Original Article

"What Were They Thinking?": The Exclusion of Medicare Home Health From Providing Supplemental Social Needs Benefits

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Abstract

There is significant literature on social determinants of health (SDOH) to improve health outcomes. In response, Congress and the Centers for Medicare and Medicaid Services (CMS) have expanded Medicare Advantage Plans' ability to cover SDOH-related services through supplemental benefits and Special Needs Plans (SNPs). Congress has not authorized Traditional Medicare to cover such services. A literature review indicates no studies of Medicare home health social worker awareness of this dichotomy and their resulting perceptions of the impacts of the lack of such coverage. This article summarizes an initial, exploratory study to address the literature gap, based on interviews of a convenience sample of 44 home care social workers from 5 different home health agencies in the New York City metropolitan area between November 1, 2021, and May 31, 2022. Results indicate social workers lacked awareness of the dichotomy in coverage of SNPs and supplemental benefits in Medicare Advantage Plans and traditional Medicare. Once made aware of the dichotomy, 4 additional themes emerged from the interviews: documented patient needs were being ignored; the supplemental needs coverage permitted for Medicare Advantage plans should be extended to beneficiaries receiving traditional Medicare; and the lack of such coverage increased the risk of onset of mental and physical health conditions, and revolving door-admissions and costs. Policymakers are urged to consider adding coverage of special needs and supplemental benefits covered in Medicare Advantage to traditional Medicare, through Medicare home health.

Keywords

medicare home health, medicare advantage, social determinants of health, medicare supplemental benefits, medicare special needs plans

Purpose

The purpose of this study was to explore Medicare home health social workers' awareness of and reaction to the patient care implications of Medicare Advantage Plans ability to address social determinants of health (SDOH)-related patient needs while traditional Medicare, including Medicare home health, is prohibited from doing so.

Establishing Context

There has been significant attention on increasing the use of non-traditional skilled and non-skilled services to improve patient and system outcomes in Medicare and Medicaid by addressing SDOH.[1-16] Amidst the increased interest in SDOH, limited Social Needs Plans (SNPS) were added only for Medicare Advantage Plans in 2006.[17] In 2018, Congress authorized only Medicare Part C providers (Medicare Advantage Plans) to deliver expanded services.[17] The services include homemaker, meals, housing, case management, home modifications, social support needs, complementary therapies, and transportation services, among others.[17]

In 2019, the Centers for Medicare and Medicaid Services (CMS) expanded the authorization.[18] The CMS guidance allows Medicare Advantage Plans to apply to offer and be paid for 2 categories of additional benefits.[4,19] One category is Expanded Primarily Health-Related Benefits (EPHRB), which includes in-home support services; adult day health services; home-based palliative care; support for caregivers of enrollees; and therapeutic massage. As of 2022, 1,034

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Medicare Advantage Plans, or 28%, were offering EPHRB services.[19]

The second category is Special Supplemental Benefits for the Chronically Ill (SSBCI), which includes food and produce; meals (beyond limited access); pest control; transportation for non-medical needs; indoor air quality equipment and services; social needs benefit (ie, community and social clubs; park passes; companion care; marital counseling; family counseling; programs to address social isolation or improve emotional and/or cognitive impairment); and housing and utility assistance, among others. As of 2022, 1292 Medicare Advantage Plans, or 34%, were offering SSBCI plans.[19]

None of the services impacting SDOH which are covered by Medicare Advantage Plans are covered either under traditional Medicare or the Medicare home health benefit.

Literature Review and Study Rationale

The article addresses a gap in the literature and presents the results of an exploratory research study of 44 home care social workers from 5 different home health agencies in the New York City metropolitan area between November 1, 2021, and May 31, 2022. The study used interviews to probe social worker awareness of the dichotomy between Medicare Advantage Plans' ability to cover SDOH-related needs and the inability to do so under traditional Medicare, including Medicare home health, and their perceptions of the impact of the dichotomy on patient care.

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 August 31, 2021, followed by an updated search after the study was conducted covering September 1, 2021, through August 31, 2022. Multiple keywords were used by applying Boolean search strategies: social determinants of health and home care; home care social work; Medicare home health social work; and psycho-social care and Medicare home health. The searches yielded one study each on Medicare home care nurses and social workers views on the lack of SDOH coverage[20,21] and multiple studies on home health and home health social work. However, there were no studies specifically on home care social workers, or other home care service providers, awareness of and reaction to the dichotomy of Medicare Advantage Plans being able to cover SDOH-related needs and the inability of traditional Medicare, including Medicare home health, to do so.

Study Method

The study used a grounded theory approach.[22] Grounded theory is the research methodology of choice because it was developed for interpreting qualitative data in the absence of a pre-existing theory. In the present study, the existing literature does not provide insight into home care social workers' awareness of and reaction to patient care implications of Medicare Advantage Plans ability to address SDOH-related needs and the inability of traditional Medicare, including Medicare home health, to do so. Data were collected through interviews of 44 home care social workers, selected from 5 different home health agencies in the New York City metropolitan area from November 1, 2021, to May 31, 2022.

Participants were selected using a snowball convenience sampling technique, whereby home care social workers known to the author constituted the initial interviewees and then identified other potential interviewees to the author. In-person interviews were conducted at locations convenient to participants and off-site from where they worked and lasted approximately 55 minutes. No payments or other incentives were given to the interviewees. Social workers were selected as the study focus because the Medicare home health social work benefit is the only one of the covered services in Medicare home health designed to address in-home psychosocial care, including SDOH-related social needs and has limited coverage.[23]

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 3-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."(p. 97).[22] 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 social workers awareness of Medicare SNPs and supplemental benefits, home care social workers perceptions of SDOH, home care social workers perceptions of impacts of ignoring SDOH in traditional Medicare, and home care social workers views of whether Medicare Advantage supplemental benefits and SNPS should be extended to traditional Medicare home health and traditional Medicare overall. Finally, using selective coding, a "story line" was identified and a "story" written that integrated the axial coding phenomena.[22] The story that emerged was home care social workers' lack of awareness of the exclusive ability of only Medicare Advantage Plans to provide SNP and supplemental benefits, and, once made aware, their views about the adverse consequences of the policy on patient care.

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

Table 1. Home Care Social Worker Participant Demographic Characteristics.

Characteristic	Number	Percent
Gender		
Male	12	27
Female	32	73
Race/Ethnicity		
Caucasian, Non-Hispanic	37	84
Hispanic	3	7
African American	3	7
Asian American	1	2
Age Range		
>55	1	2
45-55	35	80
36-44	4	9
25-35	4	9
Years as a Home Care Social Worker		
>10	1	2
6-10	10	39
1-5	25	57
<1	1	2
Average Patient Caseload		
26-30	3	7
20-25	3	7
<20	38	86

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.[24] 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 2 additional experienced qualitative researchers. Any differences were discussed by the 2 external reviewers and the author to reach final decisions used for the study results. All analyses were done using ATLAS.ti software.

Study Participants

Limited demographic data were collected from study participants using a short survey. The results appear in Table One. Overall, the social workers were 45 to 55 years old (80%); female (73%); Caucasian, non-Hispanic (84%); had 1 to 5 years of home care experience (57%); and had an average caseload of less than 20 patients (86%). 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. The first theme revealed lack of awareness by home care social workers of the Medicare Advantage Plans ability to cover SDOH-related services. After interviewees were asked the awareness question, they were told of the availability of such services in Medicare Advantage Plans and their exclusion from traditional Medicare and Medicare home health coverage. The remaining 4 themes are based on the interviewee's reactions to this new knowledge.

There was Limited Awareness of the Medicare Advantage Plans' Ability to Cover SDOH-Related Services

Virtually all social workers (98%) were unaware that Medicare Advantage Plans were allowed to offer social needs support through supplemental benefits and SNPs, but traditional Medicare was excluded from providing such benefits. Addressing the dichotomy, Social Worker TD said "What were they thinking? That is outrageous." Other social workers had similar views:

> I'm in shock. I never knew such a thing existed. Wait, are you saying that if you are [a beneficiary] on a Medicare managed care plan [Medicare Advantage Plan] that you can get all these services but regular [traditional] Medicare patients can't? Oh my God, that is so unfair? Social Worker FT

> Who knew? I didn't. Nobody told us. Why didn't they [tell us]? Social Worker LF

> No way! I had no idea. That's great for those patients. They need it [the supplemental benefits], but why can't my patients get it? They have the same needs. Social Worker SHL

Inability of Social Workers to Provide SDOH-related Services Ignores Documented Social Care Needs that Affect Patient and Caregiver Health

Multiple studies have documented the unmet social care needs of Medicare and other patients, regardless of whether they were on a home health benefit.[1-16] The social worker interviewees agreed with the empirical studies.

> Of course, they [the patients] have these needs. I have a patient who continuously is falling. We try everything including the [home care] nurses using evidence-based falls prevention interventions. Sounds like it should work, right? It doesn't. Why? I'll tell you why. It is because what the patient needs is home modifications, like bars in the bathroom, removal of wrinkled carpeting, entrance and exit modifications. That is what they need. They can't afford it and Medicare won't pay for it. It is so frustrating, and you are telling me now the Medicare] managed care plans can provide these services and we can't! How absurd and insensitive. Social Worker LL

> I have a patient who needs to see a doctor regularly. Her doctor won't do house calls [which are reimbursed under Medicare Part B]. So, she is homebound and has to get there [to the doctor's

> office] and Medicare won't cover any of the cost of the transport or someone to accompany her. The result? She mises a lot of appointments which only makes her condition worse. Social Worker SA

> Well, yes, many of my patients could use some additional food or money to help them get more and better food, but there is no Medicare coverage of that under [Medicare] home health or anywhere under [traditional] Medicare, unless, I guess, as you are saying, under this new [Medicare] managed care benefit. How frustrating. Social Worker LR

The Supplemental Needs Coverage Permitted for Medicare Advantage Plans Should be Extended to Beneficiaries Receiving Their Care Through Traditional Medicare

All social workers interviewed agreed that the supplemental benefits that Medicare Advantage Plans are permitted to deliver should be extended to beneficiaries receiving Medicare services through traditional Medicare enrollment.

> This is pure discrimination. What is the matter with them [Congress and CMS]? Yes, it should be extended to all Medicare beneficiaries, especially those who are at home. What makes a Medicare managed care beneficiary's at-home needs so different? Nothing. They have the same needs so why not have the same services available? Social Worker TJ

> For sure it should be extended [to traditional Medicare beneficiaries]. It would help our patients get out [of their homes] and move around; be less isolated; get to appointments on time; who knows what else? And why not have regular Medicare patients get these services too, even if they aren't on home health? There are lots [of patients] who still need these kinds of [SDOH] services. Social Worker KL

> Isn't this so typical of those people in [Washington,] DC to let only the [Medicare] managed care plans deliver these services. They [the Medicare Advantage Plans] have lots of money and power. That's the only reason this happened. If they [Congress] based their decisions on patient care [and patient needs] it would be a no-brainer. Your type of enrollment should not matter. They [the Medicare beneficiaries] all need these services. Social Worker MM

Inability of Social Workers to Provide SDOH-related Services Increases the Risk of Onset of Physical and Mental Health Issues for Patients

Social workers were concerned that limitations on types of services they can provide, directly or through other sources, increases the likelihood of onset of new physical or mental health conditions. "I had a patient with a significant cardiac issue who became depressed and anxious and because he could not get his food or prescriptions timely because we are not allowed to arrange transportation for them to go food shopping or get prescriptions or to see their doctor And then he developed a respiratory condition which the doctor said probably was related to non-compliance with his dietary and medication needs." (Social Worker TP)

Of those social workers interviewed, 95% (42 of 44) believed the lack of SDOH coverage resulted in development of new conditions, which also increased the number of patients with multiple chronic conditions.

> Here is a typical scenario. I have a patient with COPD [Chronic Obstructive Pulmonary Disease]. He comes on and off service frequently. He improves, gets discharged, gets worse, comes back, we discharge because he gets better, and then the cycle repeats. So he started with us several years ago. His only issue was the COPD. Nothing else. Well, one of the reasons for his readmissions is that he can't get to his doctor or the pharmacy to get what he needs on a regular basis. When we aren't there, or if he has a social worker who won't go outside the box to help, he gets depressed. So now, for the last two years, he not only has COPD, but he is depressed, yes, he's been diagnosed as clinically depressed, but then we can't treat that [the depression] because of Medicare's limits on social work services. That new coverage [for supplemental benefits] you described for patients on [Medicare] managed care sure would help us avoid these kinds of situations. Social Worker GW

> A study by the National Academies of Sciences, Engineering, and Medicine[25], among others, has validated the adverse effects of social isolation of older adults on developing or exacerbating mental health conditions.

Inability of Social Workers to Provide SDOH-related Services Has Adverse Financial Impacts Due to Readmission Rates and Increased Patient Condition Severity

CMS does measure or track readmission rates to home care. However, social workers indicated re-admission was the norm. "It is so typical. We call these patients frequent flyers and, believe me, most of our patients are frequent flyers. Most of the patients I see come back in 30 to 60 days after discharge. It is so sad." (Social Worker EM) 90% (40 of 44) of the social workers interviewed indicated that there is a significant re-admission issue attributable to lack of SDOH coverage.

> How absurd is this. We are social workers trained in case management and case coordination, yet we can't assist patients with getting Medicaid, food stamps, housing assistance. And forget counseling, you know [psychosocial] therapy, which is most of our training. That is barely covered. As a result patients get discharged with none of these issues being addressed. As long as their short-term medical need resolves well, like their wound, or post-surgery rehab, or a spike in diabetes, the get discharged. Then, usually because there is no follow-up support to ensure medication and physician access in terms of transportation or proper food or adequate personal care

> assistance or counseling, or all-of-the-above, then they get readmitted to us in 30 to 60 days. It seems like a never-ending cycle. Social Worker FD

Multiple studies have found a significant relationship between unmet social needs and increased patient costs for patients, including Medicare and Medicaid patients, and conversely, decreased readmissions and other costs when social needs services are provided. Some studies also have fund improvements in quality-of-care outcomes.[1,2,5,6,8,26-32]

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; use of a sample of home care social workers only from 5 agencies in the New York City metropolitan area; most participants had caseloads less than 20 patients; and lack of a randomized controlled trial experimental design to test specific interventions against a control group.

Discussion and Policy Options

Despite its limitations, the study does begin to address a gap in the literature and policy by exploring social workers' awareness and perceptions of the adverse patient care consequences of Medicare Advantage Plans' ability to address SNP and supplemental needs and the inability of traditional Medicare, including Medicare home health, to do so. There are several possible policy routes to achieve such policy reform.

One option is for Congress to pass legislation allowing Medicare-certified home health agencies to provide and be reimbursed for the same types of supplemental benefits using the same annual application procedure as used by Medicare managed care plans. This option also would necessitate a modification of the current Medicare home health prospective payment system to allow separate billing and reimbursement of such supplemental benefits on a fee-for-service based, probably with a national fee schedule. A related option might establish billing and reimbursement, based on a national list of supplemental benefits as add-ons to specific diagnostic categories in the current Medicare home health prospective payment system. A second option might be to create a separate Medicare Part B supplemental benefits coverage following the process currently used by Medicare Advantage plans but allowing the services to be provided by various Medicare-certified providers, including home health agencies, hospitals, nursing homes, Health Homes, Accountable Care Organizations, and other providers or provider organizations.

Conclusion

Given these data it seems policymakers should immediately consider improving both patient care and reducing costs in Medicare, by allowing traditional Medicare, through Medicare home health agencies, the same flexibility in addressing social needs as they have granted Medicare Advantage plans.

Declaration of Conflicting Interests

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