

November 16, 2018

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

Re: RFI on Social Risk Factors

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this RFI about ways to improve Medicare, particularly for those living with advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values, honors their dignity, and supports their family caregivers. C-TAC is made up of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some individuals and their families may lead to transition to hospice.

We appreciate the opportunity to respond to this RFI as those with advanced illness are often “medically complex” and have social risk factors that affect their health, quality of life, and the burden on their family caregivers. Below are our responses to your questions:

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

Because many individuals with advanced illness have social risk factors, programs developed uniquely for them, including advanced illness management (AIM) and palliative care programs, regularly identify and address such risk factors.

Participants for AIM and palliative care are initially identified through a combination of medical, utilization, and, when available, functional informationⁱ. This is then augmented by a comprehensive assessment of the beneficiary's physical, emotional, social, and spiritual needs along with the needs of their family caregiverⁱⁱ. This assessment is systematically done and captured by an interdisciplinary team. Through this highly personalized process,

the unique social risk factors of each beneficiary are revealed. These risk factors can be financial, social isolation and transportation challenges, low health literacy, poor nutritional access, etc.

Recommendation: That such a comprehensive, and ideally interdisciplinary, approach be adopted for all Medicare beneficiaries with advanced illness to better identify and address their needs and unique social risk factors.

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

Whatever a beneficiary's social risk factors, any issues identified through the AIM or palliative care comprehensive interdisciplinary assessment are then addressed in a care plan based on that beneficiary's personal goals and values. This is a highly customized and effective way of addressing the range of needs that someone living with advanced illness has, including any social risk factors. This is also where opportunities for social supports and services are identified, both for the beneficiary and their family caregiver. In addition, another hallmark of AIM and palliative care programs is care coordination, as this is particularly needed for those with social risk factors who have complex medical situations and lives.

Beyond this, Secretary Azar's recent remarksⁱⁱⁱ about caring for the "total person" are exactly the right perspective. Encouragingly, some health systems^{iv} and payers are starting to work with their local communities to better understand what resources are available there including identifying any barriers, such as long waiting lists to receive home nutrition support. Instead of just adjusting for social risk factors, it is more helpful to figure out how to mitigate social risks for those with advanced illness at the local level. Health plans and providers can and should better understand the capabilities of the social supports in the communities where they provide services. They should participate in setting the community's priorities and mitigating any shortcomings in their local areas. They should know the capacity of local services and help support those agencies to meet the community's needs. Health payers and providers are and should be involved in understanding and addressing housing and transportation issues and participating with their local community-based services to enhance the workforce and to enable more family caregiving support. In short, they need to develop corporate citizenship in the communities where they are making their living. They should move beyond addressing individual beneficiary issues to helping build communities where these issues are monitored and managed.

Recommendations

1. That Medicare move to encourage and then require comprehensive care plans including social and family supports based on the personal goals of Medicare beneficiaries with advanced illness.
2. That systemic and systematic advance care planning and goals of care conversations be the vehicle to determine and update these personal goals and care plans. Respecting Choices^v is an acknowledged leader in training people to have these

conversations.

3. That care coordination be an integral part of care for these beneficiaries.
4. That health plans and providers be encouraged to become more participatory members of their communities, better aware of available services or needs, and responsible for improving the quality of life for all with advanced illness beyond just providing medical care.

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 AIM and palliative care approaches increase the quality of life for beneficiaries with advanced illness and their family caregivers^{vi} and reduce cost^{vii} by reducing unnecessary and unwanted utilization.

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

With all due respect, this is the wrong approach. It is impossible to disentangle beneficiaries' social and medical risks and address them individually since they are inherently intertwined. 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 for decades only addressed peoples' medical issues and the gap between what they truly need and receive is growing, along with unsustainable health care costs. A more holistic approach, as Sec. Azar said^{viii}, is what is urgently needed.

Recommendation- That instead of separating social and medical risk, Medicare take a more holistic care approach for beneficiaries with advanced illness 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 that also affect their 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. However, that is only if providers in such financial arrangements are able and rewarded for gathering the right information, 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^{ix} 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 less desirable 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 methodology and is therefore unable to be factored into that calculation.

Recommendations

1. That functional assessment be added to all Medicare programs. One option would be to add the functional assessment and additional social determinant elements to the standardized data to the Annual Wellness Visit. This will ensure these elements are included in the primary care plan of care and that EHRs will be required to accommodate it. Another option is exploring third party assessors, as per GAO report, should adding these assessments be too administratively burdensome on providers.
2. That value-based purchasing formulas be adjusted so as to promote the care of beneficiaries with poor function, high social needs/risk factors, etc.
3. That Medicare additionally explore adding assessments of quality of life and family caregiver burden for those beneficiaries with advanced illness.

What are barriers to collecting data about social risk? How can these barriers be overcome?

As noted above, a key barrier is that functionality, quality of life, social risk factors, and family caregiver assessments are not required inputs for Medicare programs or providers.

Recommendations

1. Shift payment incentives to promote capturing and acting upon this more comprehensive data.
2. Consider requiring federal CEHRT changes and providing funding to promote expanding medical records to include functionality and key social and family caregiver issues identified through comprehensive assessments.

In conclusion, we strongly urge Medicare to shift to truly person-centered care driven by patient goals and values, at least for those beneficiaries living with advanced illness, when “what matters” varies enormously. More comprehensive assessments and personalized care plans that address areas beyond medical issues will also identify and address any social risk factors. The result will be healthier beneficiaries, more supported family caregivers, and less unnecessary and unwanted medical care.

Thank you for the opportunity to provide these recommendations. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

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- ⁱⁱⁱ <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html>
- ^{iv} <https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly-hospitals/age-friendly-health-systems-initiative>
- ^v <https://respectingchoices.org> , <https://altarum.org/publications/medicaring-communities-getting-what-we-want-and-need-frail-old-age-affordable-cost>
- ^{vi} Kavalieratos D, Corbelli J, Zhang D, et al. Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis. *JAMA*. 2016;316(20):2104-2114. doi:10.1001/jama.2016.16840
- ^{vii} May P, Normand C, Cassel JB, et al. Economics of palliative care for hospitalized adults with serious illness: A meta-analysis. *JAMA Intern Med*. Published online April 30, 2018. doi: 10.1001/jamainternmed.2018.0750
- ^{viii} <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html>
- ^{ix} <https://www.gao.gov/products/GAO-18-588>