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ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN FEDERAL HEALTH COVERAGE PROGRAMS

I. INTRODUCTION

This brief provides an overview of the Department of Health and Human Services' (HHS) growing recognition of social determinants of health as an important tool to address population health and bring down costs in federal health coverage programs.

We begin with a discussion of how the concept of social determinants of health came to inform innovations in key health coverage programs and examine the definition adopted by HHS (section II). Next, in section III, we provide an overview of the existing opportunities through which the federal government and states are able to positively impact social determinants of health factors for beneficiaries enrolled in Medicare fee-for-service (FFS); Medicare Advantage (MA); Medicaid and the Children's Health Insurance Program (CHIP); as well as through Centers for Medicare and Medicaid Innovation (CMMI) pilot projects. Finally, we outline what's on the horizon by looking ahead to potential regulatory levers the Trump Administration may use to either advance or, arguably in some cases, diminish social determinants of health factors in federal coverage programs (section IV).

II. BACKGROUND

A. Evolution of Social Determinants of Health in Federal Coverage Programs

Passage of the Affordable Care Act (ACA) in 2010 spurred widespread adoption of incentivized pay-for-performance programs. However, stakeholders ultimately raised concerns that the quality measures implemented under these programs failed to adequately adjust for patient-related social risk factors affecting health outcomes. This was especially a point of contention for many providers disproportionately serving socially vulnerable populations (e.g., dual-eligible individuals), including safety-net hospitals adversely penalized under the the new quality programs or in the Star Ratings rubric – the latter of which is undergoing revisions following forthcoming input from a technical expert panel (TEP).[1]

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act, signed into law in October 2014, mandated that HHS study the effects of socioeconomic status (SES) on health.[2] Pursuant to the law, HHS' Assistant Secretary for Planning Evaluation (ASPE) contracted with the National Academy of Medicine

[1] https://www.modernhealthcare.com/safety-quality/cms-wont-update-hospital-star-ratings-until-expert-panel-review
[2] https://www.congress.gov/bill/113th-congress/house-bill/4994

(NAM) to produce a five-part consensus report series evaluating methods to account for social risk factors in Medicare payment programs. During the 15-month endeavor culminating in early 2017, NAM developed a definition of SES that encompassed five social risk factors shown to impact health outcomes: socioeconomic position; race, ethnicity, and culture; gender; social relationships; and residential and community context.[3]

Separately, HHS commissioned a report from the National Quality Forum (NQF) on how provider performance might be more accurately reflected when risk-adjusted for SES factors. The agency undertook a two-year trial period (April 2015-April 2017) during which it considered risk adjustment for 303 measures, 17 of which were ultimately endorsed. Work continues today on a second, three-year trial period that will conclude in 2021.[4]

In recent years, as the health system continues to evolve toward value-based arrangements and stakeholders grow increasingly concerned with cost, the focus on SES has grown beyond the need to simply quantify and risk-adjust for such factors in the context of provider payment. Payers and providers are increasingly interested in how the health system might positively impact SES-related factors that have served as barriers to healthy living for individuals.

With this shift in thinking, came the popularization within federal health policy of the concept of social determinants of health from the public health field. Already used broadly in global health initiatives – such as the World Health Organization's (WHO) Commission on Social Determinants of Health established in 2005[5] – HHS most prominently adopted a focus on social determinants of health for domestic health programs as part of its Healthy People 2020 initiative, as discussed below, and has begun to integrate this focus into its major health coverage programs.

B. Definition and Key Factors

HHS, through its Healthy People 2020 initiative, established a "place-based" (e.g., neighborhood, school, work) social determinants of health framework to improve population health outcomes, including addressing equity gaps.

Social determinants of health are defined as the "conditions (e.g., social, economic and physical) in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[6] These factors include access to safe, affordable housing; quality education and job training; availability of social supports; access to transportation and more.[7] The five pillars, or determinant areas, of the HHS social determinants of health framework follow (Exhibit 1).

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[3] http://www.nationalacademies.org/hmd/Reports/2016/Accounting-for-Social-Risk-Factors-in-Medicare-Payment.aspx
[4] https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=87811
[5] https://www.who.int/social_determinants/thecommission/en/
[6] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[7] Ibid.

Exhibit 1: Healthy People 2020 Social Determinants of Health Framework

Source: HHS, Healthy People 2020

While these factors profoundly shape the health of individuals and communities – especially in terms of overall access to and utilization of health care – they have not typically been assessed in clinical care settings, as NAM points out.[8] Further, racial and ethnic minorities are disproportionately impacted by these factors, thus propelling the need to address these factors in the context of a national health equity agenda.[9]

III. CURRENT OPPORTUNITIES TO ADDRESS SOCIAL DETERMINANTS IN FEDERAL COVERAGE PROGRAMS

A. Medicare FFS

Since the issuance of the NAM reports, CMS continues to implement key IMPACT Act-driven provisions that call for new quality measures to assess social determinants of health among certain post-acute care providers, consistent with the broader Healthy 2020 objectives.

For example, in the Fiscal Year (FY) 2020 long-term care hospital (LTCH) prospective payment system (PPS) proposed rule, CMS proposes to collect as part of the standardized patient assessment data elements (SPADEs) the following seven social determinants of health: race; ethnicity; preferred language; interpreter services; health literacy; transportation; and social isolation.[10] Similarly, in the FY 2020 inpatient

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5253326/
[9] https://www.cms.gov/blog/actively-addressing-social-determinants-health-will-help-us-achieve-health-equity
[10] https://www.govinfo.gov/content/pkg/FR-2019-05-03/pdf/2019-08330.pdf

rehabilitation facility (IRF) PPS proposal, CMS proposes to collect the same seven SPADE data elements on social determinants of health for data reporting under the FY 2022 IRF Quality Reporting Program (QRP).[11]

In a speech last November, HHS Secretary Alex Azar highlighted the administration's interest in addressing social determinants of health in Medicare broadly. However, a predominant focus of the Secretary's remarks was on MA where plans are arguably more incentivized (and inherently structured based on a capitated payment model) to offer benefits aligned with social determinants of health. The same logic holds true for CMS' section 1115A waiver authority via CMMI pilot projects. Both MA and CMMI pilot projects are addressed in the following passages.

B. Medicare Advantage

Recent authorities pursuant to the Bipartisan Budget Act of 2018 (BBA) harness the MA program's inherently more flexible benefit structure to advance new social determinants of health policies. In guidance issued last spring, CMS outlined broad discretion to MA plans to implement special supplemental benefits for chronically-ill (SSBCI) enrollees, including supplemental benefits "that are not primarily health related" and that may be offered non-uniformly to eligible enrollees beginning in CY 2020. CMS provided a (non-exhaustive) list of examples of non-primarily health related SSBCI (see Table 1).[12]

Table 1: (Non-Exhaustive) Examples of Non-Primarily Health Related SSBCI for MA Plans

meals (beyond a limited basis), as well as food and produce	general supports for living (e.g., rent or assisted living community subsidies, electric/gas/water subsidies)	transportation for non-medical needs
pest control	indoor air quality equipment and supplies	social needs benefits (e.g., park passes, family counseling, etc.)
complementary therapies (to be offered alongside traditional medical treatment and consistent with a practitioner's state scope of practice requirements)	services supporting self-direction (e.g., interpreter services)	structural home modifications (e.g., widening of hallways or doorways and permanent mobility ramps)

Source: CMS Guidance to MA Plans (April 24, 2019)

Further, in a recent report, ASPE noted that while dually-enrolled beneficiaries are less likely to be enrolled in high-performing MA plans (based on the MA Star Ratings metric) than their non dually-enrolled counterparts, there are some valuable lessons from high-performing MA plans serving a high proportion of dually-enrolled beneficiaries. ASPE concluded that successful strategies entailed a comprehensive

[11] https://www.govinfo.gov/content/pkg/FR-2019-04-24/pdf/2019-07885.pdf
[12] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

approach to serving clinical and non-clinical needs (such as housing, transportation and meals). ASPE noted that the insights from the report may help to inform broader CMS policies in this vein.[13]

C. Medicaid and CHIP

Medicaid and CHIP are critical programs in which to address social determinants of health, given that the low-income population enrolled in these programs face a higher incidence of unsafe or unstable housing, poor nutrition, chronic disease, unemployment, or violence and trauma in their backgrounds.[14]Additionally, given the joint nature of program administration, states have a great deal of flexibility and discretion over how they might design and implement interventions for each of these challenges.

Specifically, states have the ability to implement various optional benefits within their programs, beyond the basic benefit package mandated by federal law, by seeking approval from CMS for a state plan amendment (SPA) or for one of several types of waivers, or by incentivizing certain benefit design in managed care. Three quarters of Medicaid enrollees and nine out of 10 children in Medicaid are enrolled at least partially in a managed care arrangement. Therefore, many states have looked to their contracting with managed care organizations (MCOs) to push for coverage of additive benefits.[15] For example, states may alter MCO payments based on certain desired outcomes, such as reductions in maternal mortality or improvements in blood lead level screening for children facing environmental threats to their health.[16]

States may exercise their authority under their state plan to cover case management services and link beneficiaries to services that address their other needs.[17] States, such as Louisiana, have secured section 1915(c) Home and Community Based Services (HCBS) waivers to help secure housing or to provide home delivered meals to seniors and people with disabilities who have a long-term care services plan.[18] Many states have also used section 1115 waivers to test certain interventions, such proposals by Washington State and Hawaii to link beneficiaries to housing supports, moving assistance, and tenant responsibility training, etc.[19]

Section 1115 waivers, however, have often been used in recent years to remove certain benefits from Medicaid populations. Since the expansion of Medicaid to the new adult group, some states have sought to control costs in their larger programs by stripping what would normally be considered a mandated benefit from the newly eligible population. This has included waiving the requirement to provide non-emergency medical transportation (NEMT) to beneficiaries who cannot travel to access care, or waiving retroactive eligibility, among a slew of other eligibility limitations and lock-out provisions.[20] One waiver model championed by the Trump Administration has tied the provision of Medicaid coverage to 80 or more hours of work or engagement per month as a condition of eligibility. Though administration officials argue that

[13] https://aspe.hhs.gov/system/files/pdf/259896/MAStudy_Phase2_RR2634-final.pdf
[14] https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html
[15] https://ccf.georgetown.edu/wp-content/uploads/2018/02/Leveraging-Medicaid.pdf
[16] Ibid.
[17] Ibid.
[18] https://www.aha.org/system/files/2019-01/medicaid-financing-interventions-that-address-social-determinants-of-health.pdf
[19] Ibid.
[20] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

employment is among the "determinants of health" in its waiver guidance, these types of interventions create more barriers to care rather than breaking them down.[21]

On a related front, the Trump Administration has signaled that it plans to issue a proposed rule that would provide states with greater flexibility with regards to the provision of NEMT, presumably beyond what they are currently able to accomplish for the new adult group only. There is no guarantee that such a rule will move forward, though HHS has targeted December 2021 as a potential release date.[22]

D. CMMI Demonstrations

CMS, via CMMI, is able to test new approaches for addressing social determinants of health through the advancement of new alternative payment and care delivery models. It is able to do so through wide-reaching authority granted by the ACA, which allows CMS to waive certain Medicare or Medicaid requirements in the testing of new models.[23]

Addressing beneficiaries' social determinants of health comes largely through the care coordination platforms of many Innovation Center demonstrations. For example, the Comprehensive Primary Care Plus (CPC+) model[24] encourages (and, in some cases requires)[25] primary care practices to screen patients for health-related social risk factors upon intake and to create linkages to community-based organizations that can address any identified needs.

Moreover, the Accountable Health Communities (AHC) model seeks to link Medicare and Medicaid beneficiaries to health-related social services to address needs such as food insecurity or unstable housing.[26] Model participants identify beneficiary needs through screening for social needs; refer beneficiaries to appropriate community-based services; and assist beneficiaries in navigating these services.

Last, several upcoming demonstrations will also emphasize integrated care models that address the physical, behavioral, and social needs of at-risk subpopulations, including the Integrated Care for Kids (InCK) model,[27] the Maternal Opioid Misuse (MOM) Model,[28] and the Primary Cares Initiative (which builds upon CPC+).[29]

[21] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf
[22] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=0938-AT81
[23] https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[24] https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
[25] https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf
[26] https://innovation.cms.gov/initiatives/ahcm/
[27] https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/
[28] https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/
[29] https://www.cms.gov/newsroom/press-releases/hhs-news-hhs-deliver-value-based-transformation-primary-care

IV. POTENTIAL OPPORTUNITIES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH IN FEDERAL COVERAGE PROGRAMS

A. Administration's Signaling

The Trump Administration has foreshadowed its vision on how to more fully address social determinants of health. As noted above, last November, HHS Secretary Azar indicated that CMS is preparing to place greater emphasis on funding services that address the social determinants of health through CMMI. In his speech, Secretary Azar suggested that health care providers have the flexibility to go "beyond connections and referrals," and should be able to more directly aid beneficiaries struggling with issues related to housing, nutrition, and other social needs.[30] CMS Administrator Seema Verma also spoke to the administration's plans for social determinants, stating that the agency had spent a year developing "a new cadre of models" with built-in incentives to address such issues.[31]

While some of the models to which the administration alluded have been announced – including the suite of new primary care models, kidney care models,[32,33] and the proposed radiation oncology model[34] – CMMI is reportedly targeting models focused on "other serious illnesses," indicating that further models accounting for social determinants may still be under development.

B. Potential Regulatory Vehicles

While CMMI has broad authority to bypass existing regulations, the remainder of the health care system is beholden to rules that hinder more coordinated, value-based care. Foremost among such regulations are those that prohibit providers from furnishing goods and services to patients in exchange for additional business. Known as the federal anti-kickback statute[35] and rules around beneficiary inducements,[36] these regulations were established to prevent fraud and abuse in federal programs at a time before health care providers were seen as able to address patients' social needs.

Now, however, as providers continue to explore care delivery models that account for the social determinants of health, stakeholders are finding these regulations inhibit the health care system from more robustly treating patients' broader needs. For example, providing nutritious meals to patients or transportation services may be considered illegal under these rules, thereby preventing providers from fully delivering a holistic patient care model. Moreover, beneficiary inducement laws prevent providers from distributing tablets, Fitbits, or other smart, health-related technologies.

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[30] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html
[31] https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-2019-cms-quality-conference
[32] https://www.cms.gov/newsroom/fact-sheets/kidney-care-first-kcf-and-comprehensive-kidney-care-contracting-ckcc-models
[33] https://www.cms.gov/newsroom/fact-sheets/proposed-end-stage-renal-disease-treatment-choices-etc-mandatory-model
[34] https://www.cms.gov/newsroom/fact-sheets/proposed-radiation-oncology-ro-model
[35] https://www.law.cornell.edu/uscode/text/42/1320a-7b
[36] https://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf

Upcoming regulation may seek to amend these rules, however. According to the administration's spring 2019 regulatory agenda, HHS plans to propose a spate of rules that could serve to improve providers' ability to address social determinants. One such rule – referred to as "Revisions to the Safe Harbors under the Anti-Kickback Statute and Beneficiary Inducements Civil Monetary Penalties Rules Regarding Beneficiary Inducement" – seeks to amend both the federal anti-kickback statute and rules regarding beneficiary inducements in order to promote more coordinated care.[37]

Other potential adjustments may come by way of modifications to the physician self-referral rules as well, which may widen providers' abilities to refer patients to affiliated organizations that can address social needs.[38] Finally, as discussed above, CMS also has in the regulatory pipeline a proposal delineating changes to the Medicaid rules governing states' abilities to provide NEMT to beneficiaries when they are otherwise unable to access care – a proposal that, depending on the construct, may ultimately hinder beneficiaries' access to care (e.g., if NEMT requirements of states are diminished).[39]

V. CONCLUSION

Overall, federal health coverage programs have advanced toward a greater recognition of social determinants of health over the past decade – via expanded non-clinical benefit offerings, meaningful quality measures and the like. However, there are still some program facets, particularly in Medicaid, where some contend there have been notable setbacks, such as with the imposition of Medicaid work requirement waivers and resulting coverage impediments.

As HHS continues along a trajectory of advancing value-based payment, opportunities persist to expand the Department's focus on addressing non-health care needs that ultimately impact individuals' overall health and the total cost of care. States, through innovative Medicaid waiver initiatives, and CMS, via its flexible MA program authority and CMMI demonstrations, have recently expanded their foothold in the non-health care arena. However, there is more work to do on this front, particularly in traditional Medicare, outside of the PAC-focused social determinants of health reforms to-date.

[37] https://reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=0936-AA10
[38] https://reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=0938-AT64
[39] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=0938-AT81