ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

2000 M ST NW, SUITE 400
WASHINGTON, DC 20036
P (202) 828-5100
F (202) 728-94691

March 18, 2019

To: The ASPE Impact Study at ASPEImpactStudy@hhs.gov

Re: RFI on Social Risk Factors

On behalf of the Program to Improve Eldercare at Altarum, we appreciate the opportunity to provide comments on this RFI to improve Medicare for those living with serious disabilities associated with aging.

How do plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors?

Our team is actively involved in improving care for persons living with serious disabilities in old age. We are finding that clinical teams are using a variety of ways to identify social risk factors, including putting screening questions into their EMRs, requiring close inquiry when an elderly person has dependencies in Activities of Daily Living (ADLs), and having someone in the office or clinic who is charged with working with patients and caregivers to identify and secure community services. These are variably implemented, often not supported well in records or service delivery processes, and poorly documented, on the whole. Of course, PACE and some SNP plans do better, and CMS could use their performance as a benchmark.

Recommendation: That a suitable screening for social risk factors, with follow-up for more intensive inquiry and support, be adopted for all Medicare beneficiaries with advanced illness or disability, and that the needed records be added to the requirements for certified EHRs.

What approaches have plans and providers used to address the needs of beneficiaries with social risk factors?

Unfortunately, health plans and providers nearly universally rely upon referral and navigation in response to identifying a social risk factor. Exceedingly few are involved in assuring the adequacy of the supply and quality of social supports. Most just advise the patient and family to contact one or more of the potentially available suppliers, and most do not follow up to see if the need was met. For the plans and providers who focus more on these issues, they usually find themselves up against limited supply and long waiting lists. Housing that is affordable and available for persons living with disabilities is virtually unknown, forcing many elderly persons into nursing homes (or assisted living, if they can afford the private payment). More elders are ending up homeless. Transportation is usually a predominant issue, leading to many no-shows at physician appointments and increasing isolation for the elderly person. Many elders need door-to-door support, and many local governments and providers are proud if they can provide curb-to-curb support, which is not enough. The undersupply of home-delivered meals is a national scandal. Many cities have multi-month waiting lists and find that the elderly person has died or moved into a nursing home before they make it through the waiting list. There are even widespread waiting lists for investigating elder abuse and neglect. And the lack of support for family caregivers or funding for paid caregivers is just accepted as a fixed element of our social environment.

So, we have been encouraging health plans and providers to get involved in adjusting the supply and quality of the services needed to mitigate social risk factors. A few are doing that. We are worried about health plans and providers directly providing community supportive services because those will mostly be targeted to elders who otherwise would use substantial medical care, rather than to the larger group who are hungry or homeless or otherwise in a vulnerable condition. It would be better to address the needs of the geographic community and be sure that frail and disabled elderly people can get the

basics of support when they cannot provide for themselves.

Plans have used referral (handing the patient or caregiver a list of community services that probably can meet the need, sometimes the Eldercare Locator or the Area Agency on Aging), navigation (helping the person to find a potential or actual source of the service in the community), and compromising (helping the person find a next-best way to cope when referral and navigation don't work well, such as entering a nursing home). A few plans have paid for some of the services directly — e.g., paying for a couple weeks of home-delivered meals after hospital discharge, paying for a "tuck in" service to settle at home a newly discharged person who has no family or volunteer help, paying for transportation to appointments, etc. Sometimes these payments have been worked into supplemental benefits, but sometimes they are actually paid from profits, e.g., through a foundation tied to the health plan.

All of this largely misses the critical point. In general, these services depend upon the supply and quality of services available in the geographic community where the person lives. The availability of home-delivered food, disability-adapted and affordable housing, a workforce skilled in the appropriate ways, employers that provide flexibility for family caregivers, and so on — these are all characteristics of the community, not of the health plan. It is inefficient and morally repugnant to provide the ways to mitigate social risks only to people who otherwise would be high utilizers of health care services. It is much more efficient to figure out how to mitigate social risks for frail and disabled elderly people in a town, city, or county. The health plans and providers have been slow to understand the functioning of the social supports in the communities where they provide services. Health plans and providers should participate in setting the priorities and mitigating the shortcomings in the areas where they work. They should know whether the local home-delivered meals service is developing a waiting list

and act to reduce or eliminate it. They should be speaking up at housing hearings to advocate for universal design. They should be participating with their community-based services and community colleges to enhance the workforce and should be helping to encourage employers to enable more family caregiving (without losing the family member's income). In short, health care providers need to develop corporate citizenship in the communities where they are making their living. This is the key. It is a good thing to get one patient into supported housing or to have reliable food or personal care. It is much more important to have the confidence that one lives in a community where these issues are monitored and managed so you can count on the basic supports if you need them.

Recommendations

1. That Medicare move to encourage and then require comprehensive care plans including social and family supports based on the personal situation and priorities for Medicare beneficiaries with substantial social risk factors.

2. That health plans and providers engage with their communities and participate in measuring, monitoring, and improving the social risk factors that affect their patients.

3. That health plans and providers screen and navigate – and follow up to see that the need has been met.

What is the evidence regarding the impact of these approaches on quality outcomes and the total cost of care?

The literature is now very consistent that targeted efforts to address social risk factors are reliably effective in improving beneficiary experience and reducing health care costs. We reviewed the literature for the July National Academy meeting on social risk factors for persons with advanced illness, and the array of proven interventions numbered more than 30. However, to achieve

beneficiary improvement and lower health care costs, the provider must target the intervention to persons who otherwise would use medical services (usually, as evidenced by their past history of high utilization). Therefore, the persons who would simply suffer and die would not be among those targeted.

How does one disentangle beneficiaries' social and medical risks and address each?

Here, we agree with the C-TAC response, as follows. With all due respect, this is the wrong approach. It is impossible to disentangle beneficiaries' social and medical risks and address them separately since they are inherently intertwined. For example, poor health literacy leads to difficulty managing medications and care instructions, which leads to poorer health. Lack of adequate nutrition works against medical treatment as it undermines peoples' ability to heal, maintain function, and avoid health crises. Our health care system has tried for decades to just address peoples' medical needs and the gap between what they truly need and receive is growing, along with unsustainable costs.

Recommendation– That instead of separating social and medical risk, Medicare take a more holistic care approach for elderly beneficiaries with serious disabilities associated with aging that is focused on quality of life for them and their family caregivers. An additional benefit of this approach is that it will address any social risk factors affecting their quality of life and, therefore, health.

Is value–based purchasing a tool to address social risk factors?

We agree that beneficiaries with social risk factors could benefit from such alternate payment models but only if providers in such financial arrangements are rewarded for gathering the right information on them, e.g. functionality, quality of life, family caregiver burden, etc., providing holistic

care, and are not penalized for caring for people with high needs and historically high cost.

For instance, a recent Government Accountability Office (GAO) report[i] confirmed that the current Medicare Advantage (MA) risk adjustment calculation understates the effort and cost of caring for those with poor functionality. This is problematic, as it makes it financially undesirable to care for such patients, many of whom also have social risk factors. Yet functional information is not gathered as part of MA risk adjustment methodologies, and is therefore unable to be factored into such calculations.

Recommendations

1. That functional assessment be added to all Medicare programs. We suggest exploring third party assessors, as per GAO report, should this be too administratively burdensome on providers.
2. That Medicare explore adding additional assessments of quality of life and family caregiver burden for those beneficiaries with advanced illness.
3. That value-based purchasing formulas be adjusted so as to promote the care of beneficiaries with poor function, high social needs, risk factors, etc.

<u>What are barriers to collecting data about social risk? How can these barriers be overcome?</u>

The most substantial barrier is that most providers have learned that they have little capacity to affect the social risk factors by referral and navigation. The waiting lists for services are too long, the administrative barriers are too hard for frail elderly people, and so many people have just a little too much income to get help from Medicaid. Providers do not want to

learn about the patient's situation when they can do nothing to make it better.

Furthermore, the existing requirements for EHRs do not support good care for this population. There is no place identified for social risk factors, indeed, there is no place identified for such obvious elements as functional status, mental status, and caregiver identification.

With so many providers beginning to pay attention to social risk factors, there is an urgent need for standardization of the key questions, so that improvement activities can be guided by data. If the Area Agencies on Aging and the hospitals use different screening protocols, there will be no ready way to examine the efficacy of the efforts to refer and secure services.

Recommendations

1. Shift payment incentives to promote capturing and acting upon social risk factors.
2. Require that federal EHR certification include key social and family caregiver issues.
3. Provide some incentives for plans and providers to be engaged in community action to address social risk factors.

In closing, we would like to comment on the perspective that is apparent in the ASPE RFI. ASPE, like many providers and payers, is falling into the commonplace trap of seeing ''social risk factors'' as factors that characterize a particular beneficiary — and not ALSO as factors that characterize the locality in which that beneficiary lives. Thus they note that RAND found (page 3) a list of four items in the taxonomy for MA plans addressing social needs. What's missing is any action to enhance the community's provision of supportive services, including adequate workforce (paid and voluntary). To illustrate — a beneficiary who lives alone without volunteer support and

who can no longer prepare food has a "social risk factor" in a town with a long waiting list for home-delivered food, but that same beneficiary living in a town with readily available home-delivered food has no such risk factor. So, the risk factor is not merely a characteristic of the patient but also of the mismatch between the patient's need and community's service provision arrangements.

Furthermore – the country has not come to terms concerning what families (and, for that matter, neighbors) should be expected to do to provide unpaid support. This ends up being negotiated and re-negotiated with potentially available people without any overall sense of what we expect. Most direct care is given for free by family – but that's the most stressful point in the upcoming demographics. Small and dispersed – and older – families will not be able to "take care of great-grandma" in small apartments with all adults working. We do not have large families living on the farm who can readily take in a disabled elderly person. So, putting into the EHR that the person has two children tells you almost nothing. Figuring out whether they are willing and able to do the personal care – and then seeing if they can actually deliver – is a complicated endeavor. What should be the response if the elderly beneficiary was a child abuser, or the adult child is hooked on drugs? These kinds of situations are all too common and very hard to verify or document. Even in the "usual" family, there will be real needs and limitations that limit caregiving. There needs to be a focused endeavor to sort out how to deal with family capability and willingness in the record, and the solutions are not likely to be simple.

Thank you for the opportunity to provide these recommendations. If you have any questions, please contact Joanne Lynn at Joanne.Lynn@Altarum.org .

Sincerely,

Joanne Lynn

Joanne Lynn, MD, MA, MS

Director, Program to Improve Eldercare

---

[i] https://www.gao.gov/products/GAO-18-588