Investing in Health:
Integrating Drivers of Health into Medicare and Medicaid Payment

I. The Charge

Secretary Becerra has pledged to "take a department-wide approach to the advancement of equity" including "examination of ways to address the social determinants of health." Health disparities exist independently from, but are substantially compounded by, drivers of health (DOH) – the socioeconomic, environmental and behavioral factors that drive 80 percent of health outcomes. Addressing DOH is central to efforts to improve health, advance health equity, and reduce healthcare costs.

Investing in Health: A Federal Action Plan outlines seven strategies to accelerate scalable, sustainable integration of drivers of health into the health care system. This brief is the first in a series of three which draws from the Federal Action Plan and subsequent discussions with state and federal policy makers and thought leaders describing specific policy changes that could be deployed by The Centers for Medicare & Medicaid Services (CMS) under existing authority within the next one to two years.

The focus of this document is on alignment of financial incentives to invest in health; subsequent documents will focus on development of new standards for health quality, utilization and outcomes measurement; and development of infrastructure, such as information exchange platforms and community-based social services networks, required to integrate DOH into the healthcare continuum.

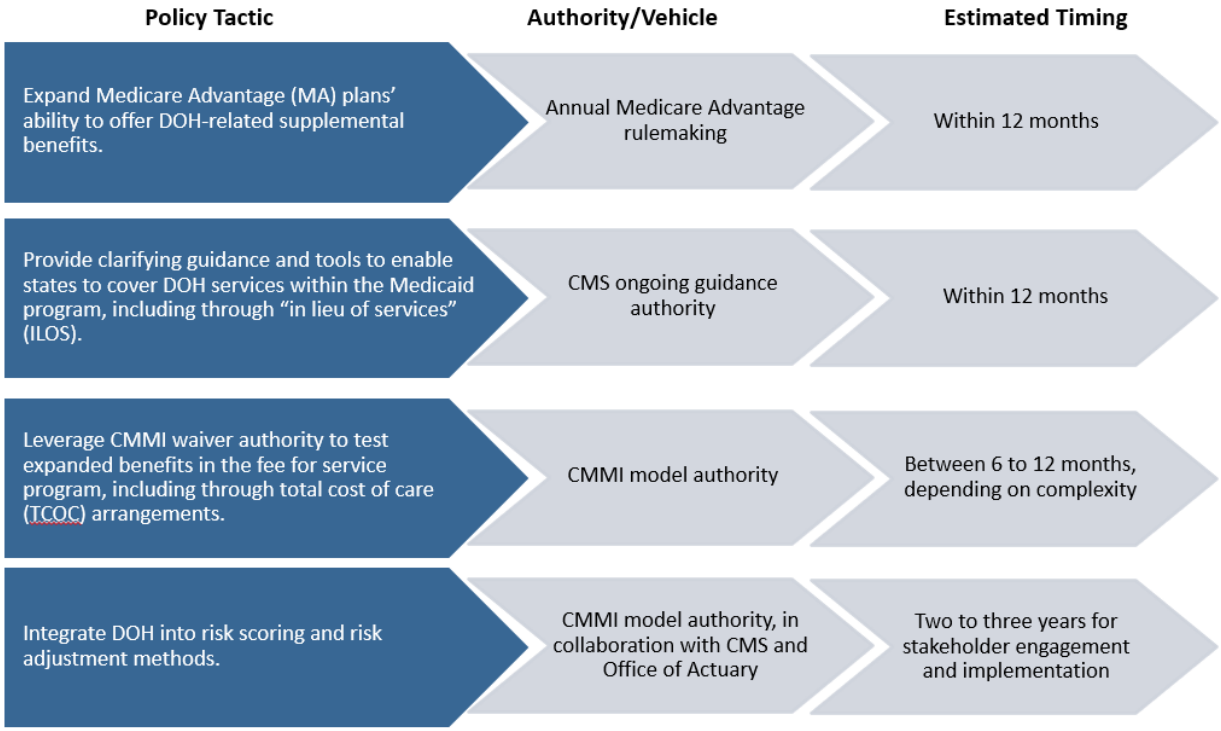
II. The Strategy: Alignment of Financial Incentives

Sustainable change requires realignment of financial incentives within our healthcare system, including what is reimbursed, what is rewarded, what "counts" as a health-related cost, and how payment rates are calculated for providers and health plans.

The transition towards financial integration of DOH is already underway. CMMI's Accountable Health Communities are now operating in 21 states. In recent years, CMS has given Medicare Advantage plans increasing flexibility to provide benefits to address DOH to targeted populations and released guidance to support states in addressing DOH in Medicaid and the Children's Health Insurance Program (CHIP). Virtually, every state in the nation includes contractual requirements related to DOH in their Medicaid Managed Care contracts; the Health Care Payment Learning and Action Network (HCP-LAN) identifies DOH as a core strategy area; and a recent survey of health systems identified 78 unique programs representing $2.5 billion in health system funds for interventions focused on housing, employment, education, food security, transportation and more.

Yet fully hardwiring DOH into healthcare reimbursement requires more. CMS can dramatically accelerate this transition and leapfrog barriers to meaningful change through implementation of the following high value policy changes. A more detailed description of each recommendation is provided in the last section of this document.

Recommendations for Integrating Drivers of Health into Medicare and Medicaid Payment



As CMS implements these initiatives, it is critical to:

- **Center on Equity.** A growing evidence base has established that addressing DOH can improve health outcomes and reduce health disparities, and do so more cost-effectively and equitably than medical interventions alone. At the same time, focusing on traditional measures of value-based care without addressing DOH and health equity may exacerbate access barriers and worsen racial disparities. Efforts to address DOH must be anchored in the broader effort to achieve health equity, with a focus on communities of color who are disproportionately impacted by DOH, and including reporting requirements stratified by race and ethnicity so that they may be evaluated and adapted to ensure they advance health equity goals.

- **Use available data to develop and improve payment models.** Public and private health and healthcare entities including NQF, NCQA, PCORI, ASPE, AHRQ, have begun to incorporate DOH into their national priority frameworks. Yet the nation still lacks standard DOH measure sets and reporting requirements, and where they do exist, they are not broadly deployed. Waiting for their scaled adoption leaves us stuck in an endless loop: we cannot tie DOH to reimbursement without measurement, but measurement will not proliferate without payment. Massachusetts's risk adjustment model illustrates that using available data to incorporate DOH into payment model is possible today *and* triggers increased reporting, allowing for further refinement of models over time.

- **Start with interventions with the greatest potential to achieve value, and build from there.** While DOH impact a broad range of consumers, to yield greatest impact, CMS should focus

initially on a defined set of DOH interventions that address the most prevalent individual and community DOH needs (especially in light of COVID-19), promote health equity and have a strong track record for efficacy. Potential high-priority DOH domains could include housing stability, food insecurity, and interpersonal safety and toxic stress. Within these domains, priority interventions should have a strong or emerging evidence base for reducing health disparities, improving health outcomes and/or cost-effectiveness; be inclusive of populations disproportionately impacted by DOH (e.g., communities of color, children, pregnant women, dual eligibles, individuals with behavioral health comorbidities); and allow for longer time horizons and account for "wrong pocket" savings that might otherwise disincentivize investment.

III. The Policy Changes

❖ Expand Medicare Advantage (MA) plans' ability to offer DOH-related supplemental benefits.

Recent policy changes afford MA plans greater flexibility to cover DOH services. In 2018, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act expanded the definition of health-related supplemental benefits that MA plans could offer (to support "daily maintenance of health") for people with serious chronic conditions. A 2019 CMS rule allowed MA plans to offer an even broader range of supplemental benefits, so long as benefits compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable ED visits. And in 2020, a subsequent rule changed the medical loss ratio (MLR) calculation to include all covered services—so long as they are recommended by a licensed healthcare provider—in the numerator, meaning that DOH supplemental benefits can be treated as service costs for purposes of the MLR calculation.

MA plans have responded, accelerating their focus on DOH benefits, with a particular focus on addressing food insecurity; 57% of MA plans will offer meals as a supplemental benefit in 2021, compared with 23% in 2018. Yet, significant limitations remain. CMS should expand MA plans' ability to offer DOH-related supplemental benefits in annual MA rulemaking to:

- Allow allocation of supplemental DOH benefits based solely on beneficiary's social need;
- Further broaden the types of DOH benefits allowed beyond those that are "primarily health related" by interpreting the term "supplemental health care benefits" to include all benefits with a plausible nexus to improving health or wellness, even if their primary purpose is to address DOH;
- Remove requirement that DOH benefits be recommended by a licensed medical professional as part of a health care plan; and
- Improve financial incentives for Medicare Advantage plans to offer DOH-related supplemental benefits, treating them as basic benefits for bid purposes through a CMMI model test.

Finally, plans have finite rebate dollars to spend on supplemental benefits, contingent on the plan bid being below the CMS benchmark. And because supplemental benefits are both a limited portion of medical spend and fragmented across plans, they are hard to link to specific outcomes. For these

reasons, it is critical that these changes happen in tandem with broader reforms in the Medicare fee for service and Medicaid programs.

❖ Provide clarifying guidance and tools to enable states to cover DOH services within the Medicaid program, including through "in lieu of services" (ILOS).

CMS recently issued guidance describing opportunities for state Medicaid and CHIP programs to better address DOH, including outlining legal authorities that permit the provision of DOH-related services for specific populations under Medicaid, along with examples of existing state initiatives. Some services can be covered under existing federal law as a standalone fee-for-service benefit or under the rubric of targeted case management (e.g. housing navigation); provided by Medicaid managed care plans under quality initiatives or as a value-added or in-lieu-of service (e.g. healthy food boxes); or offered through waiver (e.g. services not offered statewide). The recent CMS guidance reiterates previous guidance prohibiting the use of Medicaid funds to pay for room and board (defined as three meals a day or any other full nutritional regimen) except in certain medical institutions. CMS also has approved through North Carolina's 1115 waiver a set of evidence-based, high-value interventions addressing DOH.

CMS should:

- Build upon this guidance to create new templates and tools to assist states in leveraging this authority and to create greater clarity on the full range of services that can be made available under Medicaid;
- For services offered under managed care, create learning collaboratives and tools including model contract language to support states as they implement ILOS, DOH screening and navigation services, efforts to maximize enrollment in programs such as SNAP and WIC, and other mechanisms (value-added services, quality incentive payments, withholds, etc.), and rate-setting options in the Medicaid Managed Care rule to account for DOH-related services. ILOS offer particular promise as it is built into rate setting and thus addresses premium slide;
- For services offered via fee-for-service, create a State Plan Amendment (SPA) template for coverable services; and
- For services requiring a waiver, create an 1115 template for coverable services; develop tools to support states in monitoring and evaluating DOH 1115 demonstrations; and issue guidance clarifying that short-term posthospitalization, transitional housing can be covered under Medicaid.

❖ Leverage CMMI waiver authority to test expanded benefits in the fee for service program, including through total cost of care (TCOC) arrangements.

In CMMI's Comprehensive Primary Care Plus (CPC+) model, 94% of the 2,837 participating practices (serving 2.4 million Medicare beneficiaries) have implemented screening for unmet social needs. Under CMMI's Accountable Health Communities, which launched in 2016, ~1 million beneficiaries have been screened for health-related social needs (HRSN), with ~33% of beneficiaries screened having 1+ HRSNs. While these models have helped establish the prevalence of DOH among the Medicare population, they have lacked specific authority to pay for health-related interventions to address those needs. Through leveraging its waiver authority to launch integrated Medicaid/Medicare payment models that enable payment for health-related services to address DOH, CMMI can build on the evidence base for interventions that advance health equity, improve health, and/or reduce cost of care.

❖ Integrate DOH into risk scoring and risk adjustment methods.

There is growing pressure on CMS and the health care sector to incorporate social risk factors into risk adjustment models to more accurately predict cost and utilization, deliver better care to beneficiaries, and establish more precise cost benchmarks for advanced payment models (APMs) that go beyond hierarchical condition categories, disability, demographics and Medicaid status. Select states have pursued risk adjustment models that include social risk factors: Massachusetts' Medicaid, for example, includes variables such as unstable housing, disability diagnosis, relationships with other government agencies, and a neighborhood-level score (calculated for census data) that summarizes several measures of socioeconomic stress. The Minnesota Integrated Health Partnership's social risk adjustment methodology includes a set of social risk factor measures for children and for adults (e.g., homelessness, deep poverty, substance use disorder and/or serious mental illness diagnosis) that are used to enhance the medically based risk adjustment methodology obtained from administrative and claims data.

CMS should:

- Develop and test a risk adjustment model that incorporates patient-level DOH risk factors, leveraging CMMI model authority, in collaboration with CMS and Office of Actuary;
- Validate and implement for Medicare Advantage;
- Encourage states to implement the model in Medicaid Managed Care; and
- Explore use for Marketplace risk adjustment methodology.