

About this Document

Title:	Special Supplemental Benefit for the Chronically Ill Eligibility Policy and Procedure: Food and Home Utility Allowance
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Purpose

Starting in PY2026, the Food and Home Utility allowance is offered as a Special Supplemental Benefit for the Chronically Ill (SSBCI) due to the discontinuation of the Value-Based Insurance Design (VBID) model. As a function of this benefit type, enrollees must meet certain eligibility criteria to receive the benefit. Per [42 CFR 422.102\(f\)\(1\)\(i\)](#), eligibility to receive a benefit offered under SSBCI is restricted to members that are chronically ill. Chronic conditions that are considered when making an eligibility decision must be substantiated by evidence that the item/service has a reasonable expectation of improving or maintaining the health or function of a chronically ill enrollee. This policy establishes the criteria and methodology for determining member eligibility to receive the Food and Home Utilities allowance under SSBCI.

Scope

For PY2027, this policy covers the Akamai Advantage Dual Care population. All other Medicare plans are out of scope as this benefit is not part of their plan design.

Eligibility Policy

HMSA develops written documentation which outlines the eligibility criteria and process in which HMSA determines member eligibility to receive the Food and Home Utility allowance in accordance with applicable regulations and program requirements. All individuals and teams that are responsible for designing the processes that assess for eligibility and the execution of these processes must comply with this policy.

1. In 2027, HMSA will offer Food and Home Utility allowance under SSBCI.
2. HMSA will determine eligibility through the diagnoses that have been submitted by providers via ICD-10 codes on claims. As claims information may not be readily available for enrollees that are new to HMSA, eligibility may also be determined through the Mock Model Output Report (MOR) files, which mirror CMS's MOR payment files, as an ancillary process. The Mock MOR provides detail on the Hierarchical Condition Categories (HCCs) that CMS has accepted, which correspond to the conditions that enrollees have been both diagnosed with and have been submitted on claims, whether those claims came from HMSA or another payor.
3. BI/Claims Process
 - A. Background:
 - Claims that are submitted to HMSA are loaded to HMSA's BI Warehouse on a monthly cadence.
 - Diagnoses that are submitted on claims are identified by ICD-10 diagnosis codes included on the claim. HMSA's BI Warehouse utilizes Clinical Classification Software Refined (CCSR) codes rather than ICD-10s to identify conditions that enrollees have been diagnosed with. As such, ICD-10s have been mapped to corresponding CCSR codes.
 - Chronic conditions that have been determined as eligible during plan design have been mapped to corresponding CCSR codes.

- Due to the broad nature of conditions that have been selected to qualify members, qualifying CCSR codes include only CCSR codes that both correspond to an eligible condition AND are indicated to be chronic. CCSRs that have not been designated as chronic have been excluded.
 - B. On a monthly basis, HMSA will review paid claims data stored in our BI Warehouse to identify members that have been diagnosed with qualifying chronic conditions. This review will include dates of service (DOS) within the current and prior calendar year (e.g., If running eligibility for 2027, DOS from 2026 and YTD 2027 will be able to qualify a member).
 - C. The monthly review is an automated process that identifies eligible members based on enrollment and conditions submitted via claims with DOS within the lookback period.
 - D. The monthly review will produce a file listing eligible members.
 - E. An ancillary report will also be available, containing additional information regarding the condition(s) and claim(s) that made the member eligible for validation purposes.
- 4. Mock MOR Process
 - A. Background:
 - On a monthly basis, CMS provides a suite of payment reports to HMSA for validation purposes of capitated payments. The MOR file provides HMSA insight into the HCCs that CMS is factoring into each enrollee's risk scores.
 - Through the Risk View tool, HMSA has access to the Mock MOR, which mirrors the key information that is available in the MOR. The key differences are that the Mock MOR includes unique subscriber ID as a member identifier as well as being in a format that is conducive to analysis of the file.
 - The Risk View tool is refreshed with the updated Mock MOR available monthly.
 - From the HCCs that the Mock MOR file provides, HMSA can determine its enrollees' diagnoses that have been submitted to and accepted by CMS, whether HMSA has the claims data from that specific encounter or not.
 - Qualifying chronic conditions have been mapped to available CMS HCCs.
 - B. On a monthly basis, HMSA will review the Mock MOR to identify members that CMS has recognized as being diagnosed with qualifying chronic conditions. Based on the DOS that are represented in the Mock MOR, HCCs that are captured on the Mock MOR file will not vary month to month except when the DOS that are considered for payment adjust. As such, only the most recent file will be considered when assessing for eligibility to identify benefit eligibility for members.
 - C. The monthly review will produce a file, listing eligible members. Additional information regarding the condition(s) that made the member eligible will be included in this file for validation purposes.
- 5. Completed, monthly files from both processes will be picked up by an automated job for processing.
- 6. If a member has been identified to have a qualifying chronic condition through either of the BI/Claims or Mock MOR processes, they will be determined to be eligible to receive this benefit.

7. Due to the nature of chronic conditions and no change in the list of eligible conditions, members that were previously identified are assumed to continue to have an eligible condition. As such, to mitigate potential delay with accessing the benefit, members identified through the established prior year's eligibility processes will retain their eligibility for the next year.
8. Should a member, who was previously identified to be eligible but terminated DSNP enrollment, enroll again within the same plan year, they will retain their prior eligibility for the benefit. Re-identification for eligibility will not be required. Eligibility for the benefit will be shared with the vendor responsible for the administration of the benefit on the next eligibility file transfer.
9. Vendor will update its internal systems with benefit eligibility when processing the eligibility file. Newly eligible members will have access to the benefit via their shared purse as soon as the file is processed.
10. Members will be notified of their eligibility for the benefit via a written notice. Insight to eligibility will also be available in real time through the vendor's member portal.