

How Medicare Advantage Plans Use Data for Supplemental Benefits Decision-Making

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As evidence about the impact of social drivers of health grows, opportunities to address patients' social and economic adversity—such as food and housing insecurity and the lack of social connections^{1,2}—have increased across the US health care sector. Medicaid plans have been at the leading edge of developing payment models that incentivize or otherwise support social care, including expanding opportunities for plans and affiliated providers to provide nonmedical services and supports related to food and housing.^{3,4} New opportunities are emerging in Medicare⁵ to address the barriers to achieving good health that many older adults experience, such as poverty,⁶ social isolation,^{7,8} food insecurity,⁹ and transportation challenges.^{10,11}

The 2018 Bipartisan Budget Act, which included the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act (referred to as the CHRONIC Care Act),¹² and the 2018 CMS call letter (an annual set of guidelines and clarifications for Medicare Advantage [MA] plans) announced greater flexibility for MA plan supplemental benefits to address social drivers of health. MA plans, which currently enroll one-third of all Medicare beneficiaries,¹³ are required to cover traditional Medicare services, but they may also cover services not traditionally available under Medicare. MA plans now have further flexibility in offering supplemental benefits. For the first time, the federal government has authorized MA plans to offer supplemental benefits that are not “primarily health-related”^{14,15} and has given MA plans more room and discretion to design supplemental benefits that “have a reasonable expectation of improving or maintaining the health or overall function”¹⁶ of members.

Criteria for benefit structure were also expanded, such that benefits should meet at least 1 of the following criteria: diagnose, prevent, or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional or psychological impact of injuries or health conditions; or reduce avoidable health care utilization.¹⁷ Benefit offerings under the expanded structure can be diverse, including meal delivery, home modifications, personal support services, and cooking classes,^{5,15,18} and they can be targeted toward groups at highest risk of poor health, as the CHRONIC

ABSTRACT

OBJECTIVES: Health care payers are increasingly experimenting with interventions to address social risk factors. With enactment of the 2018 Bipartisan Budget Act, Medicare Advantage (MA) plans have new opportunities to offer supplemental benefits that are not “primarily health-related.” This article presents findings from interviews conducted with executives from MA plans regarding plan decision-making processes related to new social risk factor benefits.

STUDY DESIGN: Semistructured qualitative interviews with MA plan leadership.

METHODS: A total of 63 plan representatives from 29 unique MA plans were interviewed about the rationale for social risk-related interventions and how data are used to inform benefits expansion decisions. This paper combines qualitative interview data from 2 separate studies with similar target groups and interview guides. Interview transcripts were qualitatively analyzed to examine underlying themes.

RESULTS: Three main themes emerged: (1) Plans use multiple data sources to determine how to target benefits; (2) evidence gaps hinder decision-making to expand or offer new supplemental benefits; and (3) in the absence of sufficient evidence, some plans have their own research and quality improvement processes to maximize effectiveness.

CONCLUSIONS: Findings provide insights about opportunities and challenges that MA plans face in making decisions related to supplemental benefits designed to address members' social risk factors. Barriers include collecting, generating, and analyzing data critical to informing investments. Results highlight the need to ensure interoperability of new and existing data sources, foster shared learning opportunities, and narrow evidence gaps about specific social care interventions to inform the design and implementation of effective supplemental benefits.

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Care Act waived the requirement of uniform access to benefits.⁵ Plans therefore have the option to target these benefits to enrollees with specific chronic conditions.¹⁹ Importantly, insurers do not receive additional funds to offer supplemental benefits. Supplemental benefits can be paid through charging all MA enrollees a premium, through cost sharing, or through a plan's rebate dollars.²⁰

Our previous research has found that adoption of new or expanded offerings among MA plans has been gradual and limited.^{5,18,20}

However, research has yet to examine the underlying reasons for this slow uptake. Although MA plans have a role in addressing the social risks of their members, little is known about how plans address these risks and how they collect data to inform their approaches to addressing social risk. This paper addresses this gap in the literature by explicitly exploring MA plan decision-making, including how plans anticipate defining eligibility parameters around at-risk populations and how plans collect and apply social risk data to improve health outcomes.

METHODS

This paper combines data from 2 separate qualitative studies (study 1 and study 2), both of which involved interviews with MA plan leaders. Study 1 examined how MA plans address the health of MA plan members; how they design, implement, and assess the efficacy of new programs and benefits; and plans' receptivity to alternative payment models. Study 2 explored how MA plans were using the additional flexibility offered by CMS to direct supplemental benefits toward supports that address health-related social risk factors in their 2020 bid cycles and what shaped the plans' decisions to offer new or expanded benefits. Although these 2 studies were funded, designed, and conducted independently, interview topics described in this report overlapped. In total, the 2 studies involved interviews with 63 leaders from 29 different MA plans. Recruitment and data collection from each of the 2 studies and the combined analysis methods are described below.

Sampling

The research teams conducted semistructured interviews with health plan leaders in 2 qualitative studies. Study 1 interviewed 38 representatives from 17 plans; study 2 interviewed 25 representatives from 14 plans, yielding 31 total plans. Two plans overlapped across both studies, accounting for 16 of the 63 total participants. The 29 unique plans together cover 75% of the national MA population. The study 1 research team employed a purposive and snowball sampling strategy. Initially, participants from plans of varying size, geographic location, and quality rating were purposively recruited, and interview participants were asked for recommendations of potential participants from other plans at the completion of each

TAKEAWAY POINTS

Despite enthusiasm around expanding Medicare Advantage plans' supplemental benefits to social care programs, innovation or activity has been slow.

- ▶ Plans use multiple data sources to determine how to target benefits, and evidence gaps persist, which hinder decision-making to offer new supplemental benefits.
- ▶ In the absence of sufficient evidence, plans have their own research and quality improvement processes to maximize effectiveness.
- ▶ These findings highlight the need to ensure interoperability of new and existing data sources, foster shared learning opportunities, and narrow evidence gaps about specific social care interventions to inform the design and implementation of supplemental benefits.

interview. The study 2 project team used a random sampling approach to identify plans from a complete list of MA plans nationally, ensuring representation of plans from the following categories: geographical coverage and location, special needs plan (SNP) vs non-SNP, tax status (nonprofit vs for profit), and plan type (eg, health maintenance organizations, private fee-for-service plans). In instances in which the study team received no response to a request for an interview after multiple outreach attempts, the next plan was randomly selected from the list of MA plans. Twice when initial outreach attempts failed, plan representatives were contacted through professional network connections using a convenience sampling approach.

Interview guides in both studies included questions focused on health plans' responses to the CHRONIC Care Act and on factors shaping plan decision-making around offering new or expanded supplemental benefits. Common interview guide topics included organizational strategy and work regarding social risk factors; eligibility for benefits that address social risk factors; current and future plans around expanding or offering new supplemental benefits that address social risk factors; new benefit decision-making processes; evaluation plans and research capacity; and barriers and facilitators to new or expanded benefit offerings. Both interview guides are included in the [eAppendix](#) (available at [ajmc.com](#)). Both study teams piloted their respective interview guides with leaders from a health plan, and both guides were subsequently refined for clarity.

Recruitment and interviews were conducted via telephone between July and November 2018 (study 1) and between April and November 2019 (study 2). The study 1 team conducted interviews immediately after the CHRONIC Care Act was passed; interviews for study 2 were conducted while organizations were planning 2020 bids in response to the CHRONIC Care Act. This approach allows for a longer range of time from which to understand MA plans' decisions regarding supplemental benefits and provides an opportunity to understand more anticipated responses from plans (study 1) and more real-time responses from MA plans in the midst of supplemental benefits planning and implementation (study 2).

Participants

In both studies, interviews were conducted with executive leadership team members (eg, chief medical officer, chief executive officer,

chief organizational officer, department heads, or institutional focal points for enrollees' social risk factors) who could speak to overall strategy and mission related to addressing social risk factors, as well as to the plans' bid processes. When more than 1 representative was interviewed in any given plan, group interviews were conducted. Of all plans approached in study 1, 12 plans did not respond to the request for interview and 2 refused to participate. In study 2, 5 plans did not respond to the request for interview and 1 refused to participate.

Procedure

Interview participants were approached by email or phone with a request to participate in an interview focusing on MA and social risk factors. Interviews were conducted by 1 to 2 members of each research team by phone. Interviews ranged between 30 and 60 minutes; the mean interview length was 45 minutes. Participants provided verbal consent to record the interview, and the audio recordings were transcribed before analysis. The institutional review boards at the study 1 and study 2 institutions exempted the qualitative study from ethical review, as it was not considered human subjects research.

Analysis

Both teams followed a similar content analysis approach for initial transcript review.²¹ Initial coding trees based on the study-specific interview guide topics were discussed using a consensus-based team approach to identify major concepts. Two coders individually coded each transcript, met to reconcile codes, and drafted a master codebook for use in the next stage of coding. Audit trails of ongoing decisions including revision of existing codes and emergent codes were kept for both sets of interviews to ensure analytic rigor.

For this cross-study analysis, 2 members from each research team reviewed a random sample of the partner study's transcripts and engaged in open coding. After developing a preliminary codebook for themes emerging from sets of interviews, all 4 coders reviewed the separate codebooks for relevant overlapping codes and discussed reasoning for any discrepancies before reaching a consensus on a shared codebook. Coded excerpts from interviews were shared with study partners for review and analysis.

To ensure anonymity of the participating MA plans, organizations were identified by unique numbers assigned in the study. The label "ID" for identifier represents a unique MA plan, and ID numbers were assigned to study 1 and study 2 participants. This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research reporting guideline.²²

RESULTS

Three main themes emerged across both studies: (1) Plans use multiple data sources to determine how to target benefits; (2) evidence gaps hinder decision-making to develop new or expand existing supplemental benefits, and (3) in the absence of sufficient evidence, participants recognize they will need to implement their own research and quality improvement processes to maximize

effectiveness. These themes are described below, and supportive quotes are included in [Table 1](#), [Table 2](#), and [Table 3](#) for themes 1, 2, and 3, respectively.

Plans Use Multiple Data Sources and Considerations to Determine How to Target Benefits

Plan representatives described using multiple sources of data, including patient-reported data, patient-level purchased consumer data, and population-level data, to inform decisions about eligibility and services. Some plans use both individual and population-level data sources to stratify risk and determine eligibility for social care benefits. These methods included building predictive models using different social risk factors (eg, food insecurity), behavioral risk factors (eg, depressive symptoms), and medical risk factors (eg, chronic renal failure) in efforts to proactively identify "at-risk" enrollees (ID6, study 1), as well as hot-spotting techniques combining socioeconomic, medical, and demographic data (ID17, study 1). Actively screening for social risk factors in different health care settings was another strategy used to gauge members' needs (ID6, study 1). Informants also described using community needs assessments as important data sources to better understand plan membership in a particular coverage area (ID13, study 1). Some plan representatives mentioned exploring relationships with community-based organizations to acquire and leverage data points to more accurately identify community needs and social risk factors (as noted by ID7, study 2). Several plan representatives mentioned taking the opportunity to build data ecosystems or data banks that pull in data from multiple sources to target member needs more accurately, leveraging data sources such as claims data, provider data, or third-party vendor data (ID1; ID7, both study 2). See [Table 1](#) for supportive quotes.

Evidence Gaps Hinder Decision-Making to Expand or Offer New Supplemental Benefits

Although plan representatives acknowledged the importance of evidence-based approaches to decision-making, they highlighted the need for better data to build the evidence base around which social needs to target and what interventions are effective in addressing social risk factors. Plan representatives recognized that some of the data generation linking social needs, interventions, and outcomes needs to happen externally and is beyond the scope of what plans can realistically do themselves. Participants articulated that the current national evidence base is not robust enough to inform plan decisions. In particular, plan representatives expressed the challenge of obtaining "cause and effect" data to inform investment decisions (ID1, study 2). Plan representatives noted compelling evidence linking food insecurity and housing instability to health outcomes (ID8, study 2), which facilitated internal decisions related to including benefits targeting these 2 social risk factors.

Plan representatives mentioned the difficulty in the health care domain of attributing which inputs generate improvements in health outcomes and the lack of evidence to support the granular data that are needed to effectively guide plan decision-making.

TABLE 1. Theme 1: Plans Use Multiple Data Sources and Considerations to Determine How to Target Benefits

Illustrative quotes	Study 1	Study 2
"We have zip codes...where there are very different social determinants and very different health outcomes. So we try to, as closely as possible, map our populations' health needs, but also their social, behavioral, any number of community factors; we try to map and then develop resources that address those that are community sensitive."	ID1	
"With social determinants, you would think someone [who] can afford a Medicare Advantage plan wouldn't necessarily suffer from these things [social needs]. We found that not to be true. So there's not really a single archetype of person that you'd want to target. In fact, we're trying to screen as much as possible in physician clinics. We're trying to develop predictive models so that we can proactively identify people [who] may be suffering from these social determinants."	ID6	
"We heat-mapped where our population sits and what their food insecurity rates were from state data in addition to where we saw high prevalence of type 2 diabetes. When we kind of did that mapping, there was definitely a correlation between where we had high pockets of food insecurity and where we had higher prevalence of uncontrolled type 2 diabetes."	ID17	
"We look at how much of this population do we have. We look at our data and say, 'Is this an area where we [have] a significant population that we could better impact their lives, better impact their outcomes? What are the issues that they're struggling with or we can perceive that they're struggling with?' We do focus groups. We buy data. We also look at a lot of research articles whenever I want to put in a new benefit. For example, this year when I wanted to put in the postdischarge meal benefit, because supplemental benefits have to be paid with what are called rebate dollars, and a rebate dollar has to do with how much under the Part D bid....You only get 65 cents on the dollar to spend there. So, if you have 10 rebate dollars, you only have \$6.50 to spend on supplementals. So, it is limited. You can't just do everything. So, we have to do the things that are [going to] provide us with the most impact, and that would be outcome-wise. But also, I'm looking to grow my membership. We're a for-profit company, so the other thing that I'm looking at is what are going to be the things that are [going to] resonate out in [the] marketplace that people want to see and want to have."	ID14	
"We have a wellness platform where we do annual health assessments; that's about chronic conditions, lifestyle things, do you smoke, do you drink, all that kind of stuff. We have incorporated screening for certain social determinants like food insecurity and loneliness....And then we've begun to do that in our clinical programs as well, where we do telephonic disease management....They're also screening for those things. And we're creating a data ecosystem where all those screenings are coming back into place where we can marry them up with claims data and other data sources to structure it so that we can do data mining and segmentation and predictive models and all these advanced analytics that help us understand more about our membership."		ID1
"We do use the Health Risk Assessment very heavily....We looked at conditions, specific benefits, or what approach we want to take when we're doing our strategy; we then also mine our data....We use HCC codes and risk scores and claims data."		ID13
"We are evaluating what this looks like in the future. To date, we've been thinking about it within the constraints we were allowed to, which is chronic conditions and clinical acute conditions. And now I think the market's pivoting more toward allowing a more specific approach to social determinants of health, and I think everybody is working on what the best approach of doing that is. So we, like a lot of other organizations, are looking at the best sources of data, which again would be going back to: Do we pull it from our claims experience? Do we pull it from our direct provider experience? Do we pull it from our care management or a vendor's solution? So that's something that we're continuing to evaluate, and I would be surprised if we're alone there."		ID10
"We actually are kind of already beginning to look at the data and...respond to [them]. That was one of the reasons we decided to expand the food benefit a little bit. We decided that between that and some public health data that [are] obviously available to us, we started seeing that there was a larger need. I think our big issue is we haven't figured out 100% how to connect need with the services and what we can provide....I think the data collection piece will be ongoing, and it's a significant amount of data. We've already been approached by a number of organizations that are beginning to offer to sell us data about social risk factors....They are also offering a large database of information that we think could be helpful to figure out what are the needs for our membership. Then we've also looked again at public databases and public health reports that the city puts out, the state puts out, etc."		ID7

ID, identifier; HCC, hierarchical condition categories.

The challenge of investing resources using rebate dollars was highlighted among several interviews. Rebate dollars are one way to finance supplemental benefits, and typically rebate dollars are invested specifically into benefits that will have the greatest impact on health outcomes and generate a return on investment (ROI) (ID14, study 1). Some representatives described having to make more pragmatic decisions in the absence of data, basing decisions to offer new or expanded benefits more on whether it would be a market opportunity for the plan, such as whether a certain benefit will be competitive in a particular market segment or have high uptake among enrollees (ID16, study 1; ID14, study 2). One plan representative expressed the need for more guidance or improved tools to calculate the potential ROI of interventions targeting social

risk factors to synthesize emergent evidence (ID10, study 2). See Table 2 for supportive quotes.

In the Absence of Sufficient Evidence, Participants Recognize They Will Need to Implement Their Own Research and Quality Improvement Processes to Maximize Effectiveness

To address the challenge of limited data, MA plans are developing pilot programs to generate and test the feasibility of implementation and new benefit effectiveness as a means to shape future benefit design. Plan representatives noted that internal research and quality improvement processes are important to have in place to maximize learning from experimentation in offering benefits that address social

TABLE 2. Theme 2: Evidence Gaps Hinder Decision-Making to Expand or Offer New Supplemental Benefits

Illustrative quotes	Study 1	Study 2
<p>“When you launch something in the market, you would have ideally done a planned approach where...you pilot it, you measure it, you determine whether or not it’s worth it, and you roll it out. Where it gets tricky in health care is, how do you attribute the various factors that drive an improvement in one’s health? How do you measure how much of that was they talked to a different provider? Their PCP wasn’t there one day and they talked to a different doctor, and it made all the difference in the world. Or their friend introduced them....Joyce’s friend Stephanie introduced her to Paul. Or Joyce started going to the gym. Or Joyce and Stephanie decided to try a slightly different diet. Or somebody gave them a Fitbit. Any number of factors can make a change year over year. For us, we tend to measure: Is there a marketing opportunity? Will somebody want this? Because Medicare Advantage is a very competitive business. You compete on how much you pay for medical benefits, and then you compete on other stuff.”</p>	ID16	
<p>“It’s all tied to ROI. So does it make sense financially? Can we cover it within the premium? I mean, we’re capitated, and so we just can’t spend money without justifying it through savings in some way. So, the impact of the nonmedical services has to be clear. If it isn’t clear, then we probably shouldn’t do it.”</p>	ID15	
<p>“[There are] pretty strong data on food insecurity and housing nationally...and [they] seem to have the most data [national and international]....Certainly in those areas where there [are] some data that support [them], it helps make it a little easier to focus on, including some of those as some type of benefit. But I think in some of the cases, the issue isn’t that there aren’t data but that there are not enough data. [I] hope that there will be more comprehensive data in the future.”</p>		ID8
<p>“All the social determinant initiative evaluations that I’d been seeing and would really want to see if somebody would come up with something, with a tool on how to evaluate all the initiatives and show an ROI....We’ve touched on how difficult it is to provide [an] actuary an ROI for certain initiatives. We know it’s the right thing to do, and we know at some point it must provide an ROI if we’re keeping our members satisfied and we’re addressing their needs; that means we’re preventing them from hospitalization and going to the ER. It’s just not direct. I think that’s partly the same as well on the care management end, but we definitely want to know more and we’re learning more every day about everyone’s experience as they address social determinants and how they’re trying to prove the value of doing certain initiatives.”</p>		ID10
<p>“So we partnered again with a local CBO....They’ve done a lot of the research in tying food to health outcomes....I was able to bring that to our leadership team and say, ‘Look, we have an evidence base now.’ Theirs was a little bit different. Theirs I think went 12 weeks with food benefits, with certain conditions, and ours is only 4, twice a year, but at least there was something there that tied to outcome. I think a lot of the other ones don’t have the outcomes for us to kind of adopt, but it doesn’t mean we’re not interested. It’s just [that] the [benefit] that had more research and health outcomes improvement tied to it was easier for us [to invest in]. I’d love to say that it’s all data driven, but we’re just not at that data piece yet where we’ve engaged with both [organization 1] and [organization 2] to look at the data they’re offering. I think that eventually we’ll be more data and purpose driven, but we just don’t have a really great way to identify social risk factors.”</p>		ID7
<p>“When you add this sort of benefit, the question of how you build it into the bid, measure its effectiveness, expand it, or eliminate it is really challenging. I think we need more data. We need more of an evidence base that says, ‘Improving fruits, grains, and vegetables in people’s diets and increasing a healthy diet for people of a certain age group has salutary effects in terms of their overall health that are both economic and associated with improved well-being.’ At the moment, it’s just completely a guess on our part.”</p>		ID14
<p>“We know the relationships between social determinants and, to a certain extent, some quality measures, and utilization and quality of life and other things. But there’s a lack of evidence in terms of what works.”</p>		ID1
<p>“A couple of companies [health plans] have basically started up a portal where we can all go in and ask each other questions and help each other out. I think that the evidence base part is difficult because—since it’s possibly not something that was previously tracked, we do have an issue sometimes, and even just in general for other benefits we’re looking at—[we can’t] know what the utilization was. What would the cost be to better predict how much you’re going to end up spending on it? What’s the ROI? What’s your cost savings on it, both quantitative and qualitative? So that has been a tricky part for us in general for any of the product design changes that we do.”</p>		ID5

(continued)

risk factors. Plan representatives described this as the process of learning from what they are doing, tweaking processes and benefit offerings accordingly, and measuring outcomes (ID1, study 1).

Several plan representatives shared that their plan had a systematic internal procedure to review evidence and impact to steer modifications to benefit offerings (as noted by ID12, study 1); however, many plans lacked the ability or resources to build internal research capacity. Plan representatives with internal research capacity and infrastructure emphasized that data on social needs have only very recently been collected internally and that it takes time to build a credible data set on which actuaries base their decisions (ID11, study 2). Correspondingly, plan representatives noted that a longer time frame is needed to show an ROI when providing a benefit that

addresses a social need compared with other outcomes such as preventing a hospital admission (ID1, study 2).

Operational and implementation data were noted as important information sources for MA plans, including uptake rates, acceptability of the benefit to members, and member engagement with the benefit over time (ID1, study 1; ID8, study 2). These data inform investment decisions or benefit modifications that are needed, as these are more granular data on whether a certain benefit works in reducing social risk factors among one target population more than another. Some plan representatives stated that once the benefit is offered, data collection processes are put in place to monitor uptake of the benefit among members and the impact of the benefit on health outcomes such as emergency department visits.

TABLE 2. (Continued) Theme 2: Evidence Gaps Hinder Decision-Making to Expand or Offer New Supplemental Benefits

Illustrative quotes	Study 1	Study 2
"We go through actuarial processes. Internally, to make the case that we want to test something, there needs to be a reasonable expectation that it could generate an ROI. So, we go with all the available evidence out there...[which] is mostly associative and not causative....It can be challenging with social determinants because they already tend to be expensive. And addressing social determinants, because they're upstream, sometimes the ROI time frame is a little bit longer than if you're trying to keep somebody out of the hospital, like an acute sell benefit. And so, it gives actuaries heartburn."		ID1
"We don't really have sufficient data to make any judgments. So we're going to be making decisions about what benefit to offer in this space and to whom, without, you know, we really had hoped to have a little bit more data and experience before we had to make a decision about 2020, but the clock is the clock...."		ID3
"Most of the research to this point has been about correlations and associations between social determinants and health and health outcomes and things like that. And there [are] very strong linear correlations with health care utilization and costs and all these things. But what's missing right now is the evidence base around causation. If you address food insecurity, what happens to cost of care, admissions per thousand, and different things like that? In that, the evidence is lacking, frankly. And that's internal to us, it's all our competitors, it's the whole industry, and that's, I think, the reluctance [in] really heavily investing in [the] social determinant space is that there is that lack of cognitive outcomes evidence right now."		ID1
"I'm looking at the evidence base for a lot of things that are sort of popping up....What you realize, when you move from the world of caring for patients every day to the world of leading a not-for-profit business that's caring for patients in numbers, is that a lot of times, you have to make business decisions on a somewhat pragmatic basis, and we're really in the experimentation mode here. We'll have people [who] will take this [benefit] up and we'll have people [who] won't take it up, because it's amazing how you can offer a really nice benefit that people just don't use."		ID14

CBO, community-based organization; ER, emergency room; PCP, primary care provider; ROI, return on investment.

TABLE 3. Theme 3: In the Absence of Sufficient Evidence, Participants Recognize They Will Need to Implement Their Own Research and Quality Improvement Processes to Maximize Effectiveness

Illustrative quotes	Study 1	Study 2
"As a result of tackling a certain membership in a certain zip code or a certain provider, as a result of doing some type of intervention, whether it's education, whether it's a mobile clinic, whether it's a case management intervention, what impact did we see that it had? What did we learn from that? Then how do we spread it if it worked? Or, importantly, how do we stop it if it didn't, and start and do something different instead? We have a very methodical cadence of reviewing information, launching interventions, and then bringing them back to this governance structure to assess efficacy."		ID12
"We do pretty extensive tracking for all of our programs in terms of monitoring data points, looking at process measures, looking at outcome measures, and obviously making adjustments as we go. We are very focused on tracking our programs and seeing, is this working, is this not, and what group isn't working and why is it not, and adjusting accordingly. That's an 'as we go' lesson learned application of basically just taking what we're learning and tweaking accordingly."		ID1
"I'm not sure [our approach is] really the right approach; it's really just the approach we took here because obviously this is unknown territory for us. We started looking at it from a financial perspective, and there [weren't] a whole lot of data out there. We started looking at all the chronic conditions that are out there [and] utilization of the members [who] have those chronic conditions and making some assumptions based on the volume of members....We have 1200 members who have these complex conditions and various comorbidities and they were discharged. So the benefit allows then 4 weeks of 3 meals a day, 7 days a week post discharge, up to twice a year, so we'd say, worst case, we'd pay \$1 million in a meal benefit. And that's sort of how we played it out to start. That's not what we're seeing. That's why we're saying we expanded it this year based on our first year of utilization. We just weren't seeing many people take us up on the benefit—and I don't know if we're just not doing a good job, if the doctors aren't doing a good job—so we expanded it out a little bit."		ID7
"We did some analysis on interventions that we conduct—for example, on food security and emergency food clinics....[We] did find that people who used services had better utilization and outcomes. We want to look at cost savings and changes in health care utilization, and then want to look at certain health conditions they have. We put an intervention in place and evaluate: pre- and post intervention type of analysis, matched on intervention. [We] want to match gender, age, race, and look at differences [in] number of comorbid conditions."		ID8
"The actuarial outcomes are always driven by credible data sets because actuaries tend to want to have sufficient data to draw a conclusion. The problem is, I think, [that with] many of these interventions, it takes a while to get a credible data set. Reacting too soon can lead you to make hasty decisions that aren't necessarily fully credible with your data."		ID11
"People will email me a study and say, 'Look, this study...shows if you do X, then Y will happen.' But studies don't translate into real-world outcomes necessarily....It's really hard to take a study and translate that into a business case for our own population. We try that to build our own case based on local data, which is like [what] others [do] who are in the same boat. But we have conflicting opinions even within our organization....Someone will send me a study, like, 'Look, this proves it—add a transportation benefit, add a meal benefit.' We're still trying to figure out how to take the literature, which is valuable,...it's as good of a road map that we have available today, but trying to internalize that is just really difficult."		ID6

ID, identifier.

In particular, one plan representative (ID7) from study 2 shared an example that internal monitoring of the implementation of a new meal benefit demonstrated low member uptake, leading the plan to only gradually expand the benefit and monitor utilization rates in 2019. See Table 3 for supportive quotes.

DISCUSSION

We leveraged 2 unique studies that involved interviews with MA plan executives to better understand plan decision-making around supplemental benefits to address social risk factors. Despite enthusiasm among plan representatives to expand benefits to social care programs, innovation or activity around the new supplemental benefits is slow, consistent with hypotheses and findings of several recent reports.^{23,24} There may be several reasons for the slow uptake, including lack of evidence, which in part stems from lack of data; not enough clarity and guidance from CMS about what is allowed; and insufficient time to develop thoughtful proposals.

Paucity of evidence around how to use existing data in determining which risk factors to address and for which populations within the member constituency is a feasible reason for plan hesitation to structure new benefits. This hesitation is reflected in the low 4.6% adoption rate of new special supplemental benefits for the chronically ill among MA plans in 2020.¹⁹ A recent analysis found that the largest areas of growth within benefit expansion were pest control, meal programs, and produce.¹⁹ Given the evidence gaps and lack of additional funding for providing new or expanded supplemental benefits, there may be hesitation among plans to invest additional resources into new benefits.⁵ MA plan representatives stated that limited evidence was available to guide decision-making about programs or benefits that address health-related social risk factors, including ROI in terms of both financial and health impacts. This has also been reflected in other recent studies among MA plan leadership.⁵ MA plans identified that both financial ROI and health impact ROI were important factors in decision-making about which services to offer or provide related to social determinants of health. Recent (2021) guidance from CMS has noted that spending on nonmedical services is generally expected to produce health returns and therefore lower health spending. Although the evidence base was considered strong for some health-related social risk factors (eg, food insecurity), there was less evidence on the operational implementation of these benefits and what the returns were financially or healthwise and over what time horizon. MA plan representatives stated that they need more granular, tailored evidence to make financial investments, with some representatives indicating that they were collecting some of this information internally.

Plan leaders also noted that gaps in the availability of data limited their ability to make informed decisions. A number of plan representatives in this study explained that they contract out services for data collection, monitoring, and evaluation efforts, particularly for evaluating pilot programs. It could also be valuable to set requirements for consistent and reliable MA plan encounter data for plans

to learn to use data to drive decisions around modifications to benefit offerings to ensure better population reach or uptake and better outcomes. To advance this effort, consensus is needed on standardization of measures and metrics to drive plan decisions.

Although lack of data and financial resources may partially explain slow uptake of the new supplemental benefits, other reasons may be the relatively short period of time between the call announcement and the proposal deadline,²³ a challenge reflected in several interviews in this study. CMS has an important role to play in setting requirements and guidelines to steer MA plans in this new process. The ability for MA plans to learn from each other is also crucial, and currently there are limited shared data mechanisms under the MA program. CMS could be an important player in setting requirements for shared data and in monitoring and evaluating emerging data on these new supplemental benefits. Slow uptake of new supplemental benefits may result, in part, from hesitancy on the part of plans to adjust their roles. In our prior work that used interview data from study 1,⁵ we found that among MA plan representatives interviewed, although there was significant interest in identifying ways in which MA plans can have greater social and health impacts, there were differences of opinion regarding the best approach. Whereas some plan representatives expressed a desire to offer supplemental benefits to meet members' holistic needs, others preferred to engage with community-based organizations to provide support for members' social needs. This lack of consensus across MA plans may contribute to limited benefit uptake.

Limitations

There are several limitations to this work. First, although we were able to sample leaders representing 75% of the MA market, our findings may not represent the entire MA market in the United States. Second, plans may not have shared the full picture of their decision-making processes with respect to offering benefits or strategies to address members' social risk factors, and qualitative interviews provide only a part of the picture with respect to this fast-evolving payer policy landscape. A strength of employing qualitative methods is that it is the only way to understand the contextual factors of MA decision-making. Although the interview guides were not identical, the advantages of combining data outweighed that limitation because they enabled us to develop a data set reflecting the opinions and perspectives of a larger set of MA plan leaders. Our study is among the few to provide insights into how a large sample of MA plans make decisions to address members' social risk factors in response to the CHRONIC Care Act and covering a longer time range.

CONCLUSIONS

The CMS rule and CHRONIC Care Act together have provided the MA market with more flexibility to address nonmedical needs of chronically ill members. Uptake of this flexibility has been slow, overall, among plans. Emphasizing limited effectiveness evidence, our participants

expressed caution about making long-term investments in this area. Efforts to strengthen data availability and interoperability will improve the quality of research and thereby support MA investments in social care programs. A coordinated research agenda would help target future research efforts in ways that can support public and private payers looking to advance social care initiatives. ■

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Draft Interview Guide: MA Plans

Thank you so much for agreeing to speak with us. We are interested in learning more about your plan's interest in addressing the health of your members. This includes social determinants of health. We're also interested in your receptivity to alternative payment models including Pay for Success.

Before we get started, I'd like to learn a little bit more about your role and background...

What is your current role? How long have you been in it?

What are your primary responsibilities?

Non-Medical Services

We understand that MA plans may be increasingly interested in providing non-medical services to improve the overall health and well-being of enrollees. Oftentimes, this includes partnering with community-based, social service organizations to provide non-medical services to better manage the overall health of individuals with complex needs. What is your perspective on the value of community based, social services (such as transportation to appointments or home-delivered meals) as a component of your plan's design or services?

What are your organization's current priorities related to providing non-medical community-based, social services to improve the overall health of your members?

What characteristics describe your members with the greatest and most complex needs?

What do you see as the most needed/valuable services or benefits to address the needs of these enrollees?

Are these services currently provided?

If not, how do you decide what you cover?

If not, how could these services be provided?

What are the barriers to providing these services?

How would you envision services not currently provided being integrated into your service or plan designs?

How receptive do you think your provider networks would be to these efforts?

Do you think the passage of the CHRONIC Care Act, which allows for more flexibility in covering non-medical benefits, has changed or will change the way you think about designing benefits for your enrollees? How?

Pay for Success/Outcomes-Based Financing

Now I want to switch gears a bit and talk about financing arrangements to pay for possible integration of these social services in plan benefit designs, specifically Pay for Success.

As you may know, In Pay for Success financing agreements, private investors provide upfront capital for the delivery of services, and these private investors are repaid if contractually agreed upon outcomes are achieved. In this arrangement, financial risk is shifted from service providers to investors, with investors underwriting the project based on the likelihood of pre-defined outcomes being achieved. Typically, an independent evaluator determines whether the agreed-upon outcomes have been met.

To what extent are you familiar with Pay for Success?

Has your plan discussed or thought about implementing Pay for Success initiatives to pilot solutions related to the non-medical needs of your members?

Is PFS an arrangement that would be attractive to your organization, perhaps in addressing social determinants of health among your members?

Why? Why Not?

If your organization were interested in implementing Pay for Success, how might you go about getting and using data to assess feasibility?

For community-based organizations interested in partnering with you in some sort of outcomes-based financing, how do you recommend they engage your organization?

What would you want to see from them in terms of evidence, business case, data readiness, HIPAA compliance, etc., in order to feel comfortable exploring a partnership?

In Pay for Success, depending on the project you may need to engage legal counsel, finance, actuaries, compliance, quality, population health, and government affairs.

How does, or would, your organization handle innovative projects that require the input and buy-in of so many parts of the organization?

Evaluation is critical to PFS. Under what circumstances would your organization be willing to share member utilization and cost data with project partners (potentially including independent validators and evaluators) in order to establish success baselines, and then to track project success metrics?

What are your current capabilities for evaluations of new programs and products? How might these capabilities play a role in working with a community-based organization and an independent evaluator?

What other thoughts, information, feedback would you like to share with us related to this work?

Do you have colleagues from other Medicare Advantage plans that you think would be willing to speak with us? Could you please share their contact information?

Medicare Advantage Plan Leaders Interview Guide

Questions about Supplemental Benefits Definition and Coverage

- To start off, do you have a working definition or strategy of a social determinant/social risk factor within the plan?
- How did your organization reach the decision to address social risk factors and what was the motivation for doing so?
- Can you tell us a bit about the process that you plan to use to stratify or target members who might be eligible for supplemental benefits?
- How does your organization screen for social risk factors among members?
- How do you use information from screening/assessment to determine which population gets what type of coverage or benefit?
- Can you give us an example of a social risk factor your organization has focused on and why you decided to focus on that particular need?
- What about an example of a social risk factor you have not prioritized and why you chose not to focus on that need?
- Does your plan currently provide any supplemental benefits or other services that address social risk factors? Could you tell us a bit more about how long this benefit has been offered and factors determined the plans decision to offer this benefit?
- To what extent were there differences in the content of the bids submitted for 2019 versus what was submitted for 2020, specifically related to supplemental benefits targeting social risk factors?
- What factors determined whether or not the plan submitted a bid?
- Can you describe the structure of those benefits proposed?
- Did any of the plan's existing supplemental benefits change to be able to introduce new or expanded benefits specifically targeting social risk factors?
- What kind of evidence (or data) is necessary in your plan to be in a position to offer a new or expanded benefit targeting social risk factors?
- In your view, to what extent does available evidence on social risk factors enable your plan to justify investments in new or expanded benefits? How does the evidence differ (e.g., strength of evidence) within the different types of social risk factors?
- Are you conducting any internal research to calculate the return-on-investment of supplemental benefits to address members social risk factors? Could you tell us a bit more about that research?
- Are there any challenges that you anticipate in your plan in addressing the social risk factors of your members?