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MA ruling may signal industry readiness to integrate SDH into traditional medical care

It has long been recognized that social determinants of health (SDH)—defined as the conditions in which people are born, live, work, and age—have an important impact on health outcomes.

In the United States, we have traditionally looked to "social services"—nutrition, housing, early childhood development, and transportation assistance, for example—to address challenges imposed by SDH. It follows, therefore, that effective social services can have as important an impact on health outcomes as the use of medical services.

The value of social services has been clearly shown in the work of the World Health Organization, the Robert Wood Johnson Foundation, and many others. But this demonstrated success has not been enough to elicit action toward integrating social services into the delivery of health care.

We may have seen the first glimmers of change in early April, however, with the issuance by the Centers for Medicare & Medicaid Services (CMS) of the final rule on 2019 Medicare Advantage (MA) capitation rates—although the effect of the change is limited to the one-third of the Medicare population enrolled in MA plans, the private plans available as alternatives to traditional fee-for-service Medicare. The CMS rule increases the national per capita growth rate for MA plans by 3.4 percent for 2019, but what may be more important over the long-term is the rule's expansion the definition of *primarily health-related* benefits, which circumscribes what insurers are allowed to include in MA policies as supplemental benefits.

New Benefits for the MA Population

CMS will start allowing MA plans to provide care and devices that prevent or treat illnesses, compensate for physical impairments, and reduce avoidable emergency care, along with the more traditional auxiliary Medicare program benefits offered in the past, such as hearing aids or eyeglasses. Although the new benefits still must be medically appropriate and recommended by a licensed provider, they can include supportive services such as rides to physician offices, better food choices, simple modifications to senior's homes to prevent injuries, and aides for personal care needs. The MA program is not the first to provide such support services. Some of these types of services have been available in health plans for seniors outside of Medicare, such as the United Mine Workers of America's combined benefits fund plans for retirees and the customized plans facilitated by California's Institute on Aging.

The changed benefits that will be allowed in the MA plans for 2019 will lay some groundwork for the implementation of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2018, which will go into effect in 2020. That act focuses on creating the results and outcomes necessary to improve chronic care and improve at-home care. Primary objectives are to provide MA plans with greater flexibility, increase options for accountable care organizations,

and expand telehealth availability. Although the recently issued MA rule moves in this direction, the rule implementing the CHRONIC Care Act, which should be released sometime in 2019, is expected to move even further by providing greater flexibility in the delivery of support services that enable individuals with chronic care to remain in their homes.

Different Benefits for Different Needs

The MA rules' allowance of additional flexibility in differentiating benefits for people with different conditions is generally regarded as an improvement over past policy, but many believe more needs to be done to recognize the differences in medical needs among people who have the same medical condition. For example, proponents for further change suggest that, in addition to allowing MA plans to offer different benefits for people with different medical conditions, MA plans also should be allowed to offer different benefits for people with different levels of fragility within the same medical condition.

Others have expressed concern that allowing MA plans to provide different benefits and treatments for people with different medical conditions only creates confusion in the marketplace by disrupting the current requirement of uniformity of benefits for all MA members within a given plan. The clear trade-off from such a disruption, however, is that allowing for differentiation of benefits enables the plans to better meet the needs of various groups of seniors.

Even with the changes that are currently being contemplated, Medicare will continue to remain primarily a disease-based program. Yet broader concepts of care are beginning to be introduced. Among the many questions likely to be raised, aside from concerns about confusion or market segmentation, is whether the change in benefits will help keep seniors from being hospitalized. Such a result not only would have favorable budgetary consequences but also would lower the complications from acquired infections or falls that are most likely to occur in hospitalizations involving more fragile populations.

A Role for Medicaid

The recent MA rule and the CHRONIC Care Act represent the early steps in recognizing that the needs of an aging population are not being well met through a program like Medicare, with its primary focus on acute care medical needs. In seeking a remedy for this deficiency, it may be useful to look at how CMS provides coverage for dual eligible beneficiaries—individuals who are eligible for both Medicare and Medicaid. In serving the very frail population that qualifies for both programs, CMS is able provide a combination of Medicare's acute care and Medicaid's long-term care benefits.

CMS's challenge in serving dual-eligible beneficiaries is that Medicare and Medicaid operate under different rules and regulations and different financing mechanisms. Medicare is a fully federal program and operates under rules and regulations at the federal level. Medicaid is primarily a state-run program with federal oversight, although since the ACA's passage, it has operated under greater federal control with less flexibility given to states in determining benefits to be offered and populations to be covered.

At a practical level, the challenge faced by any effort to fully integrate coverage for dual eligibles is that most of the integration efforts would need to occur locally, where the care is actually delivered, while most of the resultant savings would accrue to the federal government because it fully funds Medicare and largely funds Medicaid, especially in poorer states. Suggested solutions have included allowing Medicaid to run both Medicare and Medicaid for dual eligibles, or obtaining the federal government's consent to share more of any savings resulting from better integration.

Small Steps on an Big Journey

The provisions of the MA rule and the CHRONIC Care Act addressing SDH and social services represent first steps towards providing more integrated and comprehensive care to an increasingly aging population. More still needs to be done. ■

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