



Legal and Payer Changes Focus on Addressing Social Determinants of Health

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For health care providers and payers, changes to the Stark Law, the Anti-Kickback Statute, and the reimbursement landscape encourage providing care that addresses social determinants of health for certain patient populations. Research shows that when medical care is delivered alongside non-medical services that affect health, patients, providers, and the health care system overall are better off. Social services not traditionally considered medical services, such as transportation and nutrition, are particularly crucial for high-need, high-cost Medicare beneficiaries; in addition to improving health outcomes, they may also lower costs. In the near future, we will see more health care payers and providers continue to combine forces to integrate these non-medical, social services into their treatment plans for certain patient populations. These social services are seen as a measured way to address negative social determinants of health to advance overall health equity.

Social determinants of health include community factors such as the availability of high-quality education, employment opportunities, transportation, affordable housing, broadband internet, and healthy foods. Health equity, broadly speaking, is the idea that every person should have the opportunity to attain their full health potential regardless of their social position or other socially determined circumstances.

Realizing that these social services may lower the cost of health care and improve health outcomes by addressing social determinants of health, the federal government, including the Centers for Medicare & Medicaid Services (CMS) has made certain

legal, strategic, and financial decisions to encourage the provision of these services.

These decisions involve changes to the Stark Law, which prohibits physicians from referring certain Medicare-payable services to an entity with which the physician has a financial relationship unless an exception is met, and the Anti-Kickback Statute, which prohibits payment for referrals of federal health care program business, as well as CMS' development of a new strategy for the next decade, and payments for social and community-based services for patients. The hope is that these decisions advance health equity for historically underserved patient populations and reduce costs.

Changes to Stark Law and Anti-Kickback Statute

The legal changes made to the Stark Law and the Anti-Kickback Statute are intended to create additional incentives for the health care industry to move away from volume-based health care delivery and payment, and toward population health and other payment models that do not pay based on the volume of services rendered to a particular patient.

Generally, the health care industry has seen these laws as impediments to innovative arrangements between physicians and health care entities, like hospitals, because they prohibited payments to physicians for anything other than the physicians' services. For example, even if a hospital knew that a physician ordering a certain procedure or test would result in a better payment or care outcome, the hospital was unable to financially incentivize the physician to do so based on these laws.

As of December 2020, new exceptions were added to the Stark Law, and new safe harbors were added to the Anti-Kickback Statute to allow for payments like these under certain value-based arrangements. See 42 CFR § 411.357(aa) (Stark Law exceptions) and 42 CFR § 1001.952(ee) – (gg) (Anti-kickback Safe Harbors). Tellingly, one of the value-based purposes included in these laws involves the, "transitioning from health care delivery and payment mechanisms based on the volume of items and services provided

to mechanisms based on the quality of care and control of costs of care for a target patient population.”

Under the Stark Law, these value-based exceptions permit physicians and hospitals to enter into innovative arrangements that have the specific goals of achieving better health outcomes for certain target patient populations. These laws allow for payment to a physician for, amongst other things, coordinating, managing and improving the care of a target patient population.

Under the Anti-Kickback Statute, a new safe harbor protects a value-based arrangement wherein a health care provider gives a patient in-kind tools and supports that identify and address a patient’s social determinants of health. Such tools and supports must be directly connected to the coordination and management of the care of a target patient population and must advance certain goals, like adherence to a drug or treatment regimen.

These goals ensure that protected tools and supports have a close nexus to care coordination, quality of care, and health outcomes for patients. The good news, once again, is these benefits to patients, and incentive-based payments to physicians, are no longer unlawful inducements, so long as they are offered in the context of a value-based arrangement.

Center for Medicare and Medicaid Innovation’s strategy refresh.

In the fall of 2021, the Center for Medicare and Medicaid Innovation Center (CMS Innovation Center), launched a decade-long strategy aimed at achieving equitable health outcomes through high quality, affordable, person-centered care. This strategy builds on the over 50 payment models that have been launched in the CMS Innovation Center’s first decade.

Models have been launched in advanced primary care, episode-based care, accountable care, state-based transformation efforts, and for specific populations, such as Medicare beneficiaries with end-stage renal disease, diabetes, and heart disease. Models also include Medicaid for maternal opioid-use disorders and populations

that experience a higher risk for premature births.

To achieve its goal, the CMS Innovation Center has created five objectives, one of which is to advance health equity by embedding health equity in every aspect of CMS Innovation Center payment models and increasing focus on underserved populations. All new payment models will:

- require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health, and
- include patients from historically underserved populations and safety net providers, such as community health centers and disproportionate share hospitals.

Further areas will be identified for reducing inequities at the population level, such as addressing avoidable hospital admissions arising from bad health care outcomes tied to those inequities, and targets will be set for reducing those inequities. CMS has instituted penalties in some of its payment models for hospitals that continue to see high rates of readmissions.

The CMS Innovation Center is also considering a variety of incentives to encourage and sustain participation, such as payment incentives for reducing disparities or screening for social determinants of health and coordinating with community-based organizations to address social needs.

Another objective of the CMS Innovation Center is supporting innovation. This will be done by leveraging a range of supports that enable integrated, person-centered care, such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

By supporting innovation, the CMS Innovation Center has set the goal that beneficiaries in accountable care relationships – relationships where health care providers are on the hook for the quality and total cost of the care provided – will receive more person-centered, integrated care, which could include support with

social determinants of health and greater access to care in the home and community.

Medicare Advantage payment for social and community-based services

Medicare Advantage (MA) plans participating in a Medicare Value-Based Insurance Design model are now able to offer new non-medical benefits to patients. While MA plans have been able to offer “primarily health-related” supplemental benefits not covered by fee-for-service Medicare, these benefits until recently were narrowly defined by CMS to cover only medical services and had to be available to all plan enrollees.

However, in plan year 2019, CMS expanded primarily health-related supplemental benefits to include non-medical services which has allowed plans to offer non-medical benefits, such as broader use of transportation or meal delivery, in addition to the previously allowed medical benefits.

Meanwhile, with the passage of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act, as of 2020, MA plans can offer Special Supplemental Benefits for the Chronically Ill. Plans may choose to offer these benefits to enrollees with certain chronic conditions, and the benefits do not have to be primarily health-related, as long as the item or service can reasonably improve or maintain health or function of the enrollee. Such benefits that may be offered include:

- Complementary therapies.
- Pest control.
- Food and produce.
- Meals.
- Non-medical transportation.
- Structural home modifications.
- Service dog support.

- Social needs benefit.
- Transitional/temporary supports.
- Indoor air quality equipment and services.

Payment for these types of new services demonstrates the willingness to look beyond just the presenting health issues of a patient and a desire to understand what social factors cause such issues, especially in certain patient populations, and how to address them. Addressing these social determinants of health will continue to require innovative health care models and arrangements between providers, payers, and community-based organizations.

This will result in the continued evolution of health care, its laws, and its finances.

Takeaway: Innovate to address social determinants of health

The legal and payment landscape in health care has seen dramatic, meaningful shifts in the last three years. Health care providers and payers need to consider innovative ways to care for patients and to pay for that care to enhance their financial bottom line with this shift.

New opportunities in the fraud and abuse laws for value-based arrangements and payments for non-medical services to address social determinants of health have opened the door for innovation. Providers and payers need to consider how they will meaningfully participate in the health care industry in the foreseeable future.

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