



Name: Arielle Mir  
Title: Vice President of Health Care  
Organization: Arnold Ventures  
Email: Amir@ArnoldVentures.org  
Phone: (202) 854 - 2011

Dear Representatives Bustos, Butterfield, Cole, and Mullin,

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by a recognition that the system both costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide array of issues including prescription drug prices, health care prices, payment and delivery system reform, and complex care.

Understanding social determinants of health, and encouraging the health care sector to address them as part of risk-based models, is important to Arnold Ventures. We thank the Congressional Social Determinants of Health Caucus for its commitment to this issue and for organizing this request for information. We hope to learn alongside the Caucus and that our philanthropic support of research and policy development to improve health care can complement your efforts on this important issue.

We write to you today about the focus of our Complex Care team—the 12 million people who are “dual-eligible” for Medicare and Medicaid. Dual-eligible individuals have particularly high levels of social needs. They are also more likely than the average Medicare beneficiary to be low-income, experience food and housing insecurity, and identify as racial and ethnic minorities.<sup>1,2</sup> It is no wonder that this population was among the hardest hit by the COVID-19 pandemic. Dual-eligible individuals were more than three times as likely as the average Medicare beneficiary to be hospitalized from COVID-19.<sup>3</sup> This dramatic toll underscores the need to focus on this population both in order to address their health and their social needs.

Before responding directly to the Caucus’s specific questions below, we want to emphasize that the bifurcation between Medicare and Medicaid makes care delivery for people who are dual-eligible extremely challenging. Two disconnected programs delivering services to one high-need person means complicated and disparate enrollment systems, difficulty finding providers who accept both forms of insurance, and most dangerously, lack of coordination between providers who should be working as a team. This is a bad deal for both dual-eligible individuals and state and federal budgets. Despite accounting for a disproportionate share of Medicare and Medicaid spending—\$300 billion annually—the outcomes experienced by the dual-eligible population are poor.

There is a solution to this bifurcation that can make the system simpler to navigate for consumers and lead to better health outcomes: Medicare and Medicaid integration. Several models exist that pool the Medicare and Medicaid dollars for dual-eligible individuals and give at-risk entities responsibility for their coverage and the full range of their health outcomes, including their social needs. Congress has historically supported these models, including the Fully Integrated Dual-Eligible Special Needs Plans

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<sup>1</sup> Association for Community Affiliated Plans. [Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans](#). October 2020.

<sup>2</sup> The Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-Eligible Beneficiaries](#). July 17, 2020.

<sup>3</sup> The Centers for Medicare and Medicaid Services. [Preliminary Medicare COVID-19 Data Snapshot](#). January 1-November 21, 2020. Accessed: June 1, 2021.



(FIDE-SNPs). However, too few dual-eligible individuals have access to these fully integrated models, and as a result, only one in ten dual eligible individuals is enrolled in an integrated coverage option today.<sup>4</sup> We believe these models provide a valuable platform for addressing the social needs of the dual-eligible population and must be made more widely available.

With this context in mind, we answer the questions the Caucus posed below.

**What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?**

Almost by definition, dual-eligible individuals have social needs that impact their health care needs and the health care systems they can access. Many qualify for Medicaid because of their low-income status. Ninety-three percent of dual-eligible individuals have incomes below 200 percent of the federal poverty level, compared to 26 percent of non-dual-eligible Medicare beneficiaries.<sup>5</sup> Dual-eligible individuals report high levels of unstable housing, lack of access to transportation, food insecurity, employment instability, exposure to community and interpersonal violence, and social isolation and loneliness.<sup>6</sup> The Department of Health and Human Services has recognized dual-eligibility as a significant predictor of poor outcomes<sup>7</sup> and the Centers for Medicare and Medicaid Services (CMS) adjusts payment to Medicare Advantage plans to account for dual-eligibility.<sup>8</sup>

The COVID-19 pandemic has highlighted and exacerbated these challenges. Food and social isolation and loneliness were the areas of greatest need reported in a survey of safety-net health plans' members' experience in the pandemic.<sup>9</sup> These needs were followed by housing, basic supplies (e.g., toilet paper and cleaning supplies) and personal protective equipment.<sup>10</sup> Additionally, many of those dual-eligible individuals who are home-bound because of a disability struggled to get access to vaccinations once they became available. While the Administration, state, and local governments have made significant strides to ensure that people who want vaccines are able to access to them, even if they are home-bound, ensuring that these individuals have access once again will be important as the Administration rolls out their plan for booster shots.<sup>11</sup>

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<sup>4</sup> Centers for Medicare and Medicaid Services. [Fact Sheet: People Dually Eligible for Medicare and Medicaid March 2020](#). Accessed June 1, 2021.

<sup>5</sup> The Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-Eligible Beneficiaries](#). July 17, 2020.

<sup>6</sup> Association for Community Affiliated Plans. [Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans](#). October 2020.

<sup>7</sup> Department of Health and Human Services. [Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs](#). December 2016.

<sup>8</sup> Centers for Medicare and Medicaid Services. [Announcement for Calendar Year 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter](#). April 2016.

<sup>9</sup> Association for Community Affiliated Plans. [Addressing Social Needs Amid the COVID-19 Pandemic: A Survey of Dual Eligible Special Needs Plans](#). January 2021.

<sup>10</sup> Association for Community Affiliated Plans. [Addressing Social Needs Amid the COVID-19 Pandemic: A Survey of Dual Eligible Special Needs Plans](#). January 2021.

<sup>11</sup> Arnold Ventures. [White House Must Accelerate Vaccinations of Dual-Eligible Individuals](#). February 2021.



**What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?**

One significant barrier to addressing social needs is the lack of accountability for health outcomes. In Traditional Medicare, for example, providers who are paid for a particular service have no incentive to screen for or address their patients' social needs. In contrast, value-based or capitated payment models that require accountability for costs and quality create the conditions for health care providers to take a more active role in addressing the things that might impact their patients' health outcomes, including their patients' social needs.

The challenge with using value-based or capitated models to address the social needs of people who are dual-eligible is that Medicare and Medicaid are still largely operated separately, meaning that accountability for the experience, outcomes, and costs for the dual-eligible population remains fragmented. In the absence of a single program or greater alignment between programs, a streamlined, consistent approach for assessing and responding to social needs is nearly impossible. For example, if a primary care provider identifies transportation as a barrier to a patient accessing care but has no way of coordinating with the patient's Medicaid plan to arrange for non-emergency medical transport the patient may miss important appointments. Integrated Medicare-Medicaid models hold great potential to address the whole-person needs of those who are dual-eligible through accountability for costs and quality and flexibility to use resources to address individuals' needs as they arise.

While several models exist that align Medicare and Medicaid services and financing, there is more to be done to ensure that dual-eligible individuals are able to benefit from these models. Many dual-eligible individuals today do not have access to an integrated model, and even where models do exist, enrollment is extremely low.<sup>12</sup> Further, models vary in the degree of integration offered today and in the range of services that they include. We encourage Congress to address this by first requiring that every dual-eligible individual has access to a meaningfully integrated coverage option, and then supporting enrollment in these models and ensuring that the mix of services offered through these models addresses dual-eligible individuals' wide-array of needs and provides more care in the community.

**Are there other federal policies that present challenges to addressing SDOH?**

In addition to improving integration between the Medicare and Medicaid programs, we see two distinct opportunities to identify and address social needs: the enrollment process and once an individual is enrolled in an at-risk model.

*Enrollment:* It is critical to build a greater degree of alignment around enrollment and eligibility into Medicare and Medicaid, as well as to leverage these touchpoints to better understand and address individuals' social needs. Today, enrollment is siloed and limited in scope. Each public program—including Medicare and Medicaid—has a separate enrollment process facilitated by distinct brokers or navigators. Further, few states have combined applications for Medicaid and other major social needs programs (WIC, SNAP, LIHEAP, TANF).<sup>13</sup> For dual-eligible individuals, a better model would support concurrent enrollment in both programs and respond to whole-person needs.

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<sup>12</sup> Centers for Medicare and Medicaid Services. [Fact Sheet: People Dually Eligible for Medicare and Medicaid March 2020](#). Accessed June 1, 2021.

<sup>13</sup> Code for America. [Report: Bringing Social Safety Need Benefits](#) Online. Accessed September 15, 2021.



*At-Risk Models:* At-risk entities like health plans that get a limited capitated payment ought to be able to address social needs as they arise amongst their membership. The real or perceived barrier that plans often cite is that limitations on their use of premium or capitated dollars mean they lack the flexibility to address non-medical health care needs. CMS should clarify the existing guidance, especially as it relates to plans' Medical Loss Ratio (the proportion of premium dollars spent on clinical services and quality improvement) to assuage this concern. As a compliment to this flexibility, CMS should require at-risk entities to report on their efforts in greater detail than is required today.

**Is there a unique role technology can play to alleviate specific challenges (e.g. referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?**

As mentioned above, the enrollment and eligibility processes present key opportunities to connect with individuals and assess their social needs. However, these processes can also be challenging for beneficiaries. We know from research we have funded that people, especially those with low incomes and/or disabilities, struggle to navigate these processes,<sup>14</sup> putting publicly available supports further out of their reach.

Consumer-facing technology has a role in facilitating Medicare and Medicaid eligibility and enrollment, but it should not be done in isolation. It is important to couple technology solutions with in-person or telephonic support because without it, technology solutions might be a barrier to those who either do not have access to or are not comfortable navigating the internet.

**How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?**

Holistically addressing social determinants of health requires alignment not only between Medicaid, CHIP, SNAP, and WIC, but also between Medicaid and Medicare. As indicated above, to effectively address the social needs of the dual-eligible population, there must be increased alignment between Medicare and Medicaid. Integrated Medicare-Medicaid models allow dual-eligible individuals' whole-person needs to be addressed by ensuring accountability for costs and quality and flexibility to use resources to address needs as they arise. Without integrated Medicare-Medicaid models, services for dual-eligible individuals, including those that address social needs, will remain fragmented and siloed.

**What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?**

Evidence about the effects of interventions that seek to address social needs on health outcomes is severely lacking. However, given that Medicare and Medicaid pay for some of these services and coordination, opportunities exist to study its impact. As an example, Medicare Advantage plans can provide additional benefits above and beyond the Medicare benefit package—called supplemental benefits—to their membership. Historically, these had to be medical in nature, but Congress and CMS now permit Medicare Advantage plans to provide supplemental benefits that address social needs.<sup>15</sup>

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<sup>14</sup> Mathematica Policy Research. [The Complex Art of Making it Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#). December 4, 2018.

<sup>15</sup> Health Management Associates. [Medicare Advantage Supplemental Benefit Flexibilities: Adoption of and Access to Newly Expanded Supplemental Benefits in 2020](#). May 2020.



Some non-traditional benefits offered by Medicare Advantage plans include pest control, food and produce, and transportation.<sup>16</sup> However, CMS does not currently collect data on these benefits, despite requiring Medicare Advantage plans to submit data on their members' utilization of all traditional Medicare benefits (i.e., encounter data). The expansion of these benefits and the need to better understand their impact mean the time is right to reconsider this policy.

Additionally, Medicare and Medicaid data are not well-linked today.<sup>17</sup> Researchers and policymakers must navigate two cumbersome datasets, and as a result, we do not have a lot of timely, comprehensive data on the dual-eligible population, even though we know that they have greater social needs. It is critical to improve these datasets in order to better understand dual-eligible individuals' current care experiences and study the impact of addressing their social needs going forward. For example, with higher-quality, linked Medicare and Medicaid data, researchers could better understand the impact of states' coverage of non-emergency medical transportation on medical care access for this population.

**What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?**

Data exchange between health care entities and social service providers is critical for growing our understanding of the impact of social services. This rings especially true when public health care dollars are being used to finance the services. Above, we recommend that CMS require Medicare Advantage to report the utilization of supplemental benefits. To do so, however, there needs to be a standardized language in which to collect and report this data. Health insurance companies are billed by traditional health care providers using claims. These claims rely on standardized coding, so that insurance companies understand the charge amount and why that amount is being billed. No such wide-scale standardized language yet exists between social service providers and health care entities. Recent policy conversations about these new flexibilities suggest that among the Medicare Advantage plans using the new supplemental benefit flexibility, each collects this information differently. While requiring social service entities to provide claims-level detail may be challenging and will likely require some capacity building, this kind of data collection is important so that government and independent researchers can evaluate the effect of programs and benefits on health care utilization.

**What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?**

Prior to the most recent spike in cases and deaths due to the Delta variant, nearly one-third of COVID-19 deaths were linked to a nursing home.<sup>18</sup> People living in nursing homes are more likely to be dually enrolled in Medicare and Medicaid—they are also more likely to identify as people of color, and more likely to have chronic conditions than their Medicare-only counterparts.<sup>19</sup> Unsurprisingly, CMS has

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<sup>16</sup> Health Management Associates. [Medicare Advantage Supplemental Benefit Flexibilities: Adoption of and Access to Newly Expanded Supplemental Benefits in 2020](#). May 2020.

<sup>17</sup> State Health Access Data Assistance Center (SHADAC). [Data to Inform Research on Integrated Care for Dual Eligibles](#). April 2021.

<sup>18</sup> The New York Times. [Nearly One-Third of U.S. Coronavirus Deaths Are Linked to Nursing Homes](#). June 1, 2021.

<sup>19</sup> The Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-Eligible Beneficiaries](#). July 17, 2020.



also found that dual-eligible individuals were more likely to be hospitalized with COVID-19.<sup>20</sup> Congress and CMS provided several flexibilities to address social risk factors for dual-eligible individuals during this time, including those related to continuous eligibility, increased funding for home and community-based services, and telehealth.

*Continuous Eligibility:* To be eligible to receive enhanced federal Medicaid matching rates in the COVID-19 relief legislation, Congress specified that states could not terminate most enrollees' Medicaid coverage during the public health emergency. Medicaid enrollees frequently experience breaks in coverage—sometimes referred to as “churn.” It is estimated that 30 percent of dual-eligible individuals experience churn in any given year.<sup>21</sup> Without the risk of losing coverage, it is easier for states or entities providing coverage on their behalf, including integrated programs, to address dual-eligible individuals' needs. Continuous enrollment is particularly important for addressing social needs, as doing so is a long process and it can take years to pay dividends. Without continuous eligibility, by the time entities identify a social need and begin to address it, the patient may be disenrolled, making long-term investments less feasible and less attractive.

*Enhanced Funding for HCBS:* Congress temporarily approved a ten percent increase to states' federal medical assistance percentages (FMAP) for Medicaid home and community-based services (HCBS) in the American Rescue Plan.<sup>22</sup> This funding will at least temporarily increase access to care in the community and address some social needs like home modifications. As a part of the upcoming reconciliation package, Congress is considering continuing this enhanced funding in perpetuity for states that meet certain conditions. We urge you to do so and to consider the dual-eligible population—one of the largest utilizers of HCBS—and their need for Medicare-Medicaid integration as part of such efforts.

*Telehealth:* Unlike the above recommendations, which suggest extending COVID-related policies, we urge Congress to proceed cautiously as it relates to telehealth.<sup>23</sup> On the one hand, many dual-eligible individuals struggle with transportation to doctors' visits, and some are even home-bound. Increased access to telehealth can make it easier for them to connect with their doctors and get the care they need. However, telehealth can also exacerbate inequities that exist in the system today. Not everyone can afford or has access to high-speed internet. Thus, those accessing medical care through telehealth may not be the people with the highest need. Furthermore, telehealth may be used to supplement rather than substitute traditional health care and lead to increased spending. Congress and CMS should consider whether increased flexibility to utilize telehealth will increase spending. If so, will the increased spending lead to increases in access to the people who have trouble accessing the system today or will it just make it easier for those who already have access to services? The answers to these questions should drive the decisions that Congress and CMS make around telehealth moving forward.

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<sup>20</sup> The Centers for Medicare and Medicaid Services. [Preliminary Medicare COVID-19 Data Snapshot](#). January 1-November 21, 2020. Accessed: June 1, 2021.

<sup>21</sup> Assistant Secretary for Planning and Evaluation (ASPE). [Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors, and Implications](#). May 2019.

<sup>22</sup> 117<sup>th</sup> Congress. [H.R. 1319 – American Rescue Plan Act of 2021](#). March 11, 2021.

<sup>23</sup> Arnold Ventures. [Telehealth: Good in Theory, Potentially Problematic in Practice](#). November 18, 2020.





**Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?**

As previously stated, we believe integrated models can be designed to holistically meet dual-eligible individuals' needs. First, many dual-eligible individuals do not have access to an integrated Medicare-Medicaid plan. Congress and CMS should take steps to ensure that every dual-eligible individual has access to such a coverage option. Additionally, integrated models work best when they are responsible for the full range of benefits that an individual needs, including medical, long-term care, and social support services. This requires ensuring that integrated entities have the flexibility to spend their capitated set of dollars on the services that produce better health outcomes and a better consumer experience—namely both social needs and medical services. Additionally, for these models to work, these entities must be held accountable for outcomes that matter to people.

**Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?**

If at-risk entities are held accountable for outcomes like reduced hospitalizations, reduced emergency room visits, and beneficiary satisfaction, they will be motivated to address whatever factors may improve outcomes related to these measures, assuming they have adequate flexibility to do so. Please see the above question related to innovative models for further thoughts.

## **Conclusion**

Arnold Ventures is prepared to assist with any additional information needed. Please contact Arielle Mir at [amir@arnoldventures.org](mailto:amir@arnoldventures.org) with any questions. Thank you again for your work and the consideration of the above.

Arielle Mir