One point of differentiation between the Medicare Advantage (MA) program, in which private plans are paid on a capitated basis by the Centers for Medicare & Medicaid Services (CMS), and traditional Medicare, is that MA plans can offer additional supplemental benefits for their enrollees. In 2019, MA plans were given substantially expanded flexibility to offer these supplemental benefits to address services that were not considered traditionally health related, such as in-home support services and adult day care. With the implementation of the CHRONIC Care Act in 2020, MA plans were granted additional flexibility to offer supplemental benefits that address beneficiaries’ social needs, such as nonmedical transportation and meal services. While prior studies have found that the uptake of these benefits has been generally low, it is not well known how different MA plan types have embraced these benefits.

This study by Jin and colleagues adds to the literature by examining the uptake of supplemental benefits to address social needs among dual special needs plans (D-SNPs), which are an evolving type of MA plan intended to integrate Medicare and Medicaid coverage for individuals who are eligible for both. Using publicly available plan benefits and SNP data, Jin et al compared the adoption of new benefits in 2021 among D-SNP, fully integrated D-SNP (FIDE-SNP), and general MA plans. They found that with the exception of food and produce and transportation for nonmedical needs, the adoption of supplemental benefits was low overall but relatively higher for FIDE-SNPs. One important limitation of these results is that the numbers presented are likely overestimating beneficiary uptake, as the plan benefit data only report on whether a plan offers a benefit, not for whom, how much, or whether or not beneficiaries use these benefits. The study by Jin et al adds to the developing body of evidence that the potential of these benefits may not yet be realized. It is particularly concerning that uptake of these benefits is not higher for plans that serve the population dually-enrolled in Medicare and Medicaid, who may stand to benefit the most from services designed to address social needs.

The slow increase of these benefits may stem from several important challenges to their adoption. First, CMS does not provide additional funding to plans to offer these benefits. Supplemental benefits are typically paid for by rebates that MA plans receive for submitting bids below a CMS payment threshold, and initial startup costs for MA plans creating these benefits may be costly. Paying for supplemental benefits is required to be included in the calculation of a plan’s medical loss ratio (MLR), which has raised uncertainty about how payments to organizations that provide supplemental benefits would factor into MLR calculations. Second, plans have reported challenges with understanding the potential return on investment for addressing their members’ social needs. Without more research that can directly link addressing social needs to decreased health spending, or that these benefits help plans to expand their market share, MA plans may be unwilling to fully commit to offering these services. This is particularly a concern if it may take several years for the return on investment to be realized, and beneficiaries may switch plans before those returns are met. Third, many MA plans may not have the experience or capabilities to offer these benefits themselves; this limitation may require that plans work with community-based organizations that are more experienced with offering the services that can now be covered through these benefits. While there is potential for MA plans to partner with community-based organizations...
to offer supplemental benefits, differences in goals, finances, and organizational culture may stymie these relationships.  

There are several potential solutions to improving the policy landscape to increase supplemental benefit adoption among MA plans. First, more data are needed to understand what these benefits include, who is eligible, and how many beneficiaries use these benefits. The MA plan benefits data only report the name of a benefit. It is not clear from the plan benefits data who is able to use these benefits, what services beneficiaries are entitled to, who provides those services, or how many beneficiaries use the service. Without more robust data about these benefits, it will be challenging for researchers, policy makers, and plan decision-makers to evaluate whether these benefits are improving the health and experience of beneficiaries or if they are primarily a tool to attract new members. Second, CMS could provide more clarity to MA plans on how supplemental benefits can be paid for and how they should factor into MLR calculations. Third, more efforts may be convened to help community-based organizations and MA plans to better partner with one another to offer these benefits.

The MA program will soon enroll more than 50% of all Medicare beneficiaries, many of whom may stand to benefit from supplemental benefits to address social needs. The study by Jin et al\(^3\) shows that while uptake might be higher among integrated plans, there is still a long way to go before these services are widely available for Medicare beneficiaries, including those dually-enrolled in Medicaid, who potentially stand to benefit the most.

**ARTICLE INFORMATION**

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