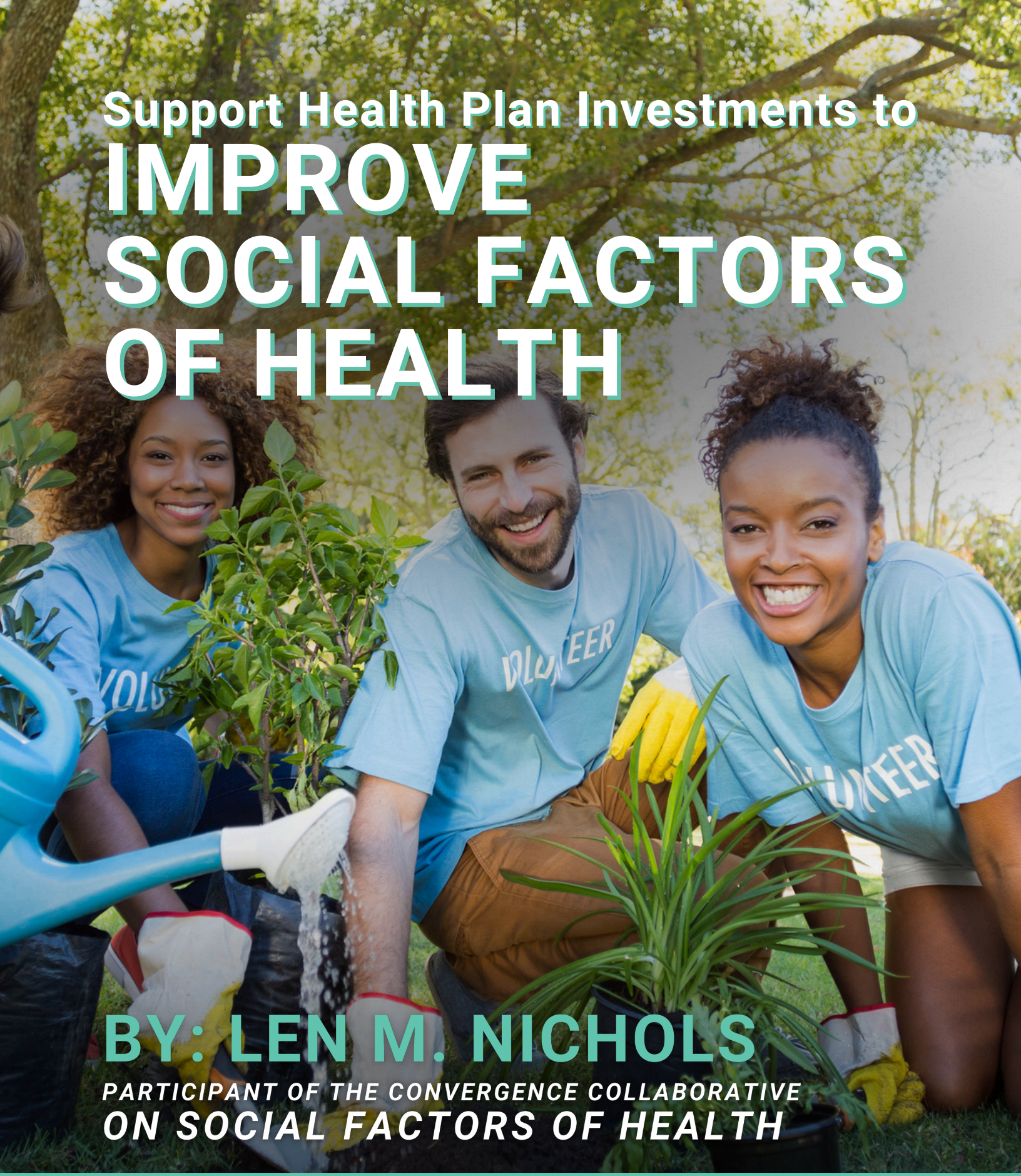
Support Health Plan Investments to

IMPROVE SOCIAL FACTORS OF HEALTH



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About the Author

Len M. Nichols, PhD., is a health economist with over 30 years' experience studying, writing, testifying, and communicating about the US health care system and various aspects of reform, including coverage, delivery system, payment, and social determinants of health. Since 2018 he has focused on rationales and mechanisms for financing investments in social factors upstream of the health care system. Recent publications can be found ***here***, ***here***, and ***here***. He is Professor Emeritus at George Mason University, a non-resident Fellow at the Urban Institute, and the President of NS Ideas, LLC, a health and social policy consulting firm he founded with his wife, Nora Super.

About the Memo

This memo is one of a collection commissioned by the Convergence Center for Policy Resolution as a supplement to ***Health Starts Here: A Blueprint for Action***, a report capturing consensus solutions of the ***Convergence Collaborative on Social Factors of Health***.

The memo represents the views of the author and do not represent the views of Convergence or necessarily the views of other Collaborative members.

About the Collaborative

It was to find such agreement that Convergence brought together a group of representative stakeholder organizations and experts from health and social policy organizations. Initially, in a series of three brainstorming sessions, the group sought to identify key themes and questions that would have to be explored to reach agreement. Then the group met as a working Convergence Collaborative over several months to identify an agreed set of policy actions, primarily at the federal and state levels. At these meetings, we also invited several "observers"—organizations and experts, including government officials, who contributed greatly to the discussion but for institutional reasons could not add their names or organizations to a policy statement.

These convenings were supported with generous financial support by **CommonSpirit Health**, the **Episcopal Health Foundation**, and **Kaiser Permanente**. Their commitment to the Convergence process of building consensus among people and organizations with different views and priorities made the project possible. We are also grateful to **UnitedHealth Group Office of Health Equity** for helping us to promote and implement the Collaborative's consensus solutions.

About Convergence

Convergence is the leading organization bridging divides to solve critical challenges through collaborative problem solving across ideological, political, and cultural lines. For more than a decade, Convergence has brought together leaders, doers, and experts to build trusting relationships, identify breakthrough solutions, and form unlikely alliances for constructive change on seemingly intractable issues. Our process is improving the lives of Americans and strengthening democracy for a more resilient and collaborative future.

CONSENSUS SOLUTIONS FROM HEALTH STARTS HERE BLUEPRINT

1 Clarify CMS Guidance

CMS should publish clear and consistent guidance for public and private health plans that explicitly specifies permissible non-clinical SDOH and HRSN services and supports, which may be included in MLR numerator calculations as wellness and health activities to improve health care quality. Appropriate spending on these services should be regarded as a quality improvement activity rather than an administrative cost, as it leads to measurable improvements in health outcomes and reduced health disparities. The guidance should:

- Distinguish and provide context regarding impermissible "general utility" services and supports, which CMS excludes for purposes of the MLR numerator.
- Include as permissible activities to improve health care quality: community health workers; HRSN screenings; and navigation, referral, and coordination of services, non-claims enrollee outreach activity expenses, and food as medicine/ nutrition security initiatives such as produce prescriptions and other initiatives designed to address SDOH and HRSN to promote holistic, beneficiary-centered care.
- Include as permissible activities: costs of evidence-based interventions that offset social service barriers to care, such as investments in CBOs that support value-based payments. For example, recent legislation in Texas permits Medicaid MCOs in the state's STAR program to include such services as quality improvement costs.

2 Protect and Broaden Funding for Quality Improvement Activities (QIA)

Congress should not cap or otherwise limit allowable "activities that improve health care quality" in 45 CFR § 158.150(b) and are not excluded under 45 CFR § 158.150(c) in calculating the MLR.

3 Convene stakeholders regularly to update QIA

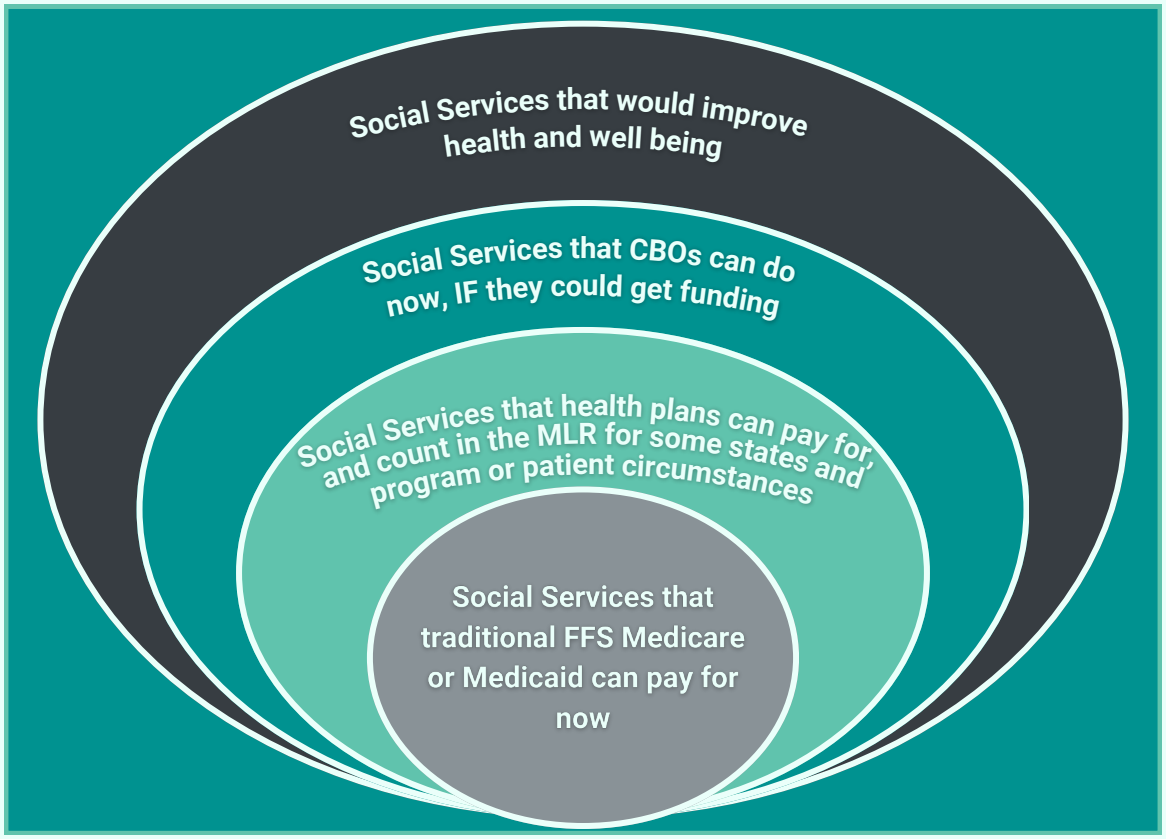
CMS should convene "state of the evidence" conferences with the intent of reaching three outcomes:

- A robust set of social service billing codes which are applicable to all public and private payors for wellness and health activities to improve health care quality;
- A strategy-to-action framework to align across public and private payors the criteria for permissible payments of public funds for innovative, not-specifically-billable SDOH/HRSN approaches, and;
- Further development of the Accountable Care Organization Investment Model and the AHEAD Model and drive innovation with expansion to community care hubs. Payment for identified wellness and health activities to improve health care quality should be permissible costs included in the MLR numerator.

If CMS determines that statutory language changes are necessary to enable the consensus services and supports to be billable, CMS should propose legislative language to the relevant Congressional committees. CMS should convene a 'state of the evidence' conference every three years after the initial conferences.

BACKGROUND AND POSSIBLE ACTION STEPS

There is a consensus in the country that social factors and conditions affect individuals' health, utilization, and outcomes, including cost. There is less of a consensus, however, about who should pay for social services that may benefit people and multiple organizations simultaneously, including health insurers, providers, local governmental units like law enforcement and schools, and even employers. Consequently, few would argue today that enough resources are being devoted to the social conditions that affect the health of many. Finding a path toward a wiser allocation of resources upstream of the health care system is a worthy goal for policy makers and stakeholders alike. Health insurance plans are in the center of any reasonable and feasible path.



The Venn diagram above reflects the unfortunate set of current realities. Long standing statutory (and arbitrary) distinctions between health services delivered by health providers vs. social services that affect health delivered by non-health providers prevent traditional Medicare and Medicaid programs from reimbursing health providers and plans for most social services (the red circle is much smaller than the others). Recent specific relaxations of prohibitions in Medicare Advantage (e.g., for medically tailored meals for a limited time for some patients) and within Medicaid rules for managed care organizations (e.g., for in lieu of services, for value added services, for services allowed through CMS-approved state plan amendments, or 1115 waivers) have led to useful innovations but still stop far short of all that would be beneficial (the blue circle is less than green and purple). Community based social service organizations (green) have developed considerable expertise in delivering social services but are constrained by funding limitations. The purple represents possible expansion of both expertise and capacity to deliver valuable social services to needy clients in real time to benefit people, communities, and a wide range of health and non-health care organizations.

BACKGROUND AND POSSIBLE ACTION STEPS

The fundamental problem with not paying explicitly for social services is that in effect, health care programs require health plans and providers to make a bet that the investment in social services will more than pay for itself in reduced health care costs. Some social service interventions for specific subpopulations have been shown to do this, but most do not, even though they improve health and well-being (in many cases, more than some health services do) and likely reduce health care costs somewhat. Thus, status quo payment policy keeps investment in social service capacity and delivery at a suboptimal level.

Current law requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR).1 It also requires them to spend at least 80% or 85% of premium dollars on such medical care, or to issue rebates to enrollees if this percentage does not meet minimum standards. Profit and administrative costs are excluded from the minimum percentage. This percentage is a mandatory "floor" not a "ceiling." States can set higher MLR percentages.

The general problem for health plans considering funding SDOH-related services is that investments to address health-related social needs, like food and nutrition insecurity and other social factors, are not explicitly considered quality improvement activities for the purposes of calculating the MLR. Moreover, CMS consistently requires that allowable QIA must address individual needs and not be of "general utility." To avoid having their investments deemed "administrative," health plans approach conservatively the MLR calculation and invest in QIA which are explicitly allowable within the MLR formula's numerator. Investments are generally not made in interventions which aren't explicitly QIA, regardless of whether the investments would support a community's highest priority to improve health outcomes, reduce inequities, improve the patient experience, and potentially reduce health costs, because such investments would be considered administrative expenses that dilute the health plan's required minimum MLR.

Members of the ***Convergence Collaborative on Social Factors of Health*** worked to create a policy environment that encourages investments by community stakeholders to address the community's priority social factors of health. The MLR formula in current law shapes how health plans evaluate and capture the return on their investments into communities. Thus, the Collaborative sought clarifications and changes to broaden the social factor interventions which may be considered within the numerator of the formula, and protection of available federal funding for social factor interventions, would support health plan investments to improve social factors of health, which policy thought leaders commonly call, "social determinants of health (SDOH)", and which include health-related social needs (HRSN). Collaborative members were also aware of two concerns that need to be addressed while encouraging health plan investments. First, the scope of expenditures that should be considered "medical services and health care quality improvement activities" needs to be clear. And second, including SDOH-related investments in the MLR numerator should not reduce or misalign available funding for direct health services.

BACKGROUND AND POSSIBLE ACTION STEPS

To accomplish this, the consensus solution urges the federal Centers for Medicare and Medicaid Services (CMS) to pursue policy paths to clarify quality improvement activities (QIA) to include evidence-based approaches to SDOH that improve individual and population health and increase the likelihood of desired outcomes and reduced health disparities. By clarifying its guidance as the Collaborative proposes, CMS would encourage public and private health plans to incorporate investments in SDOH-directed services and supports as sustainable business operations. Congress also should acknowledge the importance of social factors of health by protecting federal funding for QIA.

The goal of the MLR QIA clarifications is to align social services for which health plans can pay with the social supports and services which CBOs, if funded, could currently provide, and which some people objectively need to improve their health. Actions toward a bigger vision are needed. Thus the Collaborative recommends CMS should hold a series of convenings to update and align payment structures across public and private payors and to identify a robust set of social services and supports billing codes. The goal of the convenings would be to create a policy environment that:

1. Aligns the social services for which traditional FFS Medicare or Medicaid currently could pay with the social services which CBOs could provide with sufficient funding, and
2. Aligns federal and state policies across sectors to ensure appropriate incentives for investments from all sources into evidence-based social services and supports that improve health and wellbeing.

The call for a 'state of the evidence' conference at regular intervals reflects the Collaborative's view that the evaluation literature for social service interventions is expanding rapidly in scope and quality, faster than impressions based on older literature reviews evolve. Crucially, since so many social service interventions benefit multiple organizations, state of the art evaluations include values derived or costs saved across numerous sectors, including health care, law enforcement, education, and even employers. Recent work with longitudinal data sets allows longer term impacts to be measured, and larger sample sizes permit intervention impacts on racial and ethnic subpopulations to be identified rather than ignored. For all these reasons, regularly refreshing CMS and other policy makers' knowledge of the social service intervention literature is necessary for appropriate QIA and payment policy generally to be promulgated.

SCAN TO READ THE FULL BLUEPRINT FOR ACTION ONLINE

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