

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 16, 2018

Submitted electronically to ASPEImpactStudy@hhs.gov

Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Department of Health and Human Services
Baltimore, MD 21244-8016

Re: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors—Request for Information

Justice in Aging appreciates the opportunity to provide a response to the above-referenced Request for Information (RFI).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We appreciate the effort of ASPE to identify best practices for serving the needs of beneficiaries with social risk factors. This is critically important work. Based on our experience as advocates for low income older adults, and particularly what we have seen with the Medicare-Medicaid financial alignment demonstration, we suggest some areas where we believe improvements and identification of best practices would be particularly fruitful.

Information on social risks: We appreciate that ASPE is looking at how to capture social risk factors in electronic health records (EHR). One challenge is that non-medical providers (home health aides, social workers, residential service coordinators, etc.) who do not have EHR access are often best situated to learn of issues such as food or housing insecurity or changes in social supports. Best practices for information sharing among all members of the team serving a beneficiary, including those not providing Medicare-covered services, that also respect the privacy interests of the beneficiary, would be very valuable.

Language access: An area where there is much room for improvement is addressing the needs of beneficiaries with limited English proficiency (LEP). A recent evaluation of the Cal MediConnect (CMC) dual eligible demonstration found that half of the non-English speaking CMC beneficiaries reported that they could “never” get a medical interpreter when they needed one. Over 40% reported that it was harder to get an interpreter in 2017 than it had been in 2016.¹ This report is consistent with comments

¹ UCSF, Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey (Sept. 2018), pp. 6, 64 *available at*

www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_medicconnect_final_091018.pdf?utm_source=9%2F12%2F2018+TSF%3A+CMC+Evaluation%3B+Dr.+Chernof+Perspectives%3B+New+Videos&utm_campaign=9%2F12%2F2018&utm_medium=email

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we hear from advocates that their LEP clients in many cases either do not know of their rights to interpreters or are reluctant to ask; and, when they do express a need for language assistance, LEP individuals have difficulty obtaining language services.

There is a significant need to educate beneficiaries and their families as well as providers on the value of using trained interpreters and on how to obtain them. It is our experience that many beneficiaries do not understand that this is a right. Moreover, many LEP beneficiaries, like their English-proficient counterparts, rely on family members to help them understand information from providers and make important health decisions. It is important for plans and providers to explain that interpreters can support, rather than supplant, that family involvement.

Further, Medicare Advantage plans and financial alignment demonstration plans should have easy-to-follow procedures to facilitate obtaining interpreter services and should be proactively working to ensure that individuals needing interpreter services, for example those with specialist appointments, have those interpreter services lined up in advance of their appointments. We hope that ASPE can explore with plans best practices around these issues.

Care coordination: Care coordination, both in fee-for-service and managed care models, is particularly important for beneficiaries with social risk factors. The UCSF Study found that Cal-MediConnect beneficiaries with a care coordinator were about four times more likely to rate their care favorably compared to those with no care coordinator.² Yet progress with consistent provision of care coordination has been mixed. The UCSF Study found that less than a third of CMC beneficiaries reported having a care coordinator. Further only half of beneficiaries reported that they are getting all the help they need with care coordination.³ A national evaluation of the demonstrations similarly found a wide range of beneficiary experience with care coordination, including complaints about turnover in coordinators.⁴ We urge ASPE to look particularly closely at ways to improve this key function.

Identifying resources: To effectively address social risk factors, plan personnel need to have a full understanding of resources in the community that can be leveraged to provide needed help and services. To be effective, plans need comprehensive knowledge of what is available and how their members can access services. It would be useful to see information on strategies plan care coordinators use to systematically identify and establish working relationships with community based organizations that work with individuals with social risks, including food banks, housing advocates, independent living centers, faith-based organizations, senior centers, county and state agencies – like area agencies on aging and county, state departments of aging, and transportation boards.

Best practices would also be helpful around how plans partner with legal services organizations to help ensure that their members are receiving all benefits to which they are entitled and to untangle problems they encounter in maintaining eligibility and accessing benefits. Medical-legal partnerships, which address legal needs when an individual is in a health care setting, could be a model for how plans could partner with legal service providers. For example, the National Center for Medical-Legal Partnership has

² UCSF Study at p. 4

³ UCSF Study at p. 5

⁴ RTI International, Beneficiary Experience, Early Findings From Focus Groups with Enrollees Participating in the Financial Alignment Initiative (Mar. 2017), pp. 20-21 available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf.

highlighted data and best practices around how these partnerships can effectively address social risk factors such as homelessness and mental health--including among veterans, transgender health, the opioids crisis, and chronic health conditions.⁵ These are issues that plans serving Medicare beneficiaries could similarly address.

LGBTQ Competency: There is need for learnings on how health plans ensure that their networks include LGBTQ providers and that the entire network has received training at every level – from traditional health care providers to community based organizations. The SAGE certification program is one existing resource for plans and providers.⁶ We would encourage ASPE to promote this resource and best practices.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,



Jennifer Goldberg

Directing Attorney

⁵ See The National Center for Medical-Legal Partnership Resources, available at <https://medical-legalpartnership.org/resources/>.

⁶ SAGECare certification and LGBT training, available at <http://sageusa.care/why-sagecare/resources/>.