

Addressing Social Determinants of Health for Beneficiaries in Medicare Advantage

WHITE PAPER NOVEMBER 2018

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I. Overview

Social determinants of health are the conditions in which people live, work, and age that impact their health.¹ They include factors such as socioeconomic status, access to health services, and the social and physical environment.² Increasingly, health care payers, such as Medicare and Medicaid, are interested in more holistic care for beneficiaries by directly addressing their social determinants of health with the goal of improving health outcomes while reducing unnecessary health care utilization. This White Paper explores social determinants of health, discusses the challenges of addressing social determinants in Medicare, and provides examples of how Medicare Advantage health plans are working to directly address social determinants of health. This White Paper also recommends actions policymakers can take to improve the ability of Medicare Advantage health plans to more directly address social determinants of health to improve patients' health outcomes.

POLICY RECOMMENDATIONS:

1. Expand the definition of allowable supplemental benefits to directly address social determinants of health.
2. Expand Medicare Advantage Value-Based Insurance Design (V-BID) to Part D for integrated Medicare Advantage-Part D (MA-PD Health Plans).
3. Ensure the Star Rating System incorporates social determinants of health.
4. Include social determinants of health in risk adjustment.
5. Ensure Adequate Stable Payment in Medicare Advantage

II. Background

Social Determinants of Health

Although U.S. health care spending is the highest in the world, life expectancy is shorter than any other industrialized nation.³ Improving health care outcomes and lowering costs requires the coordination of resources to attend to social determinants of health. These social, economic and environmental factors impact the availability of resources to meet people’s non-medical and medical needs.⁴

The move to value in health care, which includes risk-assumption for the provision and cost of care for individuals over a period of time, is placing greater attention on health status beyond the outcome of specific episodes of care. Responsibility and accountability for the cost and health status of individuals or populations is incentivizing stakeholders to address barriers to care in order to improve health status and health outcomes. Increasingly health plans and providers are partnering with community-based organizations and private companies to address social and economic barriers to health that can include unsafe housing, food insecurity, and a lack of access to social services and supports that are known to contribute to the health status of individuals and communities. Key social determinants of health are outlined in Figure 1.

FIGURE 1

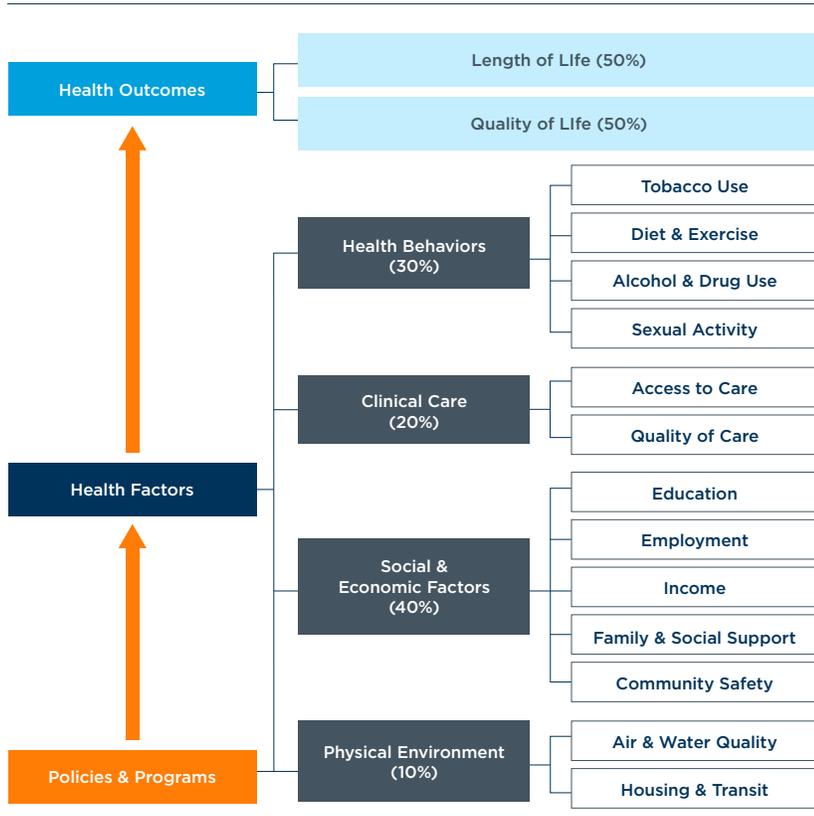
Key Social Determinants of Health					
Safety in the Home	Food Insecurity	Lack of Access to Transportation	Utility Needs	Lack of Family and Social Support	Lack of Income
Having difficulty paying rent or affording a place of one’s own, living in unsafe conditions	No reliable access to enough affordable, nutritious food	No affordable and reliable ways to get to medical appointments or purchase healthy food	Not able to regularly pay utility bills	No relationships that provide interaction and nurturing	Lack of ability to get needed income to cover expenses

Source: Deloitte Center for Health Solutions, <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/addressing-social-determinants-of-health-hospitals-survey.html>

Social determinants of health can be divided into social and physical environmental factors. The social environment is comprised of the institutions, norms, patterns, and processes that influence individual’s health such as poverty, social isolation and health behaviors. The physical environment is comprised of the air, water and soil in the natural environment, and the human-made living and working built environments that impact an individual’s health.⁵ The social and physical environment reinforce each other over time and factors such as low income, unsafe communities, and inaccessible public transit impact the health of individuals and communities down to the zip code.⁶

As Figure 2 illustrates, clinical care is estimated to account for approximately 20 percent of the health outcomes of a population, and the other 80 percent of health contributors are social determinants of health, including health behaviors, social and economic factors and physical environment. Social determinants contribute to individuals length and quality of life.⁷ Despite the fact that the largest drivers of health care costs fall outside of the clinical setting, the U.S. spends more on health care than social services.⁸ Illustrating the imbalance between investments in clinical care and social determinants of health, approximately 95 percent of the trillions spent on health care in the U.S. go directly to medical services.⁹ In spite of these investments in clinical care, an estimated 40 percent of deaths are caused by behavioral patterns.¹⁰

FIGURE 2



As the CEO and chairman of Aetna said, “Your ZIP code has more to do with your health status than your genetic code.”

Source: County Health Rankings & Roadmaps, County Health Rankings & Roadmaps, <http://www.countyhealthrankings.org/our-approach>.

Social Determinants of Health and Medicare Advantage

Medicare is the largest health care payer in the U.S., with costs projected to be approximately 5% of the total economy by 2048.^{11,12} If policymakers hope to bend this cost curve and extend the life of the Medicare program, it will be critical to directly address social determinants of health, particularly for beneficiaries with multiple chronic conditions.¹³ Studies have shown the neighborhood a Medicare beneficiary lives in is a significant predictor of functional limitations associated with multiple chronic conditions that lead to worse health outcomes.¹⁴

Medicare traditionally has not paid for supports and services that directly address social risk factors. Medicaid, on the other hand, provides some home- and community-based services, though services and coverage policies vary widely by state for Medicaid-eligible Medicare beneficiaries. In addition, those who are eligible for Medicare due to disability may have access to additional support services. However, for most seniors on Medicare, the historic disconnect between clinical care for medical needs and the services that address factors impacting health outcomes has led to inadequate investments in efforts to attend to social determinants of health, leaving risk factors unaddressed, even when they are recognized.

Conversely, Medicare Advantage, the integrated care option in Medicare whereby Medicare benefits are administered by private health plans, is increasingly delivering value-based care that includes efforts to meet patients' social and clinical needs. Medicare Advantage and plans are structured in a way that ties quality and cost to performance, establishing a rationale for increased attention to identification and intervention in order to address social risk factors that impact health. Value-based payment arrangements in Medicare Advantage facilitate effective partnerships between health plans, medical providers, and social services to integrate clinical care into a broader care model that improves population health outcomes.

Unlike Traditional Fee-For-Service (FFS) Medicare, Medicare Advantage provides an integrated care system through networks of providers, offers chronic disease management programs not available in FFS Medicare, and has strong incentives to focus on primary care and care management. Providers are increasingly held accountable for the health outcomes of patients. As a result primary care teams are at the center of care, incentivized to attend to gaps in care important to improving health status. Medicare Advantage health plans are transforming Medicare by facilitating coordination between providers and multi-sector partners to develop and implement new ways to address social determinants of health.

While Medicare Advantage health plans have more flexibility to address social determinants than FFS Medicare, comprehensive change requires fundamental cultural shifts throughout the health system, including in the way health care is paid for and how it is organized. Progress towards greater coverage of services needed to meet social determinants is being made due to recent regulatory and legislative changes to allowable Medicare Advantage supplemental benefits. These changes are expected to result in the expansion of programs to address social determinants in 2019 and 2020.

Social Determinants of Health and FFS Medicare

The fragmented nature of care in FFS Medicare leads to challenges in effectively addressing the complex social risk factors that influence a person's health and well-being. Recent policy changes, such as the addition of chronic care management payments, have illuminated the challenges of operationalizing more coordinated care in FFS Medicare. When the payments were first introduced in 2015, the Centers for Medicare & Medicaid Services (CMS) estimated 35 million Medicare beneficiaries were eligible, but nearly one year into the program, CMS had received only about 100,000 requests due to implementation challenges.¹⁵

Recognizing the challenge of addressing social determinants of health in FFS Medicare, CMS, through the Center for Medicare & Medicaid Innovation (CMMI), developed the Accountable Health Communities Model to provide funding for health care providers and community-based organizations to address gaps between clinical care and community services for Medicare and Medicaid beneficiaries through screening, referral and community navigation services. Over 30 organizations, ranging from county governments, to hospitals and universities are participating in the model. The demonstration began in May 2017 and will continue for five years. Therefore, results are not yet available for these clinical-community collaborations.¹⁶

Work is also being done to study ways to better account for social risk factors in Medicare payment. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required the Secretary of Health and Human Services (HHS), through the Assistant Secretary for Planning and Evaluation (ASPE), to examine the effect of individual's socioeconomic status on Medicare. The studies examine the impact of social risk factors such as race, health literacy, and limited English proficiency on quality measures and payment.¹⁷ To analyze social risk factors in Medicare, ASPE convened an expert panel through the National Academies of Sciences, Engineering, and Medicine. The first report was released in 2016, five reports have been released thus far, and a final report is due to Congress in October 2019.¹⁸ Four goals of ASPE reports

- 1. Reducing disparities in access, quality, and outcomes;**
- 2. Improving quality and efficient care delivery for all patients;**
- 3. Fair and accurate reporting; and**
- 4. Compensating health plans and providers fairly.**¹⁹

The ASPE reports concluded that it is critical to account for social risk factors in Medicare payment to achieve health care equity. However, the reports acknowledged that accounting for social risk factors that influence performance in value-based payment models is complex. The ASPE reports identified four key categories to account for social risk factors in Medicare outlined in Figure 3. The reports further encourage the use of value-based payment models where providers are incentivized to take on risk to achieve better population health management and greater attention to quality and cost. The assumption is that when the provider or health plan is at financial risk, investments will be made to address social risk factors to improve patient outcomes. This has proven to be accurate as evidenced in Medicare Advantage.

FIGURE 3

Four Categories of Ways to Account for Social Risk Factors in Medicare from ASPE Reports:

- 1) Public data reporting
- 2) Adjustment of quality performance measure scores
- 3) Direct adjustment of payments
- 4) Restructuring payment incentive design

III. Medicare Advantage is Addressing Key Social Determinants of Health

Evidence shows that it is difficult to improve Medicare beneficiaries' health if social determinants such as housing instability, food insecurity and access to transportation are not addressed. Medicare spending is approximately \$700 billion per year, and over half of that spending is driven by 15 percent of the sickest and highest-need beneficiaries.^{20 21} Attending to social determinants of health is a high-value way to address the challenge of caring for the influx of baby boomers in Medicare with multiple chronic conditions and social risk factors.

Social determinants of health are often interconnected, as illustrated by the story below. Approximately 40 percent of high-need isolated adults have incomes below \$15,000 per year, and 80 percent of those report worrying about having enough money to pay bills or afford healthy foods.²² Studies outlined below show that addressing social determinants like nutritional needs, social isolation, home accessibility, and poor access to transportation improves beneficiaries' outcomes and lowers health care costs.

Medicare Beneficiary Story

Elizabeth is 94 and she lives in the same rural farmhouse in Maine she grew up in, where she raised her four children and cared for her own mother as she aged. Congestive heart failure, a stroke, and other health complications have left her homebound and largely confined to a recliner. Her family is spread out across the U.S., deceased, or estranged. With only a TV and phone to pass the time, Elizabeth is challenged by social risk factors such as a limited income, food insecurity and social isolation. Across the country Medicare beneficiaries like Elizabeth are struggling to have their health basic needs met as they age in place.

Nutritional Needs

Adequate nutrition plays a critical role in the health of Medicare beneficiaries. Older adults are at risk of malnutrition and can become more nutritionally vulnerable when recovering from a hospitalization. It is estimated that 50 percent of the seniors who enter the hospital are already malnourished when they arrive.²³ Seniors experiencing hunger are three times more likely to suffer from depression, 50 percent more likely to have diabetes, and 60 percent more likely to have congestive heart failure or a heart attack compared to their peers who do not experience hunger.²⁴

Home-delivered meal programs have been found to improve diet quality and increase nutrient intake, while keeping older adults out of more expensive sites of care like the hospital and nursing homes.^{25 26 27} In addition to fewer inpatient admissions, beneficiaries of food delivery programs reported fewer falls, and lower medical spending, illustrating the positive impact of nutritious food on health outcomes for vulnerable patients.²⁸

Medicare Advantage is Addressing Nutritional Needs

Currently Medicare Advantage beneficiaries may receive nutritious meals post-surgery or hospitalization. Greg from Kentucky said his Medicare Advantage health plan provided him with food and follow-up contact after surgery and rehabilitation. Nutrition programs that would serve patients in other circumstances are also being developed through Medicare Advantage.

The Commonwealth Care Alliance (CCA), a not-for-profit, community-based healthcare organization based in Massachusetts recently participated in a study to expand access to nutritious meals. Dedicated to improving care for dually eligible beneficiaries in both Medicare and Medicaid, CCA has a Medicare Advantage Special Needs Plan called the Senior Care Options program. In a recent pilot, CCA provided beneficiaries with at least six months of continuous enrollment access to meal delivery programs. Each week beneficiaries received five days of nutritious lunches, dinners and snacks. The study found that emergency department visits significantly decreased among CCA beneficiaries who participated.

Social Isolation

A growing population of older adults is living alone, vulnerable to the negative health impacts of social isolation. Studies have shown socially isolated seniors incur higher Medicare spending and have increased risk of chronic disease and death.²⁹ Loneliness has health impacts similar to smoking, shortening a person's lifespan by an average of eight years.³⁰ The lack of social contact among older adults is associated with an estimated \$6.7 billion in additional federal spending annually.³¹ Risk factors that predict social isolation in Medicare beneficiaries include a lack of access to family support, a caregiver or a care coordinator.³²

Medicare Advantage is Addressing Social Isolation

CareMore Health, an integrated care delivery system with over 150,000 Medicare, Medicaid and dual-eligible patients in 10 states, identifies high-need seniors who lack social support. CareMore works to diagnose and treat loneliness by making sure patients have access to free medical transportation and programs like exercise classes. The CareMore “Togetherness Program” assigns patients a togetherness pal for weekly phone calls to encourage preventive care to reduce patients need for health care services. As Thanksgiving approaches, CareMore staff even call seniors to see if they have a place to go and connect them with a community organization providing Thanksgiving dinner.

Home Accessibility

Every 11 seconds, an older adult is treated in an emergency department for a fall-related injury. Every 29 minutes, an older adult dies from a fall, leading to 27,000 deaths among older adults each year.³³ Treating fall-related injuries places a significant burden on the health care system, given that such injuries are among the most expensive medical conditions to treat. The average hospital cost for a fall injury is over \$30,000, and the costs of treating fall injuries increases as seniors age. Currently, \$31 billion of Medicare annual costs are related to falls each year, and this number is expected to rise to \$67.7 billion by 2020.³⁴

Evidence-based falls prevention programs like “A Matter of Balance” developed by the Centers for Disease Control and Prevention (CDC), as well as home accessibility modifications have been shown to reduce the risk of falls in older adults. Most falls prevention programs incorporate physical activity and fitness to improve balance, flexibility, coordination, muscle strength, and endurance. In addition to falls intervention programs, approximately 44 percent of households have some need for home accessibility features due to disability or difficulty navigating areas of the home.^{35 36} Falls prevention programs and home modifications also help older adults remain in their homes safely for as long as possible.

Medicare Advantage is Improving Home Accessibility

Medicare Advantage health plans contract with community-based organizations and companies to provide falls prevention services. Research has shown Medicare Advantage beneficiaries with access to programs such as SilverSneakers report better emotional and physical health, with fewer limitations in activities of daily living to help keep people safe at home.

Greg, a Medicare Advantage beneficiary from Kentucky said he is an active user of SilverSneakers. He said the program has been particularly helpful with his hip issues following rehab. He said, “My plan has been quite useful!” In addition, Bonita, a Medicare Advantage beneficiary from Texas said SilverSneakers allows her to attend water aerobics and tai chi three to four times a week.

Access to Transportation

Providing non-emergency transportation for low-income populations has been shown to be a cost-effective way to improve life expectancy and quality of life.³⁷ Lack of accessible transportation inhibits beneficiaries’ access to needed health care services. One study found 3.6 million Americans miss or delay non-emergency medical care due to a lack of transportation.³⁸ If just one percent of medical trips result in an avoided emergency department visit, the return on investment for a state would be \$11.08 for each dollar invested in medical transportation.³⁹ The increased utilization of ride-sharing companies using private companies has shown promising results, with one study concluding that the market entry of Uber reduced the per capita ambulance volume by at least 7 percent.⁴⁰

Medicare Advantage is Improving Access to Transportation

ChenMed has physician-led, integrated care medical centers that deliver high-quality health care for seniors who are Medicare Advantage beneficiaries. The ChenMed model provides patient-centered care by elevating primary care to increase access to services, enhance care coordination, and address social determinants of health. ChenMed makes preventive care as easy as possible to access by encouraging office visits and providing patients with transportation to and from ChenMed facilities. Door-to-doctor transportation ensures these physician practices can focus on high-touch care to address patients’ needs.

IV. How Medicare Advantage is Able to Address Social Determinants of Health

Medicare Advantage is paid through a capitated system which puts health plans at-risk for the care and cost of each beneficiary enrolled in their plan. In addition, without additional payment, Medicare Advantage health plans are allowed to provide extra benefits not offered under FFS Medicare, such as hearing, dental and vision care, known as supplemental benefits. This integrated system of payment and flexibility enables and incentivizes Medicare Advantage health plans and providers to focus on primary care and early interventions, risk identification, and care management.

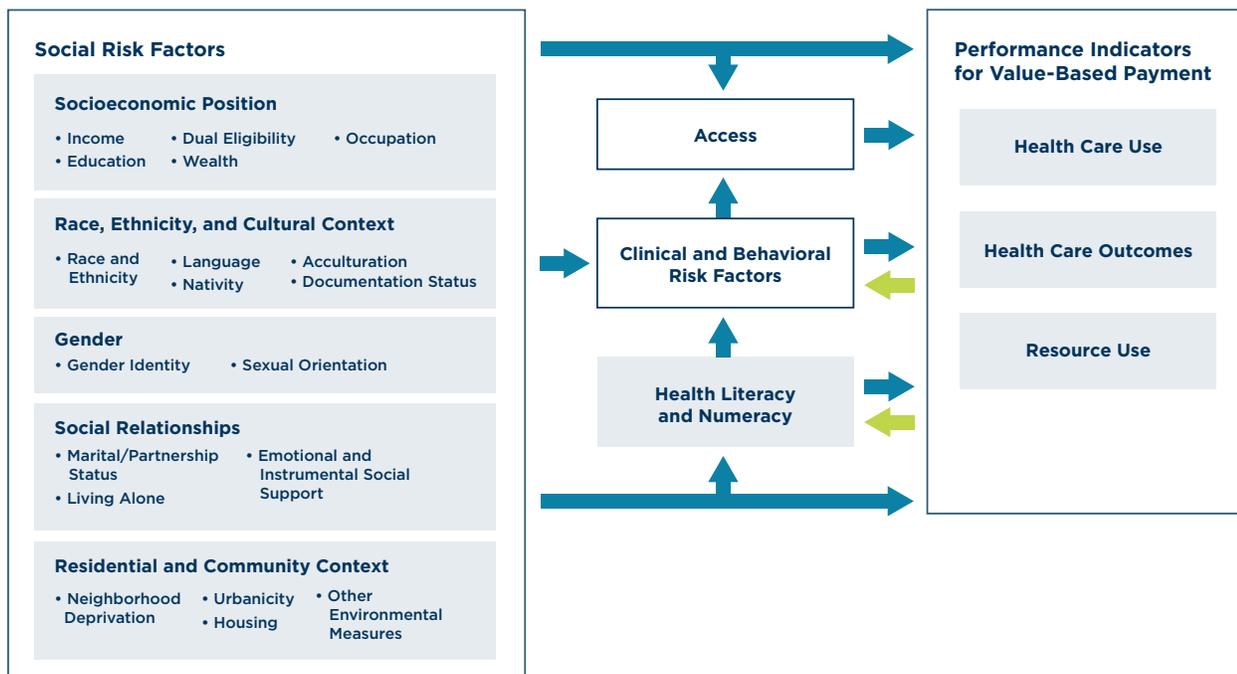
Medicare Advantage has been shown to encourage more use of preventive care, reduce hospitalizations and lengths of facility stays, and improve outcomes.⁴¹ Moreover, Medicare Advantage has maximum out-of-pocket limits for beneficiaries, which are not available in FFS Medicare. By focusing on value-based payment arrangements, tailored benefit design and care coordination, Medicare Advantage is able to deliver a higher value at an affordable cost for beneficiaries. These key elements of Medicare Advantage provide a critical opportunity to address beneficiaries' social determinants of health.

Value-Based Payment Arrangements

Medicare Advantage health plans offer innovative, value-based care delivery models to improve outcomes for beneficiaries. Medicare Advantage leads the transition to value-based care in Medicare, with more than 1 in 5 dollars paid through alternative payment models in 2016.⁴² In fact, research has shown that Medicare Advantage achieves better health outcomes at comparable or lower costs compared to FFS Medicare for high-need Medicare beneficiaries and those with chronic conditions.⁴³ Medicare Advantage health plans play a critical role in facilitating value-based, risk assumption payment arrangements with providers through data analytics and risk stratification expertise, as well as access to community-based programs that can enhance health outcomes for beneficiaries.

Medicare Advantage is a capitated system in which health plans accept full financial risk for the provision of all Medicare benefits to enrollees. Research shows that Medicare Advantage is playing a crucial role as an incubator for innovative value-based care that improves quality and access, while reducing costs. Despite lower costs for chronically ill beneficiaries, Medicare Advantage substantially outperforms FFS Medicare on quality and outcomes measures.^{44 45} Studies of provider and payer collaborations across the country have concluded that Medicare Advantage value-based contracting arrangements improve clinical outcomes and survival rates, while generating costs savings.^{46 47} Value-based contracts inherently incentivize payers and providers to identify and address social determinants to improve beneficiaries' health. The interaction between social risk factors and Medicare value-based payment are illustrated in Figure 4. The figure shows value-based payment arrangements are impacted by beneficiaries' access, clinical and behavioral risk factors and health literacy.

FIGURE 4



The National Academies of Sciences, Engineering, Medicine, January 2017

The Star Rating System

Quality care in Medicare Advantage is measured and reported through a Star Rating System. The system plays a critical role in promoting quality, ensuring public accountability, and giving beneficiaries the tools to choose high-quality plans. The Star Rating System evaluates Medicare Advantage health plans on a 1-5 scale, with a 5-star rating indicating the highest quality. Performance is based on health plan and prescription drug specific measures.

Medicare Advantage health plans' star ratings are displayed on the Medicare Plan Finder, the government's online tool that allows consumers to search for high-quality health plans and compare cost and coverage information. Medicare Advantage health plans with at least 4 Stars receive quality bonus payments on the rebates. Rebates, along with quality bonuses, must be used to directly benefit beneficiaries. These payments are used to invest in supplemental benefits including home-based care, risk stratification to identify high-need patients, care management, wellness programs, and telemedicine as well as reduced cost sharing, dental, vision and hearing services for beneficiaries, all of which enhance the availability of services and play a role in identifying and addressing the social determinants of health.

The measure development process in the Star Rating System includes identifying measures, testing measures in a clinical setting, and ensuring the data collected is accurate and meaningful. CMS measures often undergo a stringent endorsement process spearheaded by the National Quality Forum (NQF) prior to program inclusion. NQF has endorsed 17

measures to account for social risk factors which include measuring family experience with care coordination and respondent education, discharge to community and marital status, 30-day unplanned readmissions for cancer patients and dual eligible status.⁴⁸ NQF has also recommended a three-year initiative to further examine socioeconomic status and other demographic factors. Established quality entities such as the National Committee for Quality Assurance and the Pharmacy Quality Alliance are examining ways to adjust measures to take social risk factors into account.

In recent years, stakeholders have expressed concerns that the Star Rating System does not accurately reflect the quality of care delivered by health plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees. Several studies have found socio-demographically disadvantaged patients have worse outcomes on some quality measures that inform Star Ratings.^{49 50} Additionally, ASPE reported that dual-eligible status was found to be one of the greatest predictors of poor health outcomes, leading to high health care needs and cost indicated by disability status, low income, and a lack of social supports.

To address this issue, CMS implemented an interim adjustment in the 2017 Star Ratings for dual-eligible, low-income, and disabled beneficiaries for certain Star Rating measures called the Categorical Adjustment Index (CAI). CMS will continue to apply the CAI in 2018 while it works with various federal agencies and stakeholders to develop a longer-term solution and collect better data on social risk factors. The CAI has resulted in small movements of Star Ratings. While CMS left the CAI adjustment unchanged in 2019, it's expected that the agency will revisit the adjustment in years to come.⁵¹

Risk Adjustment

The Federal government, through CMS, pays Medicare Advantage health plans a capitated monthly amount per enrolled beneficiary to provide all Medicare inpatient and outpatient benefits. To ensure these capitated payments accurately reflect the expected cost of providing health care to each beneficiary, CMS uses a process called “risk adjustment” to adjust payments based on the health status of each enrollee. Risk adjustment aims to accurately predict expected health care costs, encouraging plans to compete for beneficiaries based on price and quality, not health status. An accurate risk adjustment model ensures payments to Medicare Advantage plans adequately compensate for the costs of treating and managing both high- and low-cost individuals.

In 2017, CMS modified the current risk model to account for concerns that it underpredicted costs for lower-income beneficiaries. In response to these concerns, CMS evaluated how accurately the current community risk model predicted costs for full benefit, partial-benefit, and non-dually eligible beneficiaries. CMS determined that the 2014 community model under-predicted costs for full-benefit dual-eligible beneficiaries by 9 percent, while over-predicting costs for partial-benefit dual-eligible beneficiaries by 9 percent and non-dually eligible beneficiaries by 1.5 percent. The 2017 model changes satisfy the 21st Century Cures Act requirement for CMS to provide separate adjustments for dual-eligible beneficiaries. As a result of the model change, payments for full-benefit dual-eligible beneficiaries have increased.⁵²

The 21st Century Cures Act also required CMS to evaluate the impact of certain diagnoses and the number of conditions to the risk adjustment model. For 2019, CMS will include additional adjustments for mental health, substance abuse, and chronic kidney disease diagnosis. In 2020, CMS will begin implementing the proposed “Payment Condition Count” model, which will account for the number of conditions a beneficiary has among those included in the payment model.

In the Announcement of Calendar Year 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, CMS stated the agency will continue to evaluate whether additional conditions or social determinants of health meet the requirements to be included in the risk adjustment model for future payment years.⁵³ As Medicare Advantage grows it will prove critical to gain a better understanding of how social determinants of health affect costs, and adjust payments accordingly.

Care Management

Care management is a team-based, patient-centered approach designed to assist patients in managing medical conditions more effectively. The financial framework of risk-based, capitated payments under Medicare Advantage offers the opportunity to improve care delivery through the provision of care management to better meet patient needs and improve outcomes. Successful Medicare Advantage-driven care management programs depend on access to real-time, robust data resources to identify high-need patients from integrated electronic health records and payer data.

Strong physician leadership and use of primary care teams of health professionals who work together to address the clinical and social needs of high-risk patients is key to successful risk intervention strategies. The literature on care management cites the importance of patient-centered rather than service-driven care. Other studies describe trust and continuity as foundational to effective care management. Finally, evaluations of successful care management programs emphasize the injustice of stakeholders’ ability to effectively stratify patients’ risk, using real-time data paired with flexibility in matching patient needs with appropriate interventions.⁵⁴

According to CMS, Medicare Advantage health plans are in a unique position to see the individual’s total care. Care management that coordinates both health care and social services can effectively address beneficiaries’ social determinants of health. One study showed Medicare Advantage results in more appropriate use of ambulatory services and lower rates of avoidable hospitalizations and ER visits when compared to FFS Medicare. This difference is potentially a result of a focus on preventive services and care management.⁵⁵ Another study showed connecting Medicare Advantage beneficiaries with social services decreased medical costs by 10 percent.⁵⁶ Figure 5 provides a blueprint for effective care management that includes elements to address social determinants, such as identifying patients’ needs and removing barriers to care.

FIGURE 5



Bright Spots in Care Management in Medicare Advantage, June 2017

Flexible Benefit Design & Expansion of Supplemental Benefits

Recent changes in Medicare Advantage policy offer additional opportunities for health plans to address social determinants, primarily through new flexibilities in benefit design. Building on the framework of the Medicare Advantage V-BID demonstration, CMS has reinterpreted what is known as the uniformity rule. The uniformity rule requires that Medicare Advantage health plans offer uniform benefits and cost-sharing to all enrollees in a given plan. However, beginning in 2019, health plans may target certain benefits to specific subsets of enrollees in the health plan, as long as the group of enrollees meet objective, measurable medical criteria. For example, a health plan may provide patients with diabetes access to low- or no-cost transportation and/or reduced or eliminated copays for visits to the endocrinologist. To comply with the uniformity rule, these targeted benefits must be offered to every enrollee with a similar diabetes diagnosis. These types of additional flexibilities are designed to enable Medicare Advantage health plans to implement innovative ways to eliminate barriers that prevent beneficiaries with chronic conditions from utilizing necessary, high-value care essential to treating their conditions and improving their health.

In addition to adding more flexibility in benefit design, CMS also expanded its definition of supplemental benefits starting in 2019. Medicare Advantage health plans currently may offer additional supplemental benefits beyond those covered under FFS Medicare. Common supplemental benefits offered by Medicare Advantage health plans include vision, dental, and hearing services, which are not covered by FFS Medicare. Almost all health plans offer one or more of these supplemental benefits, and over half offer all three

benefits.⁵⁷ Recently, the definition of allowable Medicare Advantage supplemental benefits has been expanded to include services to address physical impairments, health conditions, and avoidable health care utilization. Allowable supplemental benefits may now include adult day care services, in-home support services, non-opioid pain management, home safety modifications, and transportation. However, supplemental benefits must be targeted to certain populations and still cannot target health care services based primarily on social determinants, like homelessness or food insecurity.^{58 59 60}

These new benefits may include ride-hailing services, home visits, home renovations like grab bars and other accommodations to prevent falls, and home health aides.⁶¹ Studies have shown potential savings of over \$2,000 per beneficiary when social needs are met.⁶² Areas where Medicare Advantage health plans are most likely to add supplemental benefits include housing modifications, transportation and in-home support of activities of daily living as a result of this new flexibility.

Additionally, the recent passage of provisions of the CHRONIC Care Act in the Bipartisan Budget Act of 2018 (BBA) provides CMS with additional authority to re-define supplemental benefits starting in 2020. Specifically, the BBA explicitly states that effective in 2020, supplemental benefits need not be “primarily health-related,” potentially opening the door for health plans to offer additional benefits that directly address social determinants, possibly to include meal-delivery and services to address food insecurity or social isolation.

V. Recommendations for Action

1. Expand the Definition of Allowable Supplemental Benefits to Directly Address Social Determinants of Health

Congress should encourage CMS to use the new authority provided by the BBA to allow supplemental benefits, starting in 2020, to directly address social determinants of health like food insecurity and social isolation.^{63 64} Beginning in 2019, CMS is expanding the definition of “primarily health-related” to consider an item or service as primarily health related if it is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and health care utilization. While this guidance is a step forward in enabling Medicare Advantage to provide services such as expanded care in the home, transportation, and health-related items and medications available without a prescription, CMS stated that supplemental benefits cannot target health care services based on social determinants. In 2020, CMS has the opportunity to enable health plans to better serve beneficiaries by attending to their social determinants of health.

2. Expand V-BID to Part D for Integrated MA-PD Health Plans

CMS recognized the potential of V-BID strategies in Part C by recently reinterpreting the benefit uniformity requirements beginning in plan year 2019 but stopped short of enabling Medicare Advantage health plans to utilize the same V-BID flexibilities in Part D. Congress

should instruct CMS to leverage the success of V-BID strategies in Part D, particularly for integrated MA-PD health plans. V-BID has the potential to realize billions in cost savings, while improving treatment and outcomes, particularly for beneficiaries with multiple chronic conditions. Expanding V-BID to Part D for MA-PD health plans has the potential to realize cost savings for consumers, while improving quality across the health care system.

3. Ensure Star Rating System Incorporates Social Determinants

Congress should ensure CMS continues to evaluate whether adjustments to the Star Rating System for social risk factors are appropriate and effective. Research has suggested that the Star Rating System does not accurately reflect the quality of care delivered by health plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees.⁶⁵ To begin addressing this issue, in 2017 CMS implemented the CAI, an interim adjustment to overall and summary scores for dual-eligible, low-income, and disabled beneficiaries for certain Star Rating measures. CMS should continue to monitor and adjust the CAI to ensure the Star Rating System accurately incorporates needs based on social determinants of health.

4. Evaluate Social Determinants in Risk Adjustment

Congress should ensure CMS continues to evaluate whether additional conditions or social determinants of health meet the requirements to be included in the risk adjustment model for future payment years. There are six main beneficiary subgroups in the community risk model, including individuals eligible for both Medicare and Medicaid, called dual-eligible beneficiaries. The community risk model adjusts health plan payment for dual-eligible beneficiaries. In recent years, CMS has found that the current risk model underpays Medicare Advantage health plans for dual-eligible beneficiaries. It's critical that the risk adjustment model is accurate and ensures that payments to Medicare Advantage health plans adequately anticipate the costs of treating and managing both high- and low-cost individuals.

5. Ensure Adequate Stable Payment in Medicare Advantage

Medicare Advantage's financial framework of risk-adjusted capitated payment enables an integrated care delivery system designed to address the needs of beneficiaries, including the focus on primary care, early intervention, care management and care coordination, particularly for those with multiple chronic conditions. Medicare Advantage plans and risk-assuming providers are able to invest in care strategies that are patient-centered and that encourage outpatient visits, patient engagement and care in the home. In addition, the increasing flexibility in Medicare Advantage better enables plans, providers and community partners to address social risk factors. To ensure that investment in innovation in care delivery continues, particularly to meet the needs that result from social determinants of health described in this paper, Medicare Advantage requires stable and adequate payment rates.

Conclusion

Medicare Advantage is leading the way in addressing social determinants of health. Health plans are focusing on effective care management and innovative ways to meet patients' clinical and social needs, to improve health outcomes at lower costs, resulting in improved overall quality of life for beneficiaries. CMS is eliminating barriers to flexible benefit design and transforming supplemental benefits to include additional social supports and services, ultimately bridging broader health needs with clinical care to create the opportunity for a more holistic approach to health care for Medicare Advantage beneficiaries. CMS is also working to account for social determinants of health in the calculation of risk scores and Star Ratings, a major step towards a more holistic health care system.

As a result, this is a critical moment for Medicare Advantage, as health plans develop new innovations to attend to the social risk factors in the population of seniors and people with disabilities they care for. As Medicare Advantage continues to grow, it will be crucial that value-based payment arrangements, the Star Rating System, risk adjustment, care management, and flexible benefit design are optimized to address beneficiaries' social risk factors. It is essential that payments to health plans are both adequate and accurate by accounting for clinical and social determinants of health to ensure high quality, effective care for high-need enrollees. This will ensure resources are available to address social risk factors and will yield high-quality outcomes at a lower cost, particularly for chronically ill beneficiaries.

Health care alone cannot address all the social determinants of health that impact patient's outcomes. Yet, health care is a significant part of the solution. As evidence above shows, Medicare Advantage health plans, providers and community partners are working effectively to build healthier lives for Medicare beneficiaries. Greater attention to social determinants of health in Medicare Advantage can save money and improve health status and serve as an example for the entire U.S. health care system.

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