Original Article

Social Workers Assert Medicare Home Care Ignores Social Determinants of Health

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Abstract

There is significant literature on the importance of addressing social determinants of health (SDOH) to improve health care outcomes. In response, the Centers for Medicare and Medicaid Services (CMS) has expanded Medicare Advantage plans ability to cover SDOH-related services. Medicare home health does not cover SDOH-related services. A literature review indicates no studies on the nature, significance, or impacts of the lack of SDOH coverage in Medicare home health. This article summarizes an initial, exploratory study to address the literature gap, based on interviews of a convenience sample of 29 home care social workers between January 2013 and May 2014 in the New York City metropolitan area. Results indicate social workers believe the lack of SDOH coverage, including social work, in Medicare home health results in exacerbation of existing patient conditions; creation of new, additional patient conditions; increased home care readmissions and rehospitalizations; increased caregiver burden; and exacerbation of patients' mental health and substance abuse needs. Policymakers are urged to consider adding coverage of social work and SDOH to Medicare home health.

Keywords

home and community-based services, quality of life, health care policy, health care decision-making

Establishing Context

There has been significant attention recently on increasing the use of nontraditional skilled and nonskilled services to improve patient and system outcomes in Medicare and Medicaid by addressing social determinants of health (SDOH). Congress authorized Medicare Part C providers (Medicare Advantage) to deliver previously banned nonskilled services.[1] The nature and extent of these services are not clear, but they appear to include homemaker, meal, housing, case management, home modifications, social support needs, complementary therapies, and transportation services, among others.[1] A recent analysis of the Maryland Medicaid Community First Choice (CFC) has led the Commonwealth Fund to call for Congress to consider adding a new home and community-based benefit to supplement informal support from family and other caregivers.[2] The Maryland waiver included services such as home attendants and other personal care providers; care coordination; personal emergency response services; home meal delivery; and home environmental risk assessments for falls.[2] The Centers for Medicare and Medicaid Services (CMS) has indicated it is considering allowing Medicaid payments to hospitals to cover housing costs for patients.[3] Some hospitals already have a variety of initiatives to focus on addressing housing and other social needs in addition to medical needs.[4-6] A significant number of state initiatives to address social determinants through services aimed at social needs also are in progress through Medicaid innovation grants, section 1115 Medicaid demonstration waivers, and Medicaid Managed Care initiatives.[7,8]

These developments point to a recognition by some advocates and researchers of the importance of the social determinants of health as an important factor in Medicare and Medicaid benefit design.[1-3,6] The emphasis on social determinants includes paying for services related to transportation, food, housing, homemaker assistance with activities of daily living, increased use of social workers, case management, increased psychosocial services, and other social services.[1-3,6] There is a long-standing and substantial research literature on the importance of the social determinants of health on physical and mental health outcomes, establishing them even as more important than genetics and health care coverage.[9-15] The American College of Physicians issued a position paper recognizing the importance of addressing SDOH as "non-medical factors that can affect a person's overall health and health outcomes."[16(p. 577)]

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Table 1. Major Services Impacting SDOH Not Covered By Medicare or Medicaid Home Health.

Case management or care coordination
Nutritional counseling/registered dietician services
Homemakers, companions, live-ins and other personal care service providers
Housing supports
Transportation
Food, including home-delivered meals
Equipment to alleviate or prevent medical conditions (such as air conditioners for persons with asthma)
Home modifications to prevent/limit fall risks (such as bathroom and other grab-bars, disabled access home entries, or home cleaning services)
Peer-based counseling
Group counseling
Family member-caregiver support (including ongoing individual, group or patient-family member/caregiver counseling)
Complimentary and alternative therapies

Note. MedPac[17]; Medicare Benefit Policy Manual.[18] SDOH = social determinants of health.

Amidst the increased recognition of possible benefits of SDOH-related services for Medicare and Medicaid, there has been no change in the Medicare or Medicaid home health benefit to allow delivery of such services.[17] The Medicare home health benefit currently covers only six services for "homebound" individuals in need of skilled intermittent nursing care, speech therapy, physical therapy, or ongoing occupational therapy. Once eligible, there are specific limitations on each of the services: Skilled nursing, home health aides, physical therapy, speech therapy, occupational therapy, and medical social work.[18,19]

There are many major services impacting SDOH which are not covered by either Medicare or Medicaid home health. These are displayed in Table 1.

The mandatory Medicaid home health benefit only requires states to cover part-time or intermittent skilled nursing, home health aides, and medical supplies, equipment, and appliances.[20] States may add additional services; may opt to add the optional Medicaid personal care services, as they deem to define it; and may adopt additional home and community-based services through Medicaid waivers.

The Medicare home health social work benefit is the only one of the covered services designed to address SDOH-related social needs and has limited coverage. According to the Medicare Benefit Policy Manual,[18] the medical social worker may provide limited counseling services to the patient, based on a physician order, but only when the patient's social situation is impacting his or her recovery and/or treatment. The medical social worker can review the patient's financial situation, arrange for home-delivered medications and meals (if related to the patient's medical condition), and can assist the patient in gathering information to apply for Medicaid and other government benefit programs. However, even if the patient has cognitive or other limitations, the medical social worker cannot assist in filing or following up on the status of an application for Medicaid, Food Stamps, or other government programs.

Group counseling of Medicare home health patients with common issue and patient-spouse or patient-significant other counseling is not covered. Limited counseling of a patient's family member or caregiver is only covered:

> on a short-term basis when the HHA [home health agency] can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or the patient's direct recovery. (section 50.3)[18]

No other caregiver or family member counseling services or other assistance is covered, including noncoverage of group counseling for Medicare patient caregivers caring for patients with common problems.

In part as a result of the limited coverage, there has been limited use of the Medicare home health social work benefit historically, and even more limited use in the Medicare home health prospective payment system (PPS) era. From the inception of Medicare home health in the 1960s through 1996 Medicare home health social work visits never exceeded more than 2% of all national Medicare home health visits.[19,20] Between 1997 and 2015, only 1% of all Medicare home health visits were social work visits.[19,20] According to MedPac[19] from 2000 to 2015, there was a 28% decrease in Medicare home health social work visits as a percentage of all national home health visits. In 2016, Medicare home health social work visits represented less than 1% of all national home health visits.

The literature review and study focused on Medicare home health because, as previously noted, Medicare home health has a more robust benefit than Medicaid home health and requires social work coverage whereas Medicaid does not. Social work services were focused on it because it is the only one of the six required Medicare home health services that addresses social and psychosocial needs. As a result, social workers were interviewed based on their profess.

Literature Review and Study Rationale

The article presents the results of an exploratory research study of 29 home care social workers in the New York City metropolitan area between January 2013 and May 2014. The study used interviews to probe social worker perceptions of the nature and extent of SDOH coverage in Medicare home health and the impact of patients, caregivers, and Medicare. The article was prompted by a gap in the existing literature regarding the topic.

The literature review used CINAHL, PubMed, Medline, Cochrane Library, Campbell Collaboration, PsycINFO, Sociological Abstracts, and Social Science Abstracts databases with a search period of January 1, 1965, through

September 30, 2012, followed by an updated search after the study was conducted covering October 1, 2012, through June 30, 2018. Multiple keywords were used by applying Boolean search strategies: Social determinants of health and home care; home care nursing; Medicare home health nursing; and psychosocial care and Medicare home health. The searches yielded multiple studies on home health and home health nursing, but no studies specifically on coverage of social determinants of health in the Medicare home health setting.

Study Method

The study used a grounded theory approach.[21] Grounded theory is the research methodology of choice because it was developed for interpreting qualitative data in the absence of a preexisting theory. In this study, the existing literature does not provide insight into how home care nurses perceive the coverage of SDOH and the impact on patients, caregivers, and payers, including Medicare. Data were collected through interviews of 29 home care social workers, selected from the New York City metropolitan area from January 2013 to May 2014. Participants were selected using a snowball convenience sampling technique, whereby home care industry professionals known to the author identified potential interviewees. In-person interviews were conducted at locations convenient to participants and off-site from where they worked. An interview guide was used to help standardize the data collection, and all participants were assured of anonymity and confidentiality through an informed consent they signed. Qualitative analysis began shortly after the initial data were collected, and resulted in additional questions and probes that were applied to subsequent interviews, in an ongoing iterative process. Analysis followed the grounded theory three-stage coding of interview data: Open, axial, and selective coding.

Open coding was used to fracture the data to "identify some categories, their properties, and dimensional locations."[21(p. 97)] The coding and classification generated a list of 286 codes. Code and category labels were created, systematically sorted, compared, and contrasted until they were complete, with no new codes or categories produced and all data accounted for. Through axial coding, multiple phenomena were identified from the connected categories and subcategories. These phenomena included the Medicare decision-making framework, home care nurse perceptions of SDOH, home care nurse perceptions of ability to use SDOH in care planning and delivery, and home care nurse perceptions of impacts of ignoring SDOH. Finally, using selective coding, a "story line" was identified and a "story" written that integrated the axial coding phenomena.[21] The story that emerged was the influence of Medicare home health's lack of coverage of SDOH on patients, caregivers, and payers.

In keeping with the grounded theory approach, the data analysis and interpretation were facilitated by analytical and self-reflective memo writing, which helped move empirical data to a conceptual level; expanded and refined the data and codes; developed core categories and interrelationships; and integrated the experiences, interactions, and processes embodied in the data.[22] All initial abstraction, analysis, and interpretation were done by the author of this article. After the initial process, all abstraction, analysis, and interpretations were reviewed by two additional experienced qualitative researchers. Any differences were discussed by the two external reviewers and the author to reach final decisions used for the study results. All analyses were done using ATLAS.ti software.

Table 2. Social Worker Participant Demographic Characteristics.

Characteristic	*N*	%
Sex		
Male	3	10
Female	26	90
Race/Ethnicity		
White, non-Hispanic	25	86
Hispanic	2	7
African American	1	3
Asian American	1	3
Age range		
>55	2	7
45-55	12	41
36-44	12	41
25-35	3	10
Years as a home care social worker		
>10	5	17
6-10	14	48
1-5	7	24
<1	3	10
Average patient caseload		
>10	1	3
5-10	23	79
<5	5	17

Study Participants

Limited demographic data were collected from study participants using a short survey. The results are shown in Table 2. Overall, the social workers were 36 to 55 years old (82%); female (90%); white, non-Hispanic (86%); had six to 10 years of home care experience (48%); and had an average caseload of five to 10 patients (79%). Statistical analysis of the demographic variables' impact on study outcomes was not done due to the qualitative nature of the study.

Study Results

Five themes emerged from interviews, which are detailed below with supporting quotes.

Exacerbation of Existing Patient Conditions: "The Cabinets Were Bare. Oh My Gosh!"

Overall, social workers expressed concern their patients were fragile, with multiple chronic conditions; significant Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) limitations; and with many living alone. They also were concerned these limitations created needs and conditions which were exacerbated because of the home care staff's inability to provide appropriate treatment. Virtually, all (98%) of social workers interviewed believed that lack of SDOH coverage contributed to exacerbation of existing patient conditions:

> It is very frustrating. We try to help our patients but we are limited from the start. We often do not even get referrals from the nurses who open the case; not even for an assessment of need. It's because what we [social workers] do is basically not covered. We deal with real life social needs. Medicare won't deal with it. It's as though they see medical issues as unrelated to a person's income, neighborhood, job situation, education, hunger, poor housing. The end result is that it makes the patient's condition worse because we can't deal with underlying issues.

> I had a patient for a couple visits. She was poor and a severe chronic diabetic. She had limited food. She was hungry. She couldn't buy the right kind of foods, which made her diabetes worse. The cabinets were bare, Oh my gosh! I thought she was eligible for food stamps. Her spouse had dementia and was disabled. He couldn't help much. I wanted to help her apply but Medicare doesn't allow us to do that. Isn't that ridiculous? Her diabetes got worse. She was hospitalized. Medicare paid more. She got worse.

Creation of New, Additional Patient Conditions: "Then They Get More Sick"

Social workers were concerned that limitations on types of services they could provide, directly or through other sources, both exacerbated existing conditions and led to the development of new conditions. "We have many diabetic patients who become worse because we can't help arrange transportation for them to go food shopping or get prescriptions or to see their doctor. Then they get more sick" (Social Worker QP). Of those social workers interviewed, 95% (28 of 29) believed the lack of SDOH coverage resulted in development of new conditions, extending the number of patients with multiple chronic conditions:

> One of our nurses had a patient who she felt was an alcoholic. She felt it was hindering his diabetes being dealt with effectively. She thought he had underlying depression for some reason that caused him to rely on alcohol. She wanted me to give him therapy to deal with the depression and alcoholism. We met with the nursing supervisor and social work director. They concluded that other than 1-2 visits I could do nothing because of Medicare limits. The patient's depression got worse; his diabetes went out of control. He fell and broke his leg. I heard that a few months later he committed suicide.

Increased Home Care Readmissions and Rehospitalizations: "It Is Such a Shame"

CMS does measure or track readmission rates to home care. However, social workers indicated readmission was the norm. "Here we go again. That's what I usually say to myself. It seems like most of the few patients I get to see come back in 30 to 60 days after discharge. It is such a shame" (Social Worker TY). Ninety percent (26 of 29) of the social workers interviewed indicated that there is a significant readmission issue attributable to lack of SDOH coverage:

> It's ridiculous. We social workers can't assist patients with getting Medicaid, food stamps, housing assistance. We can't give them any significant counseling. So what happens? Their skilled need is dealt with, they get discharged, and in 30 to 60 days they are back. We have a lot of these frequent flyers.

Social workers similarly found high rates of rehospitalization:

> It's like a merry-go-round. I have never seen anything like it in my life. We discharge these patients, they are home for a while, then they fall or their wound or diabetes gets worse because there is no follow-up, and they are back in the hospital before you know it. Ugh! (Social Worker TL)

Ninety-six percent (28 of 29) social workers interviewed believed the lack of SDOH coverage was a significant factor in discharges to hospitals:

> I had a patient recovering from hip surgery. He needed assistance with mobility needs—getting in and out of bed, dressing, cleaning the house, cooking, grocery shopping, getting to doctor appointments. He needed a homemaker. Medicare won't cover it. We provided an aide, but only three days a week. That wasn't sufficient. He got depressed with being so homebound. I talked to him, but could only give him a couple counseling sessions because of Medicare limits. He got more depressed. He fell at home. He reinjured his hip. He was hospitalized.

Increased Caregiver Burden: "They Need Some Caring Themselves"

Overall, social workers felt caregiver burden "is there all the time but we treat it as though it's not happening" (Social Worker HG). This statement reflected a recurrent theme among social workers, with one noting that caregiver burden "seems get worse all the time. Sometimes I think they need more help than our patients" (Social Worker KD). Ninety percent (26 of 29) social workers interviewed believed lack of SDOH coverage increased caregiver burden:

> We rely on caregivers. They are essential. The nurses will tell you that too. But they need some caring themselves. They have a lot of stress. If they get too stressed out they become less reliable which then affects the patient. But Medicare will not allow us to do anything to help them. No counseling; no support.

Exacerbation of Patients' Mental Health and Substance Abuse Needs: "This Is Denying the Most Obvious Problem We Have"

Most social workers said that mental health and substance use and abuse conditions are, in the words of Social Worker SL, "ignored all the time even though they are there in our face, all the time." Most social workers complained about their limited ability to provide appropriate social work services to assess and treat mental health and substance use and abuse conditions. In the words of Social Work NR, "This is what we are trained to do. Why do they even have social workers if we can't do mental health and substance use interventions?" Of all social workers interviewed, 86% (25 of 29) believed that lack of SDOH coverage exacerbated patient mental health or substance abuse needs:

> All of our patients have multiple mental health needs. Many have opioid issues. Hello, it is 2018. And yet Medicare won't let social workers do meaningful counseling or assist patients with community outreach to resources. This is denying the most obvious problem we have. (Social Worker G)

> We cannot do any meaningful counseling; even evidence-based CBT (Cognitive Behavioral Therapy) which everyone, even the [federal] government recognizes is effective, especially for depression, which most of our patients have. So depression gets worse and that makes patient and caregiver lives worse. What's the point? What is Medicare thinking?

Limitations

The study was a qualitative, exploratory study. As such, it does not address causality and has several limitations including small sample size, lack of random sampling for sample selection, and lack of a randomized controlled trial experimental design to test specific interventions against a control group.

Discussion and Conclusions

Despite its limitations, the study does begin to address a gap in the literature and policy by exploring social workers' perceptions of the impact of lack of coverage of SDOH on Medicare home health patients and their caregivers. The study supports other studies on the significance of SDOH in determining health outcomes, including the work of McGinnis, Williams-Russo, and Knickman,[23] who found 60% of health outcomes are related to social, environmental, or behavioral factors or SDOH. The study also lends support, in the Medicare home health context, to the Bradley and Taylor[24] and Bradley, Elkins, Elbel, and Herrin's[25] research that health outcomes are better in countries where there is a better ratio of health care spending to social service spending, which includes expanded social work services. Their research found that in the United States for every $1.00 spent on health care, $0.90 is spent on social services. In contrast, on average in the Organisation for Economic Co-operation and Development (OECD) countries for every $1.00 spent on health care, $2.00 is spent on social services. In the OECD countries, the results are lower infant mortality rates, lower low infant birth weight rates, higher life expectancy, and lower premature death rates. As such, expansion of the social work coverage under Medicare home health seems the most logical policy change to address the social services needs of homebound Medicare beneficiaries.

The prior research, the current study, and recent CMS actions on Medicare Advantage seem to support further immediate action by policymakers on expanding SDOH coverage to Medicare home health agencies. Such policy reform could occur by amending the Medicare home health law or regulations to expand SDOH coverage in exactly the same manner as the recent Medicare Advantage expansion. Another option, at a minimum, would be for Congress and the U.S. Department of Health and Human Services to fund one or more demonstration projects to test the efficacy of SDOH home health coverage compared with the current Medicare home health benefit.

Such reforms would benefit caregivers, patients, and the Medicare program. Caregiver burden is a well-established significant issue.[26,27] Caregiver burden has been recognized as an issue in home health care.[28-31] The adverse impacts of hospitalization might also be better addressed by providing expanded social work and other SDOH-related services at home. Although Medicare does not track home care readmissions, they do track Medicare home health discharges to hospitals. The Medicare Payment Advisory Commission[19] reported in 2016 that 16.2% of all Medicare home health patients were discharged to hospitals, a slight increase over the steady rate of about 15% in 2013-2015.[19] Rehospitalization rates in general have been a major CMS concern, so much so that CMS has implemented financial penalties for hospitals with inappropriate rehospitalization rates.

More importantly, the Medicare home health population has significant needs which might benefit from SDOH coverage, even more than Medicare Advantage plan beneficiaries. Only a small portion of all Medicare Advantage beneficiaries (5.2%) are home health users[32] so the expansion of SDOH coverage in Medicare Advantage plans will benefit few home health beneficiaries. In addition, Medicare home health beneficiaries are a more vulnerable population in terms of social and environmental factors compared with all Medicare beneficiaries. Avalare Health found that compared with all Medicare beneficiaries, Medicare home health users are poorer (54.3% with income less than $25,000/year compared with 42%) and have more chronic conditions (52% with five or more chronic conditions compared with 26% with five or more chronic conditions).[28] In addition, Avalare Health found that 33% had two or more ADL limitations.[32]

Furthermore, Avalere Health reported that, in 2015, 44% of all Medicare home health users had a Serious Mental Illness (SMI), "defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses."[32(p. 28)] This rate compared with only 32% among all Medicare beneficiaries.[28] Of those Medicare home health users with SMI, 94% had depression and 31% had another mental disorder; 72% had an income less than 200% of the Federal Poverty Level (FPL) and 36% had an income less than 100% of the FPL.[32]

Given these data, it seems policymakers should seriously consider improving both quality and reducing costs in Medicare, if not also Medicaid, by expanding the home health social work benefit and allowing home health agencies the same flexibility in addressing social needs as they recently have granted Medicare Advantage plans.

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