

# Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans

*Gap Analysis and Policy Development*



### **About the Association for Community Affiliated Plans**

The Association for Community Affiliated Plans (ACAP) is a national trade association which represents not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than twenty million enrollees. For more information, visit [www.communityplans.net](http://www.communityplans.net).

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# Table of Contents

- Chapter 1: Executive Summary ..... 2**
  - A. How D-SNPs Access Resources to Address SDOH ..... 2
  - B. Key Findings from the Gap Analysis..... 2
  - C. Potential Policy Options ..... 3
  - D. Conclusion and Future Directions ..... 4
- Chapter 2: Introduction ..... 5**
  - A. New Supplemental Benefit Flexibilities for Medicare Advantage Plans ..... 5
  - B. Financing of Supplemental Benefits..... 7
  - C. Dual Eligible Special Needs Plans ..... 9
- Chapter 3: Methods ..... 10**
- Chapter 4: Gap Analysis ..... 11**
  - A. Assessing Members’ SDOH Needs ..... 11
  - B. Prioritizing SDOH Needs ..... 12
  - C. Addressing SDOH Needs..... 12
  - D. Identifying Gaps in Plans’ Ability to Meet SDOH Needs ..... 13
  - E. Using Other Funding Options to Address Members’ SDOH Needs ..... 14
  - F. Deciding Whether to Offer SSBCI..... 15
    - D-SNPs’ Perspective on the Value of SSBCI..... 15
    - Considerations Around Offering SSBCI in CY2020 ..... 15
      - Reasons for Offering SSBCI..... 15*
      - Reasons for Not Offering SSBCI..... 16*
    - Sufficiency of Rebate Dollars to Fund SSBCI..... 17
  - G. Examining SSBCI Interactions with Medicaid Benefits..... 17
  - H. Thinking About SSBCI for 2021 and Beyond ..... 18
- Chapter 5: Policy Options and Other Considerations ..... 19**
  - A. Policy Options ..... 19
    - Create New Flexibilities for Plans to Offer SSBCI ..... 19
    - Adjust the Star Ratings System to Reflect Levels of SDOH Needs Among D-SNP Members..... 20
      - Redesign Star Ratings Comparison Groups..... 20*
      - Allow D-SNPs to Retain a Higher Percentage of Their Rebate Dollars..... 21*
    - Add Indicators of SDOH Need to the Medicare Advantage Risk-Adjustment Model ..... 21
  - B. Other Considerations ..... 22
- Chapter 6: Conclusion and Future Directions ..... 23**
- Appendix: Subject Matter Experts Interviewed ..... 24**
- Endnotes..... 24**

# Executive Summary

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The more than 12 million Americans who are dually eligible for Medicare and Medicaid often have multiple chronic medical and behavioral health conditions, long-term care needs, and significant social determinant of health (SDOH) needs. Addressing their SDOH needs could help dually eligible individuals by improving access to and the effectiveness of their Medicare and Medicaid benefits, improving health outcomes and quality of life, and reducing health care costs.

Increasing recognition of the impact of non-medical factors on health and health outcomes led Congress and the Centers for Medicare & Medicaid Services (CMS) to create pathways for addressing Medicare beneficiaries' non-medical needs. Recent CMS guidance described Special Supplemental Benefits for the Chronically Ill (SSBCI), which can include non-primarily health-related supplemental benefits (e.g., meals, food and produce, non-medical transportation, pest control, indoor air quality equipment and services, structural home modifications) that could address SDOH needs. Beginning in 2020, Medicare Advantage plans could offer SSBCI to members with certain chronic conditions.<sup>1</sup>

The Association for Community Affiliated Plans (ACAP) is a national trade association representing not-for-profit safety net health plans. ACAP has 24 Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) members that enroll mostly full-benefit dually eligible individuals. ACAP and its D-SNPs welcome the opportunity to provide SSBCI, but recognize that the current funding mechanism for those benefits (i.e., plans' rebate dollars) may not provide sufficient resources to meaningfully address the needs of dually eligible members.

With support from Arnold Ventures, ACAP partnered with the Centers for Health Care Strategies (CHCS) to develop: (1) a **Gap Analysis** exploring D-SNP members' SDOH needs, how the SSBCI pathway is being used, and whether the SSBCI pathway provides sufficient flexibility and resources to address SDOH needs; and (2) a set of **Policy Options** that explore alternative ways for Medicare to provide D-SNPs with tools to address SDOH. Both the gap analysis and the policy options were informed by interviews with ACAP D-SNPs and nationally recognized subject matter experts.

## A. How D-SNPs Access Resources to Address SDOH

As the interventions that D-SNPs provide to address members' SDOH needs are not Medicare-covered services, their cost is not included in the capitated rate paid to plans by CMS. Plans must fund the costs of these services as an administrative or quality improvement expense, or in the case of SSBCI, fund them using "rebate dollars." Rebate dollars are generated from the difference between the plan's bid amount and its benchmark rate, with the percentage of the rebate kept by a plan varying based on its CMS Star Rating (i.e., plans with higher quality ratings retain a larger proportion of their rebate).<sup>2</sup>

This method of financing supplemental benefits poses several challenges for plans, including: (1) geographic and year-to-year variations in rebate dollars; (2) lower rebate amounts available to plans with lower Star Ratings; and (3) the need to use rebate dollars to provide other supplemental benefits such as vision, dental, and hearing services. These challenges may be especially acute for D-SNPs given that their dually eligible members are likely to have higher levels of SDOH needs than non-dually eligible Medicare Advantage enrollees,<sup>3</sup> and that D-SNPs also tend to have lower Star Ratings than other types of Medicare Advantage plans.<sup>4</sup> As a result, many D-SNPs retain a lower percentage of their rebate dollars than other Medicare Advantage plans with a smaller proportion of dually eligible members.

## B. Key Findings from the Gap Analysis

- **Assessing SDOH Needs.** Most plans use some combination of assessment tools, data analytics, and other information technologies to assess members' SDOH needs. Plans reported that few of their network providers are using ICD-10-CM Z Codes, which is a standardized mechanism for capturing SDOH needs.

- **Prioritizing SDOH Needs.** Plans use information gathered from different assessments, risk-stratification processes, and care management platforms to comprehensively understand members' SDOH needs, identify gaps in care, and identify those members with higher levels of SDOH needs. Care managers play a key role in assessing and meeting members' SDOH needs. Through active engagement, they understand how members prioritize their own SDOH needs and what SDOH-related interventions will have the greatest effect on those needs and the members' clinical outcomes.
- **Identified Gaps in Meeting Member SDOH Needs.** A lack of resources restricts ACAP D-SNPs' ability to address SDOH needs, particularly housing, social isolation, and transportation. Interventions to address some of these needs, such as housing, are very expensive and require long-term plan investment. Plans also cited challenges in identifying and coordinating the SDOH-related services their full-benefit dually eligible members may be receiving through Medicaid. Lastly, plans noted that available funding streams tend to support short-term solutions as opposed to those with lasting impact. Plans tend to troubleshoot first to close gaps where resources allow—such as finding temporary shelter for someone experiencing homeless—but do not have the resources to resolve housing and related issues over the long term.
- **Interventions to Address SDOH Needs.** ACAP D-SNPs leverage external partners and community-based organizations to help to address members' SDOH needs. Some plans also incorporate vendor-developed, web-based applications into their care management models, while others create their own databases or repositories of community services and supports.
- **Considerations Around Offering SSBCI in 2020.** ACAP D-SNPs described several considerations around why they did or did not chose to offer SSBCI in 2020.
  - ▶ **Reasons for Offering SSBCI.** The four ACAP plans interviewed that are offering SSBCI said they did so because they thought providing SDOH-related services was “the right thing to do,” aligned with their corporate culture and mission-driven approach, or made good sense clinically. Most plans did consider the potential for return on investment (ROI) when deciding to offer SSBCI, but most lacked strong data on ROI.
  - ▶ **Reasons for Not Offering SSBCI.** Most ACAP D-SNPs chose not to offer SSBCI in CY2020, citing a number of reasons for their decision including: (1) the short timeframe between CMS' announcement of the SSBCI flexibility and the bid deadline; (2) uncertainty around the potential ROI for SSBCI; and (3) the need to spend limited rebate dollars on other more traditional supplemental benefits such as vision, dental, and hearing that attract member enrollment.
- **Use of Rebate Dollars to Provide SSBCI.** Limiting funding for SSBCI to rebate dollars, which are already being using to provide traditional supplemental benefits and pay down member cost-sharing, greatly restricts D-SNPs' ability to address SDOH needs. Importantly, plans with lower Star Ratings, which often is associated with serving dually eligible individuals, receive a lower percentage of rebate dollars. These plans are even further restricted in the dollars they have to spend on SSBCI.

## C. Potential Policy Options

The gap analysis highlighted ways in which D-SNPs are limited in the extent to which they can use the SSBCI pathway to address their members' SDOH needs. These limitations stem from two factors: (1) D-SNPs' exclusive enrollment of dually eligible individuals that tends to lower plans' Star Ratings, which in turn lowers the amount of rebate dollars plans receive; and (2) competing priorities for the use of rebate dollars. Additionally, plans also noted that existing available funding streams tend to support short-term solutions to SDOH needs rather than those with more lasting impact.

While the SSBCI pathway is a welcome opportunity to provide more person-centered and holistic care, it is unlikely to be the primary mechanism to meet the extensive SDOH needs of D-SNP members. Discussions with ACAP D-SNPs and subject matter experts generated the following policy options, which could be enacted alone or in combination. Some of these policy options might come with financial trade-offs because they might require giving D-SNPs more resources to provide SDOH-related services both through SSBCI and outside of supplemental benefits:

- **Create New Flexibilities for Plans to Offer SSBCI.** ACAP D-SNPs believe that the flexibilities allowed under the SSBCI framework are very useful, but had suggestions for additional flexibilities, including the ability to: (1) tailor SSBCI based on enrollees' geography (e.g. urban or rural); (2) tailor SSBCI to individual, member's needs; and (3) offer SSBCI to

all D-SNP members instead of only those with a chronic condition. The latter flexibility, offering SSBCI benefits to all members, including those that do not have a chronic condition, would be particularly useful. By definition, D-SNP members are low-income and could benefit from services to address their SDOH needs.

- ▶ **Redesign Star Ratings Comparison Groups.** CMS could redesign the comparison groups for awarding Star Ratings through peer grouping. This would create a more accurate and equitable quality rating system for D-SNPs where high-quality D-SNPs would be able to retain a larger percentage of their rebate dollars because their members' SDOH needs, which can impact their Star Ratings, would be taken into account in the quality measurement system.
- ▶ **Allow D-SNPs to Retain a Higher Percentage of Their Rebate Dollars.** CMS could let D-SNPs keep a higher percentage of their rebate dollars by creating an "SDOH add-on" to the rebate percentage. The SDOH add-on could be equal to a few percentage points so as to not disincentivize plans to pursue higher Star Ratings. Note that all extra rebate dollars given to D-SNPs under this policy would be spent on offering additional supplemental benefits, including SSBCI, to their dual-eligible enrollees.
- ▶ **Add Indicators of SDOH Need to the Medicare Advantage Risk-Adjustment Model.** Incorporating indicators of SDOH need into the CMS Hierarchical Condition Category (HCC) risk-adjustment model could improve the model's accuracy and could increase payments to plans that enroll individuals with higher SDOH needs that are associated with increased Medicare costs.

We recognize that it is incumbent on D-SNPs to run efficient and effective programs for their dually eligible enrollees. Each of these options has certain challenges related to its implementation and as noted above, some would increase Medicare costs unless offsets were identified to ensure budget neutrality. However, each provides tools to support D-SNPs' capacity to better meet their members' SDOH needs and warrant further exploration.

## D. Conclusion and Future Directions

Dually eligible individuals have higher levels of SDOH-related needs that often result in higher medical costs and poorer clinical outcomes. D-SNPs were created to meet the special needs of this population, but have had limited opportunities to address the SDOH needs of their members. New supplemental benefit flexibilities, including SSBCI, create another pathway for all Medicare Advantage plans to help address SDOH needs, but funding for SSBCI – plan rebate dollars – are limited, particularly for D-SNPs.

Better understanding the SDOH needs of dually eligible individuals and how D-SNPs are using available flexibilities can inform the development of new policy options that might provide more resources for D-SNPs to address their members' SDOH needs. Recognizing that policy change takes time, ACAP has identified the following future directions for work in this space that may facilitate implementation of these policy options:

- **Incentivize Collection of SDOH Data.** D-SNPs could offer incentives to providers, perhaps through value-based payments, to encourage the data collection on SDOH-related needs.
- **Z Code Demonstration.** CMS could work with D-SNPs, and Medicare and Medicaid providers to develop a pilot or demonstration that would evaluate whether Z codes can be widely documented and whether incorporating Z code data into the HCC risk-adjustment model would affect payment rates.
- **Evaluation of ROI.** More data on the ROI of SDOH-related interventions could help plans and CMS to better evaluate which interventions work best for certain sub-populations of Medicare beneficiaries, including dually eligible beneficiaries.

ACAP looks forward to working with federal and state partners, its D-SNP members, and other stakeholders to explore policy options and pursue future directions. State and the federal policymakers have an interest in not just better integrating Medicare and Medicaid for dually eligible individuals, but also in mitigating the effects of SDOH for this population to improve their quality of life, improve health outcomes, and reduce the cost of their care.

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## CHAPTER 2

# Introduction

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The more than 12 million individuals who are dually eligible for Medicare and Medicaid often have multiple chronic medical and behavioral health conditions, as well as long-term care needs.<sup>5</sup> They also experience needs related to social determinant of health (SDOH) like poverty, food insecurity, housing instability, and lack of transportation at a greater rate than non-dually eligible individuals.<sup>6</sup> These challenges can make it more difficult for them to access needed care and follow care recommendations and medication regimens, resulting in unnecessary hospitalizations or emergency department visits and avoidable declines in health status.<sup>7,8</sup> As a consequence, dually eligible individuals account for a disproportionate share of spending relative to their share of enrollment in both the Medicare and Medicaid programs.<sup>9</sup> Services and supports that address SDOH needs could help dually eligible individuals by improving access to and the effectiveness of their Medicare and Medicaid benefits, improving health outcomes and quality of life, and reducing health care costs.

The Association for Community Affiliated Plans (ACAP) is a national trade association representing not-for-profit safety net health plans, including 24 Dual Eligible Special Needs Plans (D-SNPs) that exclusively enroll dually eligible individuals.<sup>10</sup> Most ACAP D-SNPs enroll full-benefit dually eligible individuals who have high SDOH needs, and ACAP plans have developed a variety of programs and community partnerships to address those needs. Recently created flexibilities allow Medicare Advantage plans, including D-SNPs, to offer new supplemental benefits to their members called Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI enable Medicare Advantage plans to offer some non-medical services to certain chronically ill enrollees. Some of these services, such as general housing supports, help to address SDOH needs. While ACAP and its member D-SNPs welcome the opportunity to provide SSBCI, the current funding mechanism for those benefits (i.e., plans' rebate dollars) may not provide sufficient resources to meaningfully address the SDOH needs of dually eligible individuals.

With support from Arnold Ventures, ACAP partnered with the **Centers for Health Care Strategies (CHCS)** to develop:

- 1) A **Gap Analysis** that assesses the SDOH needs of ACAP D-SNP members, explores how ACAP D-SNPs are using the SSBCI pathway, examines whether the SSBCI pathway is an effective policy mechanism to provide D-SNPs with flexibility and resources to manage and meaningfully address their members' SDOH needs; and
- 2) A set of **Policy Options** that explore alternative ways for Medicare to provide D-SNPs the necessary tools to manage SDOH. These policy options could provide more stable and sustainable funding for supplemental benefits and make SSBCI or related services more accessible to individuals who need them.

ACAP intends to broadly disseminate the policy recommendations in this report to advocate for federal policy changes that provide additional ways for Medicare to give D-SNPs the necessary tools to manage their members' SDOH needs.

## A. New Supplemental Benefit Flexibilities for Medicare Advantage Plans

Medicare Advantage plans cover all the hospital and medical benefits provided under original Medicare, and have been permitted by the Centers for Medicare & Medicaid Services (CMS) to offer primarily health-related supplemental benefits (i.e., an item or service whose primary purpose is to prevent, cure, or diminish an illness or injury) as extra benefits to members.<sup>11</sup> Common supplemental benefits include vision, hearing, and dental services; gym memberships; medical transportation; and debit cards for purchasing over-the-counter medications and other supplies. Historically, Medicare Advantage plans have not been permitted by CMS to offer supplemental benefits to address SDOH needs.

Increasing recognition of the impact of SDOH on health and health outcomes led Congress and CMS to identify pathways for addressing SDOH needs. Recently, Congress and CMS have provided three new supplemental benefit flexibilities for all Medicare Advantage plans; two of which (i.e., SSBCI and relaxation of uniformity requirements) permit Medicare Advantage plans to address SDOH needs.

■ **Expansion of the Definition of “Primarily Health-Related Supplemental Benefits.”** In its CY2019 Advance Notice and Call Letter for Medicare Advantage plans, CMS announced an expansion of the primarily health-related definition that was then further clarified in guidance.<sup>12,13</sup> The expanded definition allows Medicare Advantage plans to offer supplemental benefits that “diagnose, compensate for physical impairments, acts to ameliorate the functional/ psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization.” Examples of these benefits include:

- ▶ Adult day health
- ▶ Home-based palliative care
- ▶ In-home support services
- ▶ Support for caregivers
- ▶ Medically approved non-opioid pain management
- ▶ Standalone memory fitness benefit
- ▶ Home and bathroom safety devices
- ▶ Transportation for non-emergency medical needs

While this change in definition allows Medicare Advantage plans to provide benefits to address long-term service and support (LTSS) needs, supplemental benefits that are used to address SDOH needs are specifically excluded. Plans could begin offering benefits meeting the expanded definition of “primarily health-related” in 2019.

■ **Creation of Special Supplemental Benefits for the Chronically Ill.** The Bipartisan Budget Act of 2018 called for a further expansion of supplemental benefits that may be offered by Medicare Advantage plans to include services that address SDOH needs. Subsequent guidance from CMS described new Special Supplemental Benefits for the Chronically Ill (SSBCI), which are not primarily health-related, but should “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.”<sup>14</sup> SSBCI may take the form of reduced cost-sharing for Medicare-covered benefits, reduced cost-sharing for primarily health-related supplemental benefits, additional primarily health-related supplemental benefits, or non-primarily health-related supplemental benefits. Examples of the latter include, but are not limited to:

- ▶ Meals beyond a limited basis delivered either in-home or in a congregate setting
- ▶ Food and produce
- ▶ Transportation for non-medical needs (e.g., grocery shopping, banking)
- ▶ Pest control, including cleaning supplies
- ▶ Indoor air quality equipment services
- ▶ Social needs benefits (e.g., access to community or plan events and programs such as community or social clubs, family or marital counseling, and other activities to reduce isolation or improve emotional/cognitive functioning)
- ▶ Complimentary therapies (e.g., non-traditional therapies delivered by a licensed or certified practitioner)
- ▶ Services supporting self-direction
- ▶ Structural home modifications
- ▶ General supports for living (e.g., plan-sponsored housing consultations and/or subsidies for rent or assisted living communities, subsidies for utilities)



Plans could begin to offer SSBCI to members with certain chronic conditions (e.g., diabetes, asthma, congestive heart failure) beginning in 2020.<sup>15</sup>

- **Relaxation of Uniformity Requirements.** Medicare Advantage plans had been required to offer the same supplemental benefits to all members in the same service area.<sup>16</sup> Beginning in 2019, CMS relaxed this requirement to allow Medicare Advantage plans to offer different supplemental benefit to members with specific diagnosed medical conditions, as long as all individuals with that condition are offered the same benefits. In addition, the Bipartisan Budget Act allowed CMS to waive the uniformity requirement completely beginning in 2020 for SSBCI.<sup>17</sup> This allows Medicare Advantage plans to specifically tailor supplemental benefits, including those that address SDOH, to the needs of individual members with chronic conditions.

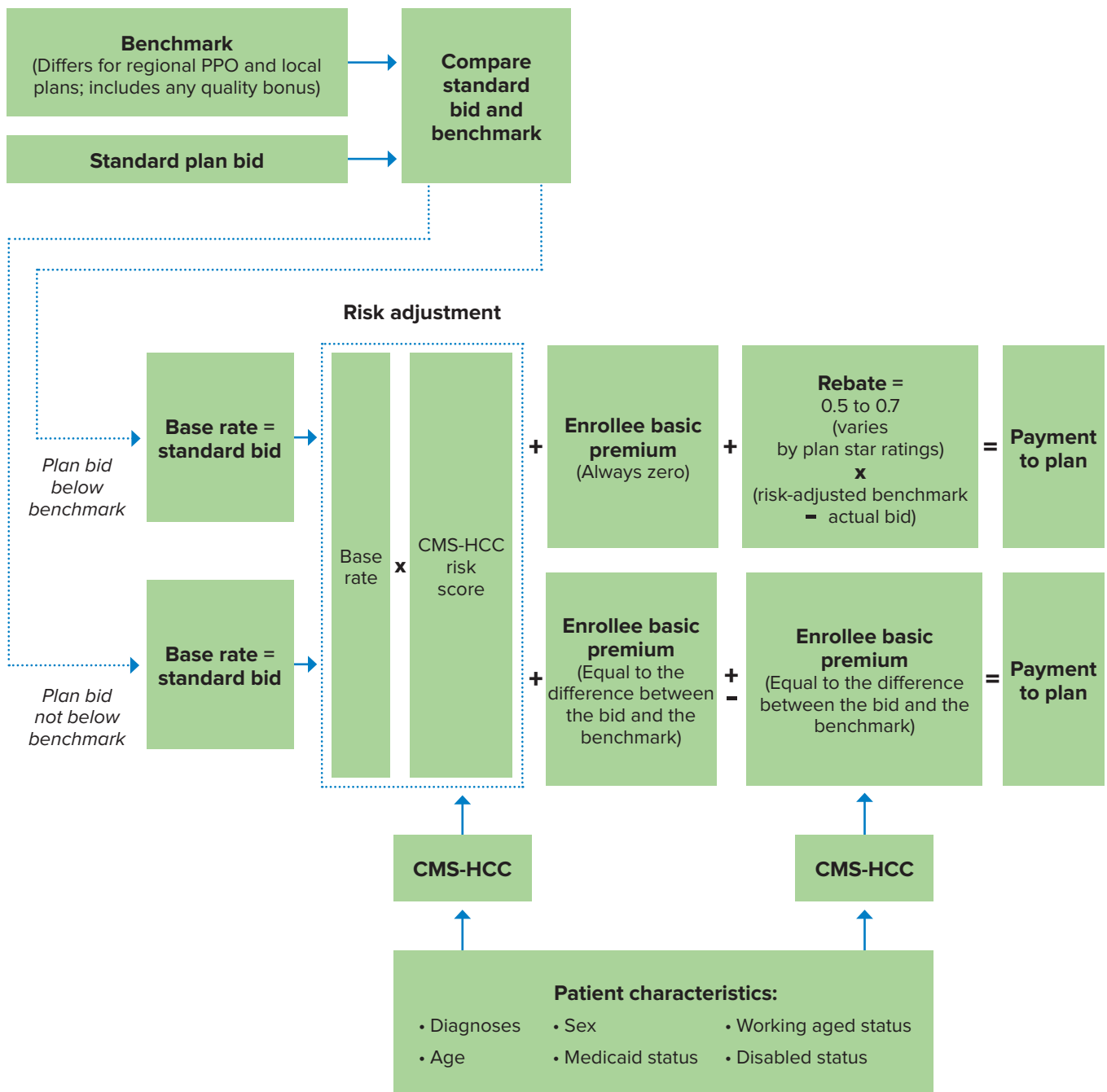
Given that 40 percent of all dually eligible individuals are enrolled in Medicare Advantage plans,<sup>18</sup> these new supplemental benefit flexibilities could be very important for dually eligible individuals if they can help Medicare Advantage plans to more holistically address the full range of their health, LTSS, and SDOH needs.

## B. Financing of Supplemental Benefits

Supplemental benefits are not Medicare-covered services; therefore, their cost is not included in the capitated rate paid to plans by CMS. By allowing Medicare Advantage plans to provide supplemental benefits that could address SDOH needs, CMS created a pathway for plan members to access these services without incurring additional Medicare costs.

Medicare Advantage plans must use “rebate dollars” to pay for all types of supplemental benefits—vision, dental, and hearing benefits, as well as SSBCI and supplemental benefits meeting the expanded definition of “primarily health-related.” As described by MedPAC, these rebate dollars are generated when a Medicare Advantage plan’s bid<sup>19</sup> is below a predetermined benchmark (see **Figure 1**).<sup>20</sup> The plan gets to retain a portion of the difference between the bid amount and the benchmark. The percentage of rebate dollars a plan retains varies depending on its CMS Star Rating—an indicator of plan quality of up to five stars.<sup>21</sup> The highest-performing plans (i.e., those with the highest quality Star Ratings) can retain 70 percent of the rebate amount, while plans with three stars or fewer retain only 50 percent of the difference between their bid and the benchmark.<sup>22</sup> Rebate dollars must be returned to members in the form of supplemental benefits or lower premiums.

**Figure 1. Medicare Advantage Payment System for Non-Drug Benefits, 2021**



Note: PPO (preferred provider organization), CMS-HCC (CMS-hierarchical condition category). If the plan bid equals the benchmark, there is no enrollee basic premium. Medicare payments also reflect an intro-service area adjustment based on the county of residence of the enrollee.

Source: Medicare Payment Advisory Commission (MedPAC). "Payment Basics: Medicare Advantage Program Payment System." 2020.

This method of financing supplemental benefits poses several challenges for plans, including:

- Geographic differences in the amount of rebate dollars available.
- Potential differences in the amount of rebate dollars available from year-to-year.
- Differences in the amount of rebate dollars available to plans with lower stars ratings.
- Tensions between using limited rebate dollars to provide supplemental benefits such as vision, dental, over-the-counter drug cards, and hearing services that have historically been shown to drive member enrollment or using those dollars to provide benefits that address SDOH needs.

## C. Dual Eligible Special Needs Plans

In 2003, Congress authorized the creation of Dual Eligible Special Needs Plans (D-SNPs).<sup>23</sup> D-SNPs enroll only dually eligible individuals and must coordinate their members' Medicare and Medicaid benefits. As a type of Medicare Advantage plan, D-SNPs are able to use the supplemental benefits flexibilities described above to meet their members' needs. However, the use of rebate dollars to finance those benefits may be especially challenging for D-SNPs given that:

- Their dually eligible members are likely to have higher levels of SDOH needs than non-dually eligible Medicare Advantage enrollees.<sup>24</sup>
- They tend to have lower Star Ratings than other types of Medicare Advantage plans,<sup>25</sup> a dynamic supported by recent analyses showing that dual eligible status is the single most important predictor of poor member outcomes on quality measures.<sup>26</sup> As a result, many D-SNPs retain a lower percentage of their rebate dollars than other Medicare Advantage plans with a smaller proportion of dually eligible members.

Thus, some D-SNPs may have more members with SDOH needs than other types of Medicare Advantage plans, yet have comparatively fewer dollars available to address those needs.

## CHAPTER 3

# Methods

As originally conceived, the gap analysis was to consist of semi-structured telephone interviews with staff from ACAP D-SNPs and an in-person meeting with the plans' senior leadership. However, the rapid spread and subsequent impact of COVID-19 led to the cancellations of two interviews due to plans' competing priorities related to the pandemic. In addition, because of travel-safety concerns and social distancing measures, the in-person meeting transitioned to a virtual event.

All ACAP-member D-SNPs were invited to participate in the interviews, and asked to complete a pre-interview survey to gather information about the plans' current efforts to address SDOH for dually eligible individuals and the views of plan leadership on SSBCI, including why they did or did not choose to offer SSBCI benefits in 2020. Eleven of the 12 interviewed ACAP-member D-SNPs completed a survey. Their survey responses were used to tailor the interview guide for each plan, which were then shared with participants ahead of their interview.

Interviews were completed with 12 ACAP-member D-SNPs between February and May 2020. **Table 1** lists the plans interviewed and the state in which they operate. Interviews often included multiple staff members from across each organization (e.g., executive leadership, medical directors, directors of government and regulatory affairs, quality and clinical directors, directors of care management.). Follow-up questions were submitted via email.

The virtual meeting, held in early April 2020, provided an opportunity to share and discuss key takeaways from the interviews and surveys with ACAP members across the following topic areas: D-SNPs' current interventions to address members' SDOH needs; gaps identified by plans in their ability to meet those needs; D-SNPs' use of the SSBCI flexibility; and potential use of SSBCI in the future. A few plan representatives also shared thoughts and considerations around how changes to Medicare Advantage policy might help them to better address their dually eligible members' SDOH needs.

To inform policy option development, telephone interviews were conducted in May and June 2020 with 10 subject matter experts with relevant expertise and deep knowledge of the dually eligible population, Medicare Advantage policy, and SDOH (see **Appendix**). They were provided with an interview guide that asked for feedback on the same proposed policy recommendations discussed with plan staff in their interviews as well as their opinions on the potential benefits or unintended consequences of each option, potential challenges with operationalization, and the extent to which the proposed option would provide D-SNPs with the flexibility and funds necessary to address SDOH needs.

**Table 1. ACAP D-SNPs Interviewed**

Plan Name	State
Banner University Health Plans	Arizona
BMC HealthNet	Massachusetts
CareSource Ohio	Ohio
Community Health Plan of Washington	Washington
Commonwealth Care Alliance	Massachusetts
Gateway Health Plan	Pennsylvania
Geisinger Health Plan	Pennsylvania
Hamaspik Choice	New York
Health Partners Plans	Pennsylvania
UPMC for You	Pennsylvania
Virginia Premier Health Plan	Virginia
VNSNY CHOICE Health Plans	New York

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## CHAPTER 4

# Gap Analysis

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Nearly 93 percent of all dually eligible individuals have incomes below 200 percent of the federal poverty level (as compared to 26 percent of non-dually eligible Medicare beneficiaries).<sup>27</sup> This level of poverty may drive many of the SDOH needs of dually eligible populations. The most common SDOH needs of dually eligible members reported by ACAP D-SNPs include unstable housing; lack of access to transportation; food insecurity; employment instability; exposure to community and interpersonal violence; and social isolation and loneliness. While D-SNPs may have few levers to address their enrollees' underlying poverty, plans can and do actively work to address other member needs.

This gap analysis describes how ACAP D-SNPs assess and prioritize their members' SDOH needs. It discusses the types of interventions plans use to address member needs as well as gaps where plans have not been able to identify or finance available or effective interventions. The section concludes with a discussion of how ACAP D-SNPs are using SSBCI, including additional flexibilities needed and thoughts on the use of rebate dollars to fund these services.

## A. Assessing Members' SDOH Needs

ACAP D-SNPs described several approaches to assessing their members' SDOH needs. These approaches were often used in combination:

- **Standardized Assessment Tools.** Most plans indicated that they used Health Risk Assessments (HRAs), as well as community needs assessments, to get a more complete picture of members' SDOH needs. D-SNPs are required to conduct HRAs on all members at the time of their enrollment, as well as during annual reassessments or more often as needed. HRAs are paper-based or electronic questionnaires that collect information on demographic characteristics; lifestyle behaviors, such as exercise, alcohol and tobacco use; physical health; emotional health; preventive screenings; and the myriad social factors that impact health and well-being. Although the questions included in the
- **HRA can vary from plan to plan, the majority of plans surveyed used their HRAs to collect information about SDOH needs. Plans use information identified in HRAs to not just develop care plans for individual members, but also to inform benefit design, population health management, and strategic planning. For example, one plan mentioned its HRA data showed that stable housing was a common need among members, leading the plan to work to establish stronger relationships with community-based housing providers and resources to meet its members' housing needs. Some plans are also using specialized screening tools like PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences), which was designed to help community health centers and other providers collect and understand an individual's SDOH data.<sup>28</sup>**
- **Customized Assessment Tools.** Some plans are developing their own SDOH assessment tools to facilitate the documentation of SDOH needs. These plans are also integrating the assessment tools into care management systems to give a more accurate picture of population health trends and plan responses. One plan has developed its own comprehensive care management platform that takes a member's physical health and SDOH needs into consideration when developing a care plan. The goal is to collect data on its members' health and SDOH needs in a more systematic and standardized manner in order to assess the effectiveness of interventions designed to address social needs.
- **Care Managers.** All of the plans interviewed employ care management staff who are also responsible for assessing members' SDOH needs. Staff routinely collect information on health status and barriers to accessing care and are well positioned to recognize members' SDOH needs. Some plans have dedicated community needs or referral coordinators, or staff who both assess members' SDOH needs and help connect them with necessary community resources.

- **Data Aggregation and Supports.** A few plans are developing their technological capabilities to integrate data from multiple sources, including county health rankings, human services agencies, census data, Medicaid claims, community partners, and vendor interactions to better identify the barriers experienced by the communities they serve, and then mobilize resources appropriately. One plan formalized a data-sharing agreement with a county health agency to monitor and better understand enrollee needs, and also uses data to assess the capacity of community-based organizations (CBOs) to address SDOH needs. One plan is leveraging the capabilities of a 2-1-1 phone line so that members can identify community-based resources in their own zip code. Case managers in this plan also use 2-1-1 to identify resources for members in need, and referral data is collected to assess member needs, identify gaps, and target resources.
- Several plans mentioned concerted efforts to expand their data capabilities to better monitor population health activities and have the capacity to assess the impacts of various SDOH interventions. Through technical assistance and grants, plans are supporting providers in their efforts to systematically track SDOH data, as well as develop their electronic health record capabilities.
- **ICD-10-CM Z Codes.** ICD-10-CM Z codes, commonly referred to as Z-codes, were introduced in 2015 to help providers to capture “factors that influence health status and contact with health services,” and specifically assess SDOH by identifying individuals with potentially hazardous socioeconomic and psychosocial circumstances.<sup>29</sup> There are nine categories of Z codes related to SDOH and several sub-codes, comprising a total of 97 granular codes. Broad categories of the types of SDOH needs that can be captured include: low-literacy; unemployment; housing; social environment; family circumstances; and psychosocial circumstances. While reporting ICD-10 Z codes is optional for most providers, in 2017, the five most-utilized Z codes for dually eligible individuals were: homelessness; problems related to living alone; death of a family member; psychosocial circumstances; and problems in relationship with spouse or partner.<sup>30</sup>

ACAP D-SNPs noted significant variability among providers in the use of Z-codes. Some plans are encouraging the use of Z-codes, and even offering provider training to support tracking and the development of systems to connect members to needed services, while others reported that uptake among providers is fairly limited.

## B. Prioritizing SDOH Needs

Most plans indicated that they used risk-stratification processes to identify high-risk members with significant SDOH needs and gaps in care. One plan developed an analytics team to better analyze population health data and the social and financial impacts of SDOH investments. Its goal is to leverage data from multiple sources in order to get a more holistic view of member capacity to manage clinical and social stressors. Similarly, another plan is signing data-sharing agreements with county health services departments to better understand member needs, what the capacity of CBOs might be to address these needs, and the ways in which the plan can be a supportive partner.

A few plans indicated that care management and referral platforms, such as Aunt Bertha, UniteUS, and GuidingCare, which are online networks that connect people seeking help to social care providers, provide a ‘window into members’ needs.’ Typically used by providers to identify community resources and make connections, some plans are analyzing member search activity on these online networks to help prioritize their efforts to address members’ needs.

Finally, plans noted that person-centered care requires care managers to actively work with members to help them identify the barriers they face to achieving optimal care, and to also understand members’ own prioritization of their social and clinical needs. Care managers then play the critical role of making appropriate connections to community social services to help members achieve their goals.

## C. Addressing SDOH Needs

ACAP D-SNPs described a large range of programs and interventions that they use to address their members’ SDOH needs. While this gap analysis does not attempt to catalogue each intervention, a few relevant themes emerged:

- **Connections with Community Programs and Partners.** All plans indicated that establishing connections with community-based social service providers was critical to addressing their members’ SDOH needs. These providers include local governmental agencies such as Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers, all of which can provide important care management support and typically have deep community ties. Plans have also developed strong relationships with social service providers such as food banks, community mental

health centers, county social services, supportive housing providers, and employment services. Some plans are providing grants and capacity-building support to community-based partners to develop more effective programs. For example, plans are supporting expansions of CBOs' infrastructure to receive and manage plan referrals. These relationships can be mutually beneficial; some plans report that partnerships with CBOs have extended beyond referrals and that plans are learning more from CBOs about how to identify and build internal capacity to better support members' non-clinical needs. Examples include learning how to navigate the housing services system and developing an understanding of how a large food bank serves thousands of residents in different locations throughout the state. Other plans have noted that working collaboratively with agencies already providing these services allows them to stretch collective resources further.

Plans mentioned leveraging community partners' expertise to support successful transitions from hospitals to community-based settings, including working with CBOs such as Meals on Wheels to provide medically tailored meals to high-risk members post-discharge. One plan referred to a published analysis of Community Servings, a Massachusetts-based organization that provides meals for people with critical illnesses, which found a 16 percent reduction in health care costs among patients who received medically tailored meals, due to reductions in admissions to hospitals and nursing facilities.<sup>31</sup>

- **Use of Specialized Providers.** Noting the substantial burden of behavioral health conditions among their members, some plans reported developing robust relationships with community mental health centers, which have helped to serve members with co-occurring physical and behavioral health conditions. Several plans noted leveraging the expertise and connections of Community Health Workers (CHWs) and reported that they rely on CHWs to help members during care transitions, navigate community resources, and find hard-to-reach members. Other plans created specific staff roles to address SDOH needs among members, including as referral coordinators. Providers can refer patients to these referral coordinators, who are well-connected to a broader statewide network of community-based programs and resources.
- **Investment in Specialized Technology Platforms.** Several ACAP D-SNPs noted they were using or developing applications or technology platforms

to address particular SDOH needs. One plan, for example, serves a largely rural population and is attuned to the high rates of social isolation and loneliness among its members. This plan is using **Pyx Health**, a mobile solution that reduces loneliness and social isolation by identifying health-related social needs, and providing timely interventions, particularly during care transitions. Other plans are exploring Amazon's Alexa to check-in on vulnerable members.

- **Other Localized Efforts.** A few plans map or list all available resources by specific geographic regions (e.g., food pantries, alternative source of transportation supports, etc.) for use by care management staff and plan members. Another plan launched a neighborhood campaign by identifying and then working with providers and stakeholder groups within specific zip codes in a 10-county area to identify gaps and barriers that members are facing in their community. Another plan developed a data-sharing agreement with a large county to track and analyze members' utilization of local social services. Although it took concerted effort and time to develop this agreement, it has been a valuable investment to better understand who was accessing different community resources and where they are getting services. ACAP has conducted other research to document additional examples of how its member plans are addressing SDOH needs, such as housing.<sup>32</sup>

## D. Identifying Gaps in Plans' Ability to Meet SDOH Needs

Plans consistently noted that some SDOH needs were particularly challenging to meet: lack of affordable housing, social isolation, and limited access to transportation. To a lesser extent, some plans reported that food insecurity, as well as coordinating effectively with the Supplemental Nutrition Assistance Program (SNAP) and other systems, was a key challenge.

Meeting housing needs was the biggest gap in members' SDOH needs. These supports are very expensive, which makes it difficult to scale up, and many plans reported that the demand for both affordable and accessible housing is much greater than the supply. Even in areas with available affordable housing units, there is a scarcity of housing that is also safe, designed for a population that needs extra supports, and accessible to individuals with physical disabilities. In addition, a few plans noted that they view secure housing as a more complicated issue than just providing physical shelter. Many members have unstable or

unsafe housing situations, which can be just as detrimental to physical and mental health and heighten other SDOH needs.

Addressing social isolation is also a challenge because isolated individuals are less likely to participate in available programs, making it more difficult for plans to identify members at risk and meet those and other related needs. Many plans noted difficulties in finding the right community vehicles to increase engagement with disengaged populations. COVID-19 has exacerbated this issue, particularly as congregate and other in-home supports are no longer available or offer limited access.

Non-medical transportation supports are critical for some dually eligible members to get to work, grocery stores, social settings, and other important daily activities other than medical appointments. Similar to housing, plans report that the demand for accessible transportation is greater than the supply. Some plans have had difficulties with Medicaid transportation brokers, including late or missed member pick-ups and limited ability to provide service when members need to schedule same-day appointments with providers. Many have opted to offer Medicare-covered supplemental non-medical transportation benefits, often using Lyft or Uber, but these vendors are more difficult to monitor. Similar to growing challenges with social isolation, COVID-19 has made access to safe, accessible transportation options much more limited.

Plans reported several factors that can exacerbate gaps in dually eligible individuals' SDOH needs. First, by definition nearly all of dually eligible beneficiaries are low-income. As noted above, poverty compounds many health, social, and environmental challenges that plans cannot easily impact.

Many plans discussed difficulties with locating members to assess their needs, and then engage them in the development and implementation of a care plan. One plan reported that nearly half of its members had changed addresses within the last two years, while another noted that it was only able to reach 30-35 percent of its members via traditional methods, like phone calls or mail. Other plans noted that even when care managers can locate members, many screening or assessment tools do not capture the level of detail needed to understand complex social needs. For example, a question about whether an individual has "run out of food in the last 12 months" does not address the healthfulness of the food to which they have access. Likewise, questions that screen for homelessness do not capture whether a housing environment is safe or secure; someone living in a car or on friends' couches may not consider themselves to be homeless.

D-SNPs may also find it challenging to identify and coordinate with the entity covering or providing their full-benefit dually eligible members' Medicaid LTSS services, especially to understand what Medicaid covered services members are receiving that might be aimed at addressing their SDOH needs. This can be particularly problematic after hospital stays or other health events for which members require coordinated, home-based supports.

Lastly, plans noted that available funding streams tend to support short-term solutions as opposed to those with lasting impact. Plans often troubleshoot first to close gaps where resources allow—such as finding temporary shelter for someone experiencing homelessness—but do not have the resources to resolve housing and related issues over the long-term.

## E. Using Other Funding Options to Address Members' SDOH Needs

In addition to the SSBCI pathway, plans utilize other funding options to address members' SDOH needs. Some plans reported focusing on specific quality improvement activities, which are counted as medical or clinical expenses, to address SDOH needs. Plans can also use administrative funds to support case-by-case interventions for individuals that need social supports, because administrative dollars can pay for care management and disease management activities that are not part of covered services. However, plans are limited in the amount of administrative funds available for this purpose because these costs cannot be included in the Medical Loss Ratio numerator, which must be at least 85 percent of premiums.

In addition, plans reported examples of how they worked creatively, at times with other entities, to support non-medical interventions through braiding or blending funding. Many plans noted that despite their great interest in investing dollars in SDOH, they could not bear the sole responsibility to fund these interventions, and they identified ways to combine funding with other organizations. Braiding or blending different funding streams into one pot of money can reduce system duplication and expand the resources that like-minded organizations have to support the same populations that need social services. For example, one plan invested in a community housing partner that can directly fund housing services. The plan pays this organization a per-member-per-month fee to support plan members who meet criteria for an unstable housing situation.



Early results demonstrate improvements in both housing indicators (e.g., the length of time individuals are homeless, the time it takes to receive a housing voucher, etc.) and health-related outcomes such as significant decreases in unplanned care. The plan estimates that, after an individual experiences about 10 months of stable housing, there is a decrease in their health care utilization and spending.

These alternative options to fund SDOH-related interventions are still available to plans even with the creation of the SSBCI pathway. CMS has even clarified in its 2021 and 2022 Medicare Part C and D final rule, that expenses for SSBCI interventions can be counted as quality improvement expenses in the calculation of the Medical Loss Ratio.<sup>33</sup>

## F. Deciding Whether to Offer SSBCI

The SSBCI pathway creates another valuable opportunity to help ACAP D-SNPs identify and address their members' SDOH needs. Through the plan surveys and interviews, we focused on how plans viewed this flexibility and how they were using it. This includes reasons why plans did or did not choose to offer SSBCI in 2020, if they had ideas for how additional flexibilities related to SSBCI might be useful, and if rebate dollars provided sufficient and stable funding to provide these benefits.

In 2020, the first year in which SSBCI were available, four of the 12 ACAP D-SNPs interviewed offered these benefits to their members. Examples of the types of benefit provided include: meals; non-medical transportation; pest control services; indoor air quality equipment and/or services; and bathroom safety equipment. This relatively modest rate of SSBCI uptake seems to mirror the findings of several national analyses that found slightly less than five percent of all Medicare Advantage plans are offering SSBCI in 2020, although one-third of the plans that are offering these benefits are Special Needs Plans.<sup>34,35,36</sup>

### D-SNPs' Perspective on the Value of SSBCI

Among the ACAP D-SNPs that offered perspectives on the value of SSBCI in addressing members' social needs, most viewed SSBCI as potentially having the ability to improve member outcomes. One plan suggested that if these benefits were designed correctly, they could be very beneficial for partial-benefit dually eligible individuals who do not qualify

for Medicaid LTSS benefits. This plan also believed that SSBCI could allow plans to create innovative benefit packages for subgroups of the dually eligible population.

Few ACAP D-SNPs had data that would allow them to calculate the return on investment (ROI) of providing SSBCI, which would better help them determine whether to offer these benefits and for which members. Plans that offered SSBCI in CY2020 said that, because they had only been providing these benefits for a few months, they did not yet have the data needed to calculate ROI. Plans that did not offer SSBCI for CY2020 indicated that having more data on the ROI of interventions would be helpful to inform future benefit design decisions.

One plan interviewed did not view SSBCI as being that useful because of the limited amount of rebate dollars available to fund these benefits. This plan said that it has been providing SDOH-type services to its members all along and that the scale on which it provided these services – in both the range of services provided and the number of members receiving services – was “light-years” ahead of what bigger, national plans were offering through the SSBCI pathway. Although the plan firmly believed that SDOH-type interventions benefit members and improve outcomes, it felt that the funding of SSBCI using rebate dollars would allow it to cover only a very small fraction of the SDOH-type services that the plan is actually providing. The plan decided to offer SSBCI in 2020, but believes that the effect of these benefits will be marginal.

### Considerations Around Offering SSBCI in CY2020

ACAP D-SNPs described several considerations around why they did or did not choose to offer SSBCI in 2020.

#### *Reasons for Offering SSBCI*

The ACAP D-SNPs that offered SSBCI in CY2020 named multiple different considerations that influenced their decisions, including that providing SDOH-related services was “the right thing to do,” was in keeping with their corporate culture and mission-driven approach, and offering SSBCI made good sense clinically.

Most plans did try to account for ROI when deciding to offer SSBCI, although one plan said that it did not because it was too difficult to attribute outcomes to particular benefits. One plan asked its actuarial team to examine what costs could be offset by use of SSBCI,

including costs associated with potentially avoidable service use. Another plan consulted with its population health team to determine the most prevalent conditions among its members, and then assessed its own data for evidence of ROI and consulted with its clinical team about what benefits would be most meaningful to members. This plan cited examples of two SSBCI for which it has a proven ROI: 1) additional meals after hospital discharge for members with ESRD; and 2) interventions to improve indoor air quality (e.g., air purification devices, new bedding, house cleaning, etc.) for members with asthma and COPD.

### *Reasons for Not Offering SSBCI*

The majority of ACAP D-SNPs did not offer SSBCI in CY2020. Many plans commented that the short time frame between when CMS announced the availability of the SSBCI flexibility and the deadline for plans to submit their benefit packages and bids for CY2020 was one factor in their decisions not to offer these benefits. However, the plans cited multiple other considerations that played a larger role in their decision-making:

- **Using Rebate Dollars for Other Purposes Deemed More Necessary.** By far the most common reason that plans cited for not offering SSBCI was that they wanted to use their rebate dollars to offer other types of more traditional supplemental benefits. This was either because: (1) the states in which they operated required them to offer those benefits; or (2) from a marketing and enrollment point-of-view, they needed to do so in order to remain competitive among other plans in their market.

One plan in a very crowded D-SNP market said that it had to use some of its rebate dollars to buy down Part D premiums for its members as well as offer a sizeable monthly over-the-counter (OTC) benefit to remain competitive. In this market, enrollment is driven in part by supplemental benefit offerings. After covering Part D premiums and the OTC benefit, it does not have many rebate dollars left to spend on SSBCI. Because most of its members are eligible for Medicaid in a state with relatively generous Medicaid benefits, the plan believes that many of its members' SDOH needs are being addressed by Medicaid and offering traditional supplemental benefits brings more value to their members.

Another plan does a thorough competitive analysis of Medicare Advantage plans in its local market as well as D-SNPs operating in other areas of the country with similar markets to its own to see what supplemental benefits they are offering.

Year-over-year, it finds that it is very important to offer an OTC pharmacy benefit to be competitive. It would need to weigh the decision carefully to use fewer rebate dollars on the OTC benefit to offer SSBCI instead.

Other plans spoke about how they decided to use their rebate dollars to offer transportation, vision, and dental coverage as well as to reduce premiums and cost-sharing. One plan explained that it analyzes: (1) what types of supplemental benefits vendors are offering; (2) the amount of rebate dollars that it can spend on benefits; (3) what benefits will be utilized effectively by members; and (4) if the plan can measure the effect of those benefits on member outcomes.

Finally, one plan thought that while SSBCI was an interesting opportunity, because it has a lower Star Rating, it has more limited rebate dollars to spend on supplemental benefits and had to be more cautious about how it spent those dollars. Plan staff said that they did not yet have the data they needed to show that SSBCI would have value. They were concerned about taking rebate dollars away from supplemental benefits that were proven to increase membership and for now remain focused on offering more traditional value-added services such as vision, hearing, and dental benefits.

- **Having FIDE SNP Status or Enrolling Only Full Benefit Dually Eligible Individuals.** Two ACAP-member D-SNPs that are Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) said that they chose not to offer SSBCI because their members are all eligible to receive Medicaid benefits. They believed that the states in which they operate offer robust Medicaid benefits (e.g., grocery shopping, laundry, and chore assistance, home-delivered meals, a respite benefit for caregivers, etc.) that are already helping to meet their full-benefit dually eligible members' SDOH needs. One of these plans commented that its care managers had a good understanding of what services were covered under its state's Medicaid managed LTSS program, and they there were able to connect members with those services. The other plan offers two D-SNP products in its state – one fully integrated, the other not. This plan also chose not to offer SSBCI in 2020 because it considered its state's Medicaid benefits to be robust. However, because of budget cuts, the state Medicaid program was not able to cover environmental modifications for members who need functional support as it had intended to do. The plan believes that its members could benefit from these services, and so it is considering offering them as SSBCI in 2021.

Interestingly, two other ACAP D-SNPs that are FIDE SNPs did choose to offer SSBCI. These plans operate in the same states as the FIDE SNPs that chose not to offer these benefits, but came to a different determination about the value of offering these benefits.

Somewhat similarly to the FIDE SNPs, another ACAP D-SNP that operates in a state that only permits D-SNPs to enroll full-benefit dually eligible individuals also said that it decided not to offer SSBCI because the state offers a rich array of Medicaid benefits. The plan felt that because all its members were also enrolled in Medicaid managed LTSS, there were no benefits that it could offer that were not already covered through Medicaid.

- **Implementing Other Supplemental Benefit Flexibilities Was More Attainable.** Some plans said that the ability to offer other supplemental benefits or to use rebate dollars to reduce cost-sharing non-uniformly to members based on their disease state or condition seemed more straightforward to implement than SSBCI. One plan said that it wanted to offer its members something different and determined that a more valuable benefit to its members would be to use Uniform Flexibility to reduce cost-sharing to zero. The plan offered this benefit for not only primary and specialty care visits, but also for services like oxygen for people with COPD and retinal exams for people with diabetes. It is also offering post-discharge meals for a longer period of time. Another plan used Uniform Flexibility to offer in-home tele-monitoring for members with diabetes and CHF. The plan said it has had very good uptake in members using these benefits.

## Sufficiency of Rebate Dollars to Fund SSBCI

ACAP D-SNPs also shared their thoughts about the sufficiency of rebate dollars to fund the provision of SSBCI for their dually eligible members:

- **Effect of Star Ratings.** Several plans noted the effect of Star Ratings on their rebate amount and the subsequent impact on their ability to offer supplemental benefits. One plan, which is currently a 3.5 star plan, receives a lower rebate and feels the need to concentrate its more limited rebate dollars on offering more traditional supplemental benefits like vision, dental, and hearing. In contrast, another plan said that having 4 Stars provides sufficient funding to offer SSBCI for its population. A report from HHS' Assistant Secretary for Planning

and Evaluation found that dual eligibility was one of the greatest predictors of poor health outcomes.<sup>37</sup> This can reduce Star Ratings, and several D-SNPs reported that due to serving a membership with high health care and social support needs, it can be very difficult to obtain and/or maintain a Star Rating of 4 or higher.

- **Rebate Dollars Are Not Predictable from Year-to-Year.** Many plans also mentioned the unpredictability of rebate dollars as creating a barrier to offering SSBCI. One plan said that because the amount of its rebate dollars varies from year-to-year, it makes it difficult to know the amount of supplemental benefits it can offer. This plan believed that rebate dollars were not a reliable resource for funding these benefits. The plan said that it did not want to offer a certain level of benefits in one year and then have to cut the benefits offered in the next year.
- **Geographic variation.** In addition, rebate dollars can vary based on different geographic location because CMS sets the plan bid benchmark using regional data. Thus, D-SNP bids across different regions may result in different rebate amounts for supplemental benefits.

## G. Examining SSBCI Interactions with Medicaid Benefits

As described previously, many full-benefit dually eligible individuals are able to access Medicaid-covered benefits, which may address some of their SDOH-related needs. CMS as well as many policymakers and other Medicare stakeholders recognize that there is the potential for duplication of SDOH-related services between Medicaid-covered benefits and the SSBCI provided by Medicare Advantage plans. Plans that offer integrated or aligned Medicare and Medicaid services—such as Fully Integrated D-SNPs (FIDE-SNPs) and Highly Integrated D-SNPs (HIDE-SNPs) are in a strong position to reduce duplication and to better target SDOH services, SSBCI, or other supplemental benefits to dually eligible members' needs and gaps in services across both programs. ACAP D-SNPs with aligned Medicaid lines of business generally reported a higher level of investment—via SSBCI or another pathway—in identifying and meeting members' social needs.

From a state perspective, it may be advantageous to seek to shift the provision of SDOH-related services from Medicaid to Medicare Advantage by adding

requirements to state Medicaid agency contracts with D-SNPs, calling for plans to offer SSBCI. For the most part, ACAP D-SNPs reported that very few of the states in which they operate had discussions with the plans about offering SSBCI or about managing these benefits relative to any Medicaid benefits their members received that might help to address their SDOH needs.

One plan, for example, noted that while its state is proactively involved with its Medicaid health plans and focused on aligning what its health plans, providers, and community agencies were doing related to SDOH, it had not spoken with its D-SNPs about the supplemental benefits they were offering. Another plan said that it had wondered about potential coordination with Medicaid and how it should manage benefits – like meals – that were also covered benefits under Medicaid.

Only one ACAP D-SNP said that its state Medicaid agency was very actively discussing supplemental benefits and its D-SNPs' role in addressing their members' SDOH needs. However, two subject matter experts noted that they have heard of increasing state interest in requiring D-SNPs to offer supplemental benefits. They were concerned that if states begin to impose these requirements, it may have unintended consequences for D-SNPs. If D-SNPs are required to use their limited rebate dollars to offer SSBCI, it means that they would have less opportunity to offer the traditional supplemental benefits like vision, dental, and hearing services that attract member enrollment. This would put them at a competitive disadvantage in comparison to non-D-SNPs, potentially driving them out of the market.

## H. Thinking About SSBCI for 2021 and Beyond

Most plans said that it has been difficult to decide whether to offer SSBCI in 2021.<sup>38</sup> Plans that did offer SSBCI in 2020 have only a few months' experience with implementing these benefits and very little data on the impact on members' health and service utilization. A few plans said that it may take several years before they have enough data to calculate a return on their investment in SSBCI. These plans stated that, for the most part, they will continue to offer the same SSBCI for 2021, and perhaps add some new types of SSBCI or new conditions. For example, one plan was considering adding non-medical transportation for members with diabetes to help them leave their homes for things like group exercise classes or mall-walking that would promote a more physically active lifestyle. Other plans that chose not to offer SSBCI in 2020 said that they will continue to monitor their local markets and will likely try to match the supplemental benefits that their competitors offer.

# Policy Options and Other Considerations

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The preceding gap analysis described the broad range of SDOH needs among members of ACAP D-SNPs as well as the extensive range of programs and services that ACAP D-SNPs use to help address those needs. This section describes potential policy options and other considerations to provide D-SNPs with additional resources for SDOH-related interventions.

## A. Policy Options

As discussed, ACAP D-SNPs are limited in the extent to which they can use the SSBCI pathway to address their members' SDOH needs. These limitations stem from two factors: (1) D-SNPs' exclusive enrollment of dually eligible individuals, which can make it more difficult to achieve high Star Ratings and therefore lower the amount of rebate dollars plans receive; and (2) competing priorities for the use of and other complications with rebate dollars. In addition, when D-SNPs do offer SSBCI, they cannot offer them to all those who might benefit because of the requirement that SSBCI only be offered to plan members with a chronic condition. As a result, ACAP D-SNPs continue to use administrative dollars, quality improvement activities, or other sources to fund SDOH-related interventions and to expand the reach of these services. Although the SSBCI pathway is a welcome opportunity to provide more person-centered and holistic care, neither the rebate dollars available to fund SSBCI nor existing administrative dollars are sufficient to meet the extensive SDOH needs of D-SNP members.

ACAP has identified several policy options to give D-SNPs more resources to provide SDOH-related services both through SSBCI and outside of supplemental benefits. The following policy options could be enacted by CMS, alone or in combination, to accomplish those goals.

### Create New Flexibilities for Plans to Offer SSBCI

As CMS and Medicare Advantage plans continue to gain experience with the provision of SSBCI, it

is likely that CMS will refine its guidance about the implementation of this benefit flexibility. For example, in its Contract Year 2021 Medicare Advantage and Part D Final Rule, CMS made a policy modification to broaden the chronic condition diagnoses that could qualify an individual to receive SSBCI to include others that may meet the statutory definition of a chronic condition.<sup>39</sup> Also in the Final Rule, CMS amended Medicare Advantage's Medical Loss Ratio regulations to allow plans to include in the MLR numerator as "incurred claims" all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of "provider" as defined at § 422.2.<sup>40</sup> Historically, "providers" were individuals or entities that were licensed or certified by a state. The new rule would allow health plans to include payments to non-traditional providers for the delivery of SDOH-related services in the numerator of the MLR. These changes may give plans more opportunities to direct and tailor their supplemental benefit offerings to the members who need them. They also provide more direction for plans about how to characterize their costs for providing these benefits.

Overall, ACAP D-SNPs believe that the flexibilities allowed under the SSBCI framework are very useful, and they appreciate CMS' willingness to explore how the SSBCI opportunity could be further refined to better meet members' needs. Plans noted that they need to think creatively to identify new services and funding streams for SDOH services such as peer supports, culturally tailored services, and financial assistance, among others that can impact members' overall needs. Although in general plans were positive about the SSBCI opportunity, they also had suggestions for additional useful flexibilities, including the ability to:

- **Tailor SSBCI to Different Groups of Members.**<sup>41</sup> Some plans noted that members' SDOH needs varied according to whether they lived in urban, suburban, or rural areas, with members in rural areas often having more needs related to lack of transportation and loneliness or isolation. Plans would like additional flexibilities to tailor SSBCI based on geography. One plan said that this type of flexibility might allow plans to tap into opportunities

in their local markets that may not be traditional but that would benefit individual members or members within that community with a specific need.

- **Tailor SSBCI to Individual Members.** One plan said that it would like the ability to target SSBCI to specific member needs. For example, one member might find it more helpful if the plan could reduce their Part D cost-sharing to \$0 while another member might find it more helpful to have more help with transportation or food. The plan does not now have the flexibility to do that (i.e., CMS' benefit uniformity rule requires that all "similarly situated" members in a plan receive the same benefits, so while a plan can offer individually tailored services as a care management intervention, it cannot offer individually tailored benefits); however, this flexibility to tailor supplemental benefits to members would be consistent with person-centered care.
- **Offer SSBCI to all D-SNP Members.** One plan said that it would like to offer SSBCI benefits to all its members, including to members that do not have a chronic condition. This plan believes that because, by definition, all of its members are low income, they could all benefit from services to address their SDOH needs. The plan said that it had wanted to offer non-medical transportation to all its members, but was told by CMS that it could not do that and that SSBCI needed to be targeted to members with specific chronic conditions. The plan said that while it made sense to tie the more "LTSS-like" supplemental benefits to specific conditions, it would like CMS to consider all dually eligible individuals as having SDOH needs that could be addressed by SSBCI.

## Adjust the Star Ratings System to Reflect Levels of SDOH Needs Among D-SNP Members

As noted previously, dually eligible individuals have higher levels of SDOH needs than other Medicare Advantage beneficiaries, and thus D-SNPs tend to have lower Star Ratings.<sup>42</sup> Yet, the Star Ratings system as currently designed does not reflect the levels of SDOH among health plans. Plans with fewer Stars retain less of their rebate dollars and so have fewer resources to offer supplemental benefits, including SSBCI. As a result, D-SNPs with lower Star Ratings who enroll dually eligible individuals with high SDOH needs, have fewer resources to offer SDOH services through SSBCI. Adjusting the Star Ratings system to reflect the varying levels of member SDOH needs across plans could

provide more resources for D-SNPs to offer additional SDOH-related services through SSBCI.

### *Redesign Star Ratings Comparison Groups*

One option is for CMS to redesign the comparison groups used for awarding Star Ratings by peer grouping, or comparing D-SNPs to D-SNPs. Under this redesigned approach, a plan's performance for its full-benefit dually eligible population would be compared with the performance of other organizations in the same market area for their full-benefit dually eligible populations. This would create a more accurate and equitable quality rating system for D-SNPs where high-quality D-SNPs would be able to retain a larger percentage of their rebate dollars because their members' SDOH needs, which can impact their Star Ratings, would be taken into account in the quality measurement system. Some subject matter experts interviewed for this report advocated this approach, and it was discussed extensively and recommended by the Medicare Payment Advisory Commission in its June 2020 report to Congress.<sup>43</sup>

This policy option would level the playing field for plans that provide high quality of care, and whose members have high levels of SDOH needs. These plans would be able to achieve a higher Star Rating under this policy option and thus retain a higher percentage of their rebate dollars. More broadly, redesigning the comparison groups could also make true quality differences more visible across all plans.

There are two potential challenges with implementing this policy option. First, all Medicare Advantage plans would have to report their Star Ratings at the Plan Benefit Package level, rather than at the contract level, which could be burdensome to some plans. Second, if not implemented appropriately, peer groupings could hold D-SNPs to a different standard of quality. Beneficiary advocates have raised this issue, and a recent report by the Assistant Secretary for Planning and Evaluation (ASPE) opposed the use of peer group for that reason.<sup>44</sup> The ASPE report argues that peer grouping establishes different quality standards across providers. Instead, ASPE recommends that safety-net providers should have additional tools and resources to help them achieve high-quality outcomes for all beneficiaries, regardless of their performance on specific measures or programs.

## Allow D-SNPs to Retain a Higher Percentage of Their Rebate Dollars

Another way for CMS to use the Star Ratings system to provide D-SNPs with more resources to address SDOH needs would be to let them retain a higher percentage of their rebate dollars. When Medicare Advantage plans bid below the benchmark, a rebate amount is added to their risk-adjusted base payment rate. The rebate amount varies between 50 percent and 70 percent of the difference between the bid and the benchmark, depending on the plan's Star Rating (see **Table 2**).

<b>Table 2. Medicare Advantage Plan Rebate Amount by Star Rating<sup>45</sup></b>	
<b>Star Rating</b>	<b>Rebate Percentage</b>
3 Stars or fewer	50%
3.5 to 4 Stars	65%
4.5 to 5 Stars	70%
New plans/plans with low enrollment	65%

Under this policy option, CMS could create an “SDOH add-on” to the rebate percentage equal to one or a few percentage points. For example, an SDOH add-on could provide a 3.5 Star D-SNP with a 67 or 68 rebate percentage, rather than 65 percent. While the 3.5 Star D-SNP would not retain as many rebate dollars as a 4.5 Star plan through the SDOH add-on, it would still increase the resources available to address SDOH needs through supplemental benefits while maintaining the plan's incentive to improve its Star Rating. Additional rebate dollars could provide resources to plans to offer SSBCI, particularly for those plans that are in competitive markets for traditional supplemental benefit offerings, (i.e., vision, hearing, or dental services).

Under this option, the Star Ratings methodology would not be changed, which could make this option more straightforward to implement. CMS would need to create clear criteria regarding which plans would be eligible to receive this SDOH add-on so that it was targeted to plans that enroll beneficiaries with the greatest SDOH needs. CMS would also need to structure the SDOH add-on in a way that provides more resources to plans whose members have high SDOH needs, but also does not remove the incentive for plans to meet the quality thresholds for achieving a higher Star Rating. One consideration is whether the opportunity to provide more SSBCI is a sufficient reason

to increase rebate dollars, particularly if a plan has low Star Ratings. Another consideration is whether CMS should award additional rebate dollars at the plan or contract level, the latter of which is used to determine Star Ratings. In addition, this option would redistribute the rebate dollars, with more rebate dollars kept by plans and fewer dollars returned to Medicare. While this would likely be less administratively burdensome than revising the Star Rating system, it would also increase federal Medicare costs. CMS or other federal policymakers might want to explore options to reduce spending in other areas or to make this option cost-neutral. However, those decisions would require trade-offs and create new dynamics of winners and losers in the industry, which could deter support.

## Add Indicators of SDOH Need to the Medicare Advantage Risk-Adjustment Model

A third option is for Medicare to provide D-SNPs with more resources to fund SDOH services outside of supplemental benefits by incorporating indicators of SDOH need into the Medicare Advantage Hierarchical Condition Category (HCC) risk-adjustment model. Doing so would likely increase the accuracy of the risk-adjustment model, which in turn would increase payments to plans that enroll individuals with higher SDOH needs that are associated with increased Medicare costs.

CMS has made recent refinements to the HCC model, and this proposed policy option aligns with many of those changes. For example, in 2017, CMS modified the HCC model because it had been under-predicting costs for lower-income Medicare beneficiaries, specifically full-benefit dually eligible individuals. Medicare Advantage plans are now paid more for their full-benefit dually eligible members. For 2019, CMS included additional adjustments for members' mental health, substance abuse, and chronic kidney disease diagnoses. In 2020, CMS is implementing a “Payment Condition Count” model, which accounts for the number of conditions a member has. In its Announcement of Calendar Year 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, CMS stated that it will continue to evaluate whether additional conditions or SDOH needs meet the requirements to be included in the risk-adjustment model for future payment years.

Refining the risk-adjustment model to include indicators of SDOH need could make the model more accurately reflect the SDOH-related needs of a plan's membership, which could provide more funding for

plans to design and implement interventions to address those needs through their quality improvement or care management programs.

This option has challenges to implementation as well as other considerations to take into account. As mentioned above, the HCC risk-adjustment model has already been refined to account for the higher costs associated with full-benefit dual eligible status. Further refinements to add an indicator(s) of SDOH need may not improve the predictive accuracy of the HCC model.

Another challenge is that adding indicators of SDOH need into the HCC model would increase payment rates for some Medicare Advantage enrollees but reduce them for others, which may have unintended consequences. For example, depending on the way the HCC adjustment model was adjusted to account for SDOH needs, payment rates for full-benefit dually eligible individuals might be even higher in comparison to payments for partial-benefit dually eligible individuals and non-dually eligible individuals than they are now. This could discourage Medicare Advantage plans from enrolling as many partial-benefit dually eligible individuals who otherwise derive value from enrollment in these plans.

A third challenge, and perhaps the most difficult to address, is the lack of standardized data on plan members' SDOH needs. Medicare Advantage plans all use their own Health Risk Assessment tools, which may or may not capture information on SDOH needs. State Medicaid agencies commonly have standardized assessment tools that capture this type of data, but there is a great deal of variation across states.

As described in the gap analysis section, ICD-10-CM Z codes allow providers to capture SDOH-related needs. Unlike data on SDOH-related needs that might be collected by Medicare Advantage plans, data captured through Z codes would be available for both Medicare Advantage enrollees and Medicare fee-for-service beneficiaries. However, these codes are not widely utilized. For example, an analysis of 2017 data found that only 1.4 percent of 33.7 million Medicare fee-for-service beneficiaries had claims that included Z codes.<sup>46</sup>

CMS could use existing authority to require providers to document Z codes, but imposing such a requirement would likely be burdensome to providers. Before taking such a step, CMS could work with D-SNPs and Medicare and Medicaid providers to develop a pilot or demonstration that would evaluate on a small scale ways to systematically capture Z code data on Medicare beneficiaries and whether incorporating Z code data into the HCC risk-adjustment model would

improve the accuracy of the risk-adjustment model. It should be noted that the collection of Z codes supports conversations between providers and patients about important issues that affect health. Even if Z codes ultimately are not helpful in refining the HCC risk-adjustment model, they still contribute to an important policy goal of improved patient-provider communication.

## B. Other Considerations

Other considerations around supporting D-SNPs to address the SDOH-related needs of their members, include:

- **Need for ROI Data.** There is a lack of good data on the ROI for providing SSBCI. Moreover, there is a need for agreement on what outcomes should be measured, which might include improved health outcomes, improved well-being and member experience, and cost of care, or a combination of all three. Several subject matter experts speculated that effective interventions to address SDOH-related needs might pay for themselves, obviating the need for CMS to provide more resources. Federal officials may be more inclined to consider the policy options above if they had ROI data demonstrating that positive beneficiary outcomes can be achieved with lower spending or in a cost-neutral manner.
- **SDOH as a Long-Term Investment.** SDOH-related interventions likely do not have an immediate effect and require a longer-term investment by plans. One expert pointed out that if members tend to switch plans from year to year, plans may be less willing to invest in providing these interventions.
- **Need for Transparency.** The SSBCI opportunity is new, and the available data shows only which plans are offering benefits and what benefits are being offered. Moving forward, there is a need for more data on who is receiving those benefits. More transparent information could increase accountability.
- **Administrative Burden.** While many experts mentioned the need for plan reporting and accountability, others were concerned that potential policy options should not be too administratively burdensome for plans because it may decrease their ROI and discourage them from offering SDOH-related interventions.



# Conclusion and Future Directions

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Dually eligible individuals have been shown to have higher levels of SDOH-related needs than other Medicare Advantage beneficiaries, which tend to result in higher medical costs and poorer clinical outcomes. D-SNPs were created to meet the special needs of this population, and have used the limited tools available to them to meet members' SDOH needs, including focusing quality improvement activities on SDOH, using administrative funds to support case-by-case interventions, and making charitable donations to CBOs that provide SDOH related services. These approaches can be bolstered by new supplemental benefit flexibilities, including SSBCI. However, the funding source for these new benefits – plan rebate dollars – are limited, particularly for D-SNPs.

Better understanding the SDOH needs of dually eligible individuals and how D-SNPs are using available flexibilities provides the information needed to develop new policy options that might provide more resources for D-SNPs to address their members' SDOH needs. Recognizing that policy change takes time, ACAP has identified the following future directions for work in this space that may inform or facilitate implementation of these policy options:

- **Incentivize Collection of SDOH Data.** D-SNPs could offer incentives to providers, perhaps through value-based payments, to encourage the collection data on SDOH-related needs.
- **Z Code Demonstration.** CMS could work with D-SNPs, and Medicare and Medicaid providers to develop a pilot or demonstration that would then evaluate whether incorporating Z code data into the HCC risk-adjustment model would affect payment rates
- **Evaluation of ROI.** More data on the ROI of SDOH-related interventions could help plans and CMS to better evaluate what interventions work best for certain sub-populations of dually eligible beneficiaries or types of plans.

ACAP looks forward to working with federal and state partners, its D-SNP members, and other stakeholders to explore these policy options and pursue future directions. Policymakers at all levels of states and the federal government have an interest not just in better integrating Medicare and Medicaid for dually eligible individuals, but also in mitigating the effect of SDOH for this population to improve their quality of life, improve health outcomes, and reduce the cost of their care.

## Appendix: Subject Matter Experts Interviewed

- Mike Adelberg, Principal, Faegre Drinker
- Melanie Bella, Chief of New Business and Policy, Cityblock Health
- Jon Blum, Managing Principal and Narda Ipakchi, Senior Consultant, Health Management Associates
- Eric Goetsch, Principal, Consulting Actuary, Milliman
- John Gorman, Chairman, Nightingale Partners, LLC
- Rachel Harrington, Research Scientist, National Committee for Quality Assurance
- Kevin Prindiville, Executive Director and Georgia Burke, Directing Attorney, Justice in Aging
- Allison Rizer, Principal, and Tyler Cromer, Principal, ATI Advisory
- John Rother, President, National Coalition on Health Care

## Endnotes

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- 20 The benchmark is a target amount set by CMS using historical, county-level average spending rates for Medicare fee-for-service beneficiaries.
- 21 Each year CMS publishes Star Ratings for Medicare Advantage plans that indicate the quality of health services received by enrollees. Plans are rated on a scale of 1 to 5, with a 5-star rating being the highest score a plan can achieve. The Star Rating summarizes plan performance across five main categories: 1) staying healthy; 2) chronic conditions management; 3) member experience; 4) member complaints; and 5) customer service.
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**ACAP**

**Association for Community  
Affiliated Plans**

1155 15th Street NW, Suite 600  
Washington, D.C. 20005  
202.204.7508

[www.communityplans.net](http://www.communityplans.net)