers</i> who participated in the HEP had significantly lower overall health care costs and significantly lower outpatient costs compared to those to participated in usual care • The total cost savings for caregivers and care recipients who participated in HEP was \$309,461.14 (compared to a program cost of \$27,000)
Limitations	<p>The study did not account for all costs - the HMO claims database did not include institutional costs, day care costs, respite care costs, or dental costs, and drug costs for study participants were only captured if purchased in the HMO pharmacy (and not for drugs filled at neighborhood pharmacies or by mail). The study is also dated, having been published in 2006.</p>
Study Title	Caregiver Integration during Discharge Planning of Older Adults to Reduce Resource Utilization: A Systematic Review and Meta Analysis of Randomized Controlled Trials ⁵⁴
Author(s)	Juleen Rodakowski, Philip B. Rocco, Maqui Ortiz, Barbara Folb, Richard Schulz, Sally C. Morton, Sally Caine Leathers, Lu Hu, and A. Everette James III
Size and Description of Population	Systematic review and meta-analysis of 15 randomized controlled trials of older adults with informal caregivers discharged to a community setting.
Intervention	Discharge planning with caregiver integration begun prior to patient discharge.
Findings	<p>This paper found caregiver intervention was associated with:</p> <ul style="list-style-type: none"> • A 25% reduction in 90-day readmissions • A 24% reduction in 180-day readmissions • Reduced rehospitalization costs
Limitations	<p>This study had few studies due to including only randomized controlled trails. Methods of inclusion and intervention varied across studies, which limits the ability to determine which aspects of the intervention were most impactful.</p>
Study Title	Medicaid Alternative Care and Tailored Supports for Older Adults ⁵⁵
Author(s)	Center for Health Systems Effectiveness

54 Rodakowski et al. "Caregiver Integration during Discharge Planning of Older Adults to Reduce Resource Utilization: A Systematic Review and MetaAnalysis of Randomized Controlled Trials" (August 2017). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5555776>

55 Center for Health Systems Effectiveness. "Medicaid Transformation Project Evaluation Interim Report" (December 2020) <https://www.hca.wa.gov/assets/program/mtp-interim-report.pdf#page=120>

Size and Description of Population	<p>Analysis of less than 50 individuals aged 55 and older who are eligible for nursing home care, eligible for Medicaid, and need Long-Term Services and Supports (LTSS), but are not yet using traditional Medicaid-paid LTSS, and have an unpaid informal caregiver. The group of individuals had the following characteristics:</p> <ul style="list-style-type: none"> • 77% had help with at least one ADL • 23% had a fall that caused injuries or 3+ falls during the last 6 months • 25% had family with concerns for their memory, thinking, or decision-making abilities • 18% had considered moving to a nursing home or assisted living facility
Intervention	<p>Medicaid Alternative Care (MAC) programs provide supportive services for informal caregivers, such as caregiver training and education, counseling on adapting to the role of a caregiver, respite care or home-delivered meals to relieve caregiver burden, help with things like housework or errands, assistive technology, and durable medical equipment.</p>
Findings	<p>This study examined the association between receipt of Medicaid Alternative Care services and health care utilization. The findings include:</p> <ul style="list-style-type: none"> • Emergency department visits dropped from 125 per 1000 member months to 81 visits per 1000 member months • Hospitalizations dropped from 59 per 1000 member months to 9 per 1000 member months • The 30-day readmission rate (%) dropped from 26% to 0%
Limitations	<p>The study used a pre-post study design and the findings identified here were on a small sample size (under 50 individuals).</p>

SUMMARY OF SOCIAL NEEDS BENEFIT RESEARCH

Below are a series of tables summarizing key research in this area.

Study Title	Reducing Isolation and Loneliness Through Membership in a Fitness Program for Older Adults: Implications for Health ⁵⁶
Author(s)	Samantha Brad, Lisa A D'Ambrosio, Adam Felts, Elizabeth Y Rula, Kenneth P Kell, Joseph F Coughlin
Size and Description of Population	3,457 members of a large Medicare Advantage insurance provider who were eligible for the SilverSneakers program as a plan benefit.
Intervention	The intervention was participation in the SilverSneakers fitness program for older adults.

56 Brady et al. "Reducing Isolation and Loneliness Through Membership in a Fitness Program for Older Adults: Implications for Health" (March 2020). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7005930/>

Findings	<p>The study examined the impact of SilverSneakers participation on social isolation and physical activity. The findings include:</p> <ul style="list-style-type: none"> • The SilverSneakers membership impacted health through direct and indirect paths. Membership directly accounted for 60% of the total effect on health. Membership also impacted health indirectly via increased physical activity, reduced social isolation, and reduced loneliness. • The SilverSneakers membership also impacted social isolation through direct and indirect paths. Membership directly accounted for 85% of the total effect on isolation.
Limitations	The cross-sectional study design does not allow for causal statements to be made. There may also be selection bias due to use of email survey and self-selection into the intervention group.
Study Title	Home-Delivered Meals and Risk of Self-Reported Falls: Results From a Randomized Trial ⁵⁷
Author(s)	Kali S. Thomas, Ravi B. Parikh, Andrew R. Zullo, and David Dosa
Size and Description of Population	371 older adults who were on Meals on Wheels programs' waiting lists. Over 25% of the participants were enrolled in Medicaid, and over 26% of the participants had a hospitalization in the past 3 months.
Intervention	The participants were split into three groups: daily meal delivery; once weekly, frozen meal delivery; or control (remaining on waiting list).
Findings	<p>After 15 weeks following the start of the intervention, participants responded to a survey regarding their risk of falling. The researchers found:</p> <ul style="list-style-type: none"> • 28.6% of the control group reported a fall • 27.4% of the once weekly, frozen meal recipients reported a fall • 23.7% of daily meal recipients reported a fall • If these estimates were to persist in larger confirmatory studies, they would suggest that for every three previous fallers provided with a daily, traditional meal over a 15-week period, we could prevent one additional fall on average.
Limitations	Relatively small sample size and was not focused on a Medicare population.
Study Title	More Than A Meal: Results from a pilot randomized control trial of home-delivered meal programs ⁵⁸
Author(s)	Kali S. Thomas and David Dosa
Size and Description of Population	626 participants were selected from waiting lists at 8 Meals on Wheels sites across the United States. 31% of the participants were enrolled in Medicaid, 34% of participants were Black, and the average age was 76.3 years.
Intervention	The participants were split into three groups: daily meal delivery; once weekly, frozen meal delivery; or control (remaining on waiting list).

57 Thomas et al. "Home-Delivered Meals and Risk of Self-Reported Falls: Results from a Randomized Trial" (January 2018). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6620777/>

58 Meals on Wheels America. "More Than A Meal: Results from a pilot randomized control trial of home-delivered meal programs" (March 2015). <https://www.mealsonwheelsamerica.org/docs/default-source/News-Assets/mtam-full-report---march-2-2015.pdf?sfvrsn=6>

Findings	<p>After 15 weeks following the start of the intervention, participants responded to a survey regarding their mental health, feelings of loneliness, isolation, safety, and increased ability to remain in the home. The survey also measured health care visits, rates of falls, and program satisfaction. The study found that:</p> <ul style="list-style-type: none"> • 79% of individuals receiving daily meals who had fallen in the past did not fall again during the study period compared to 46% of the control group (p<0.01) • 14% of individuals receiving daily meals were hospitalized compared to 20% of individuals in the control group (p=0.08) • Among those that live alone, 42% of participants receiving daily-delivered meals reported less worry at follow-up compared to 26% of participants receiving weekly, frozen meals and 18% of the control group (p=0.01) • 36% of individuals receiving daily-delivered meals exhibit improvement in feelings of isolation compared to 29% of individuals receiving frozen, weekly-delivered meals and 14% of the control group (p=0.01)
Limitations	Relatively small sample size and was not focused on a Medicare population.
Study Title	CareMore's Togetherness Program Addresses a Symptom of Living With Chronic Illness: Loneliness ⁵⁹
Author(s)	Robin Caruso
Size and Description of Population	700 participants in a pre/post study who enrolled in a CareMore program.
Intervention	The CareMore program links patients to Togetherness Connectors. Participants also have home visits from social workers, who aim to connect them to social services and other CareMore Health programs, such as Nifty After Fifty gym, a tailored exercise program.
Findings	Preliminary results from the CareMore intervention show a 5% decrease in outpatient emergency room use and an 11% decrease in acute hospital admissions.
Limitations	This study is still ongoing and intervention specifics and results are preliminary. No statistical significance was reported yet.

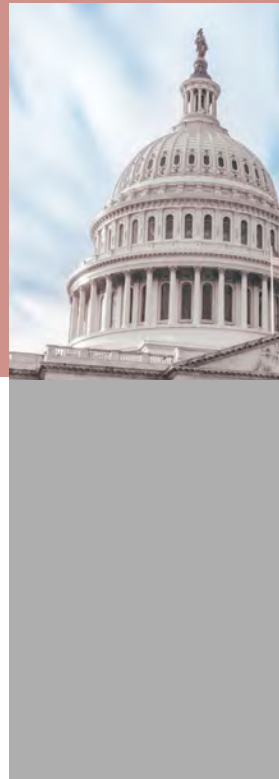
59 Caruso, Robin. "CareMore's Togetherness Program Addresses a Symptom of Living With Chronic Illness: Loneliness" (August 2018). <https://www.ajmc.com/view/caremores-togetherness-program-addresses-a-symptom-of-living-with-chronic-illness-loneliness>

ATI Advisory

ATI Advisory is a DC-based advisory services firm that helps business and government leaders transform care delivery for frail older adults and their families. ATI conducts research, develops new ideas and insights, and enables strategic partnerships to break down public and private sector barriers that prevent innovative solutions to siloed, broken systems across acute, post-acute, and long-term services and supports (LTSS). For more information, visit atiadvisory.com.

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.



ACKNOWLEDGEMENT

With support from The SCAN Foundation, ATI Advisory and Long-Term Quality Alliance (LTQA) have released a number of reports and resources on non-medical supplemental benefits in Medicare Advantage, including implementation reports, policy recommendations and briefs, data briefs, rule summaries, and blogs. This work, and more, are all available on the [Advancing Non-Medical Supplemental Benefits in Medicare Advantage landing page](#).

