INQUIRY: The Journal of Health Care Organization, Provision, and Financing
Volume 56: 1–4

DOI: 10.1177/0046958019862120
journals.sagepub.com/home/inq
SAGE

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

Melony E. Sorbero, PhD[1] and Ashley M. Kranz, PhD[2]

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

What do we already know about this topic?
Very little; we do not know how Medicare Advantage plans will implement Special Supplemental Benefits for the Chronically Ill and whether it will be used to address social determinants of health.
How does your research contribute to the field?
We summarize a portion of recent legislation that is related to supplemental benefits for Medicare Advantage enrollees with chronic illnesses and discuss how the supplemental benefits could be used to address social determinant of health.
What are your research's implications toward theory, practice, or policy?
Medicare Advantage plans could use Special Supplemental Benefits for the Chronically Ill as a mechanism to address social determinants of health.

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,[2-5] with similarly poor outcomes observed for health outcomes and quality of care among beneficiaries in Medicare Advantage (MA) plans with greater social risk.[6-8] 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

[1]RAND Corporation, Pittsburgh, PA, USA
[2]RAND Corporation, Arlington, VA, USA

Received 2 April 2019; revised 24 May 2019; revised manuscript accepted 31 May 2019

Corresponding Author:
Melony E. Sorbero, RAND Corporation, 4570 Fifth Avenue, Suite 600, Pittsburgh, PA 15213, USA.
Email: msorbero@rand.org

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."[9] 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 nearly of MA beneficiaries (43.6%) have difficulty with one or more activities of daily living (ADL).[10]

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.[9] 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,[11] 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.[12-14] 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.[11] 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.[10] Dually enrolled beneficiaries are also more socially frail being much more likely than nonduals 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.[10,15] 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.[11]

Stakeholders did not support means testing as part of eligibility for SSBCI,[12-14] 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.[12,16]

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."[11] Housing support, an intervention a small number of MA plans have successfully piloted,[17] 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.[17] 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.[17,18]

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.[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.[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.[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.[22] To help plans and community partners plan and evaluate partnerships to address SDOH, the Commonwealth Fund recently released a ROI calculator,[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 nonmedical 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.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Melony E. Sorbero https://orcid.org/0000-0001-9222-8798
Ashley M. Kranz https://orcid.org/0000-0003-0507-7800

References

1. Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annu Rev Public Health*. 2011;32:381-398.
2. Office of the Assistant Secretary for Planning and Evaluation. Report to congress: social risk factors and performance under Medicare's value-based payment programs. https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf. Published 2016. Accsesed May 20, 2019.
3. Meddings J, Reichert H, Smith SN, et al. The impact of disability and social determinants of health on condition-specific readmissions beyond Medicare risk adjustments: a cohort study. *J Gen Intern Med*. 2017;32(1):71-80.
4. Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. *JAMA*. 2011;305(7):675-681.
5. Johnston KJ, Joynt Maddox KE. The role of social, cognitive, and functional risk factors in Medicare spending for dual and nondual enrollees. *Health Aff (Millwood)*. 2019;38(4):569-576.
6. Ayanian JZ, Landon BE, Newhouse JP, Zaslavsky AM. Racial and ethnic disparities among enrollees in Medicare Advantage plans. *N Engl J Med*. 2014;371(24):2288-2297.
7. Sorbero ME, Paddock SM, Damberg CL, et al. Adjusting Medicare Advantage star ratings for socioeconomic status and disability. *Am J Manag Care*. 2018;24(9):e285-e291.
8. Breslau J, Elliott MN, Haviland AM, et al. Racial and ethnic differences in the attainment of behavioral health quality measures in Medicare Advantage plans. *Health Aff (Millwood)*. 2018;37(10):1685-1692.
9. Centers for Medicare & Medicaid Services. Advance notice of methodological changes for calendar year (CY) 2020 for Medicare Advantage (MA) capitation rates, part C and part D payment policies and 2020 draft call letter. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part2.pdf. Published January 30, 2019. Accessed March 31, 2019.
10. DuGoff EH, Buckingham W, Kind A, Chao S, Anderson G. *Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs*. New York, NY: Commonwealth Fund; 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/targeting-high-need-beneficiaries-medicare-advantage. Accessed May 22, 2019.
11. Centers for Medicare & Medicaid Services. Announcement of calendar year (CY) 2020 Medicare Advantage capitation rates and Medicare Advantage and part D payment policies and final call letter. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf. Published April 1, 2019. Accessed April 1, 2019.
12. Medicare Rights Center. Letter to CMS RE: advance notice of methodological changes for calendar year (CY) 2020 for Medicare Advantage (MA) capitation rates, part C and part D payment policies and 2020 call letter. http://medicarerights.org/pdf/2020-cms-call-letter-comments.pdf. Published March 1, 2019. Accessed March 31, 2019.
13. Center for Consumer Engagement in Health Innovation. Letter to CMS RE: advance notice of methodological changes for calendar year (CY) 2020 for Medicare Advantage (MA) capitation rates, part C and part D payment policies and 2020 draft call letter. https://www.communitycatalyst.org/resources/comment-letters/document/CCEHI-Comments-on-part-2-CMS-2020-Call-Letter_FINAL_03_01_19-1.pdf. Published March 1, 2019. Accessed March 31, 2019.

14. National Committee for Quality Assurance. NCQA comments on Medicare Advantage 2020 call letter. https://www.ncqa.org/comment-letter/ncqa-comments-on-medicare-advantage-2020-call-letter/. Published March 1, 2019. Accessed March 31, 2019.
15. Medicare Payment Advisory Commission. A data book: health care spending and the Medicare program. http://medpac.gov/docs/default-source/data-book/jun18_databookentirereport_sec.pdf?sfvrsn=0. Published June 2018. Accessed May 24, 2019.
16. Center for Medicare Advocacy. Center comments on 2020 Medicare parts C & D call letter. https://www.medicareadvocacy.org/center-comments-on-2020-medicare-parts-c-d-call-letter/. Published March 1, 2019. Accessed March 31, 2019.
17. Sorbero ME, Kranz AM, Bouskill KE, Ross R, Palimaru AI, Meyer A. *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans*. Santa Monica, CA: RAND Corporation; 2018.
18. Sorbero M, Lovejoy S, Kandrack R, Taylor EA, Bouskill K. *Types and Costs of Services for Dual Beneficiaries by Medicare Advantage Health Plans: An Environmental Scan*. Santa Monica, CA: RAND Corporation; 2018.
19. Berkowitz SA, Terranova J, Hill C, et al. Meal delivery programs reduce the use of costly health care in dually eligible Medicare and Medicaid beneficiaries. *Health Aff (Millwood)*. 2018;37(4):535-542.
20. Shan M, Gutman R, Dosa D, et al. A new data resource to examine meals on wheels clients' health care utilization and costs. *Med Care*. 2019;57(3):e15-e21.
21. Gusmano MK, Rodwin VG, Weisz D. Medicare beneficiaries living in housing with supportive services experienced lower hospital use than others. *Health Aff (Millwood)*. 2018;37(10):1562-1569.
22. Ruiz S, Snyder LP, Rotondo C, Cross-Barnet C, Colligan EM, Giuriceo K. Innovative home visit models associated with reductions in costs, hospitalizations, and emergency department use. *Health Aff (Millwood)*. 2017;36(3):425-432.
23. The Commonwealth Fund. High need high cost payments for social services calculator. https://www.commonwealthfund.org/publications/maps-and-interactives/2018/may/roi-calculator-assesses-risks-and-rewards-integrating. Published 2019. Accessed June 28, 2019.