Perspectives on Opportunities and Challenges for Medicare Advantage Plans to Address Social Determinants of Health via the CHRONIC Care Act

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Abstract
There is increasing recognition of the role of social determinants of health (SDOH) in the ability of Medicare Advantage (MA) enrollees to obtain needed care. The 2018 CHRONIC Care Act established Special Supplemental Benefits for the Chronically Ill (SSBCI), which for the first time gives MA plans the flexibility to provide supplemental benefits to enrollees to address SDOH. Given the role of SDOH in chronic disease, this represents an opportunity for MA plans to address underlying issues not strictly health care related with which MA enrollees struggle and that affect their overall health. MA plans have experimented with different approaches to address SDOH but have been limited by the lack of ability to offer services as part of covered benefits and reliance on partnerships, grants, and other funding sources to support the provision of these services. The effect of this policy and how it may evolve before implementation begins in 2020 remains uncertain as we wait to see how MA plans will interpret eligibility criteria and services offered without any additional allotted funding.

Keywords
medicare part C, Medicare, social determinants of health, health care disparities, insurance, benefits

Social determinants of health (SDOH), which reflect individuals' economic and social opportunities and resources, are increasingly recognized by health care providers, payers, and policymakers as key factors related to health outcomes.1,2 Medicare beneficiaries with greater social risk, which includes racial/ethnic minorities and those dually enrolled in Medicare and Medicaid, receive lower quality of care and have higher spending and hospital readmissions,2,3 with similarly poor outcomes observed for health outcomes and quality of care among beneficiaries in Medicare Advantage (MA) plans with greater social risk.4,5 Despite the potential health benefits and cost savings of addressing SDOH, historically Medicare did not pay for supplemental benefits that did not result in a direct medical cost and MA plans were not allowed to offer services that were not available to all plan enrollees (known as the “uniformity requirement”). However, beginning in 2020, MA

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plans will be able to use supplemental benefits to pay for services related to SDOH for beneficiaries with chronic conditions.

Signed into law as part of the Bipartisan Budget Act (BBA) of 2018 (Public Law No. 115-123), the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act nudges MA plans in the direction of delivering personalized value-based care by increasing the flexibility of MA plans to use supplemental benefits to pay for services thought to improve the overall health of beneficiaries with chronic conditions (termed Special Supplemental Benefits for the Chronically Ill [SSBCI]). In contrast to previous requirements for supplemental benefits, the uniformity requirement is waived and SSBCIs do not need to be primarily health related, but rather, as noted in the CHRONIC Care Act, SSBCIs must have a “reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.” The law broadly defines enrollees eligible for these services as those who have all of the following criteria: (1) have “one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee,” (2) have a “high risk of hospitalization or other adverse health outcomes,” and (3) require “intensive care coordination.”

Many MA beneficiaries are likely to be eligible for SSBCIs, as recent analysis suggests that greater than 90% of MA beneficiaries have one or more chronic conditions and nearly half of MA beneficiaries (43.6%) have difficulty with one or more activities of daily living (ADL). Through the 2020 Call Letter, the Centers for Medicare and Medicaid Services (CMS) sought comments from stakeholders on specific implementation questions for SSBCI related to (1) eligibility for the benefits, including (a) whether plans should have discretion in what is considered a chronic condition; (b) whether plans should have flexibility in how enrollees with chronic conditions are identified; and (c) whether financial need and other factors should be considered as part of the SSBCI eligibility criteria, as well as (2) limits on the scope of supplemental benefits. Comments from various stakeholders highlight interest in opportunities for expanding the potential impact of the law to address SDOH.

**SSBCI Eligibility**

Although the majority of comments received by CMS supported using the list of chronic conditions that identifies who can enroll in a chronic condition special needs plan to determine who is eligible for the SSBCI, some stakeholders supported a broader interpretation of eligibility that is standardized across MA plans and would include the use of functional status measures in order to prevent/slow decline in function among enrollees. While restricting SSBCIs to MA enrollees with diagnosed chronic conditions misses the opportunity to address SDOH early before negative health impacts are realized, almost three quarters of MA enrollees have at least one of the specific chronic conditions and therefore will be eligible for SSBCI. Furthermore, beneficiaries dually enrolled in both Medicare and Medicaid are most likely to benefit from SSBCIs, as dual-enrollees are more likely than Medicare enrollees to be disabled and have multiple chronic conditions. Dually enrolled beneficiaries are also more socially frail being much more likely than non-duals to live below poverty the federal poverty level, not have a high school diploma, live on their own or in an institution and experience limitations in ADLs, presenting opportunities to address SDOH among those most in need. Once some implementation experience is gained by MA plans, CMS intends to convene a technical advisory panel to update the list of chronic conditions eligible for SSBCIs by 2021.

Stakeholders did not support means testing as part of eligibility for SSBCI, but some supported consideration of financial need as part of eligibility criteria. A narrower definition of SSBCI eligibility that includes financial need may allow MA plans to direct resources to enrollees most likely to benefit from SSBCIs. Furthermore, some stakeholders supported expanding services to beneficiaries enrolled in traditional Medicare.

**Scope of Benefits**

CMS provided examples of potential SSBCIs in the draft call letter, including home-delivered meals and groceries and transportation for non-medical needs. In the final call letter, the list of examples was expanded to include “pest control, indoor air quality equipment and services, and benefits to address social needs.” Housing support, an intervention a small number of MA plans have successfully piloted, was not specifically mentioned; however, a restriction on capital or structural improvement to homes, such as permanent ramps and widening of doorways, was removed from the final call letter. Based on public comments, stakeholders generally supported the broad interpretation of services that would be appropriate for SSBCI. The final call letter established the ability of MA plans to contract with community-based organizations to provide covered SSBCIs.

The effect of the CHRONIC Care Act remains uncertain as we wait to see how eligibility criteria and services offered as SSBCI will be interpreted and implemented by MA plans. Prior to the law, some MA plans reported directly addressing SDOH—although efforts were limited as MA plans reported challenges to funding these efforts and often relied on grants and partnerships. Examples of innovative efforts by MA plans to address SDOH include housing placements to address homelessness; meal delivery; in-home visits and risk assessments; 24/7 access to providers via phone or Internet; provision of tablets with health education and wellness applications; and transportation to meetings to promote sobriety.
Because the law provides no additional monies, MA plans will need to be innovative and closely evaluate potential return on investment (ROI) for SSBCIs provided. Few studies have examined the effects of addressing SDOH on the health of MA beneficiaries, likely due to the fact that these services are not widespread. An evaluation of a partnership between an MA plan and a meal-delivery program found reductions in ED visits and inpatient admissions among recipients of tailored meals over 6 months compared to a matched control group.\textsuperscript{19} Additionally, studies of community-based organizations efforts to address food insecurity and affordable housing have found reductions in ED visits and hospital use, respectively, among Medicare beneficiaries.\textsuperscript{20,21} Less is known about ROI. Evidence from a case study indicates that for one MA plan, a housing stability program led to savings of up to $500 per participant per year due to reductions in unplanned utilization.\textsuperscript{17} Among traditional Medicare beneficiaries, a home-visiting program that focused on extending independent living of low-income adults led to quarterly cost savings of $2765 per participant, over a 2-year period.\textsuperscript{22} To help plans and community partners plan and evaluate partnerships to address SDOH, the Commonwealth Fund recently released a ROI calculator,\textsuperscript{23} which MA plans and community partners may find to be a helpful resource to evaluate partnerships and strategies to address SDOH.

The CHRONIC Care Act represents an important opportunity for CMS and for MA plans to offer personalized services and address SDOH. MA plans will now have the flexibility to offer a broader range of services likely to improve health and also to contract with community-based organizations, which should lead to improvements in coordination with community-based organizations and other entities providing non-medical services. As MA plans design and implement SSBCIs, it will be important to track their successes and challenges to inform future actions to address SDOH.

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