JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

August 31, 2020

Lance Robertson
Administrator and Assistant Secretary for Aging
Administration for Community Living
330 C Street S.W.
Washington, DC 20201
By email: ACLFramework@acl.hhs.gov

Re: ACL: Strategic Framework for Action

Dear Administrator Robertson:

Thank you for the opportunity to comment on the Administration for Community Living's "Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities."

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 and populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Justice in Aging has long experience with Medicaid programs that deliver home and community-based services to low income older adults. Our comments also are informed by our engagement with the dual eligible demonstration projects in the Financial Alignment Initiative (FAI). We have been involved with the FAI since its inception, working closely with advocates in the affected states and participating in policy analysis and development.

We offer some overarching comments, followed by others addressing specific portions of the Framework.

Value of this ACL Initiative

We very much appreciate that ACL is focusing on practical assistance to strengthen Community Based Organizations (CBOs), both on the business acumen side and to strengthen their ability to deliver services to older adults and persons with disabilities. CBOs are a linchpin for delivery of person-centered care and particularly situated to address social determinants of health (SDOC). The Framework is rich with specific strategies to strengthen CBOs and develop more rational and efficient delivery of services addressing the social determinants of health.

COVID-19 and CBOs

The COVID-19 pandemic has put a spotlight on the importance of having systems in place that make it possible for older adults to live safely in the community, especially those located in underserved

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communities. The pandemic also has put CBOs, the organizations that provide these critical services, under significant strain both financially and operationally. It takes years, and sometimes decades to develop healthy functioning CBOs that are serving the needs of older adults. These CBOs can be anchors in their communities, especially in communities of color and underserved areas, yet without adequate funding and support they can be lost quickly. We ask that ACL, in addition to the longer term strategies discussed in the Framework, also work with states to urgently address the short-term stability and survival of this critical infrastructure of services. We know that state Medicaid budgets are facing extraordinary challenges and urge ACL to work with states to prioritize preserving home and community-based services in Medicaid budgets and system design.[1] Any significant cuts to Medicaid funding of home and community-based services, even if framed as temporary, can create an existential threat to the CBO network.

Further, over the longer term, a premise of the Framework is that Medicaid funding has declined relative to demand for services so CBOs need to blend and braid other funding streams to shore up their financial stability. While we certainly agree that Medicaid funding, particularly for home and community-based services, is inadequate and CBOs unfortunately must scramble to ensure sustainability, we urge that the genuinely sustainable longer term solution is to provide adequate state and federal funding for those services that address SDOH and prioritize healthy community living over institutional placement. This approach is more rational and less expensive than institutional placement and is consistent with the wish of most older adults to age in their community. ACL can provide both expertise and leadership in articulating the need to improve the underlying program design and funding streams.

Equity and Addressing Disparities

We ask that the Framework directly address equity issues and take a hard look at disparities.

Person-centered approaches also need a population-centered element. It is important to look at how CBO/state/plan networks in communities are functioning now, and specifically to capture data on race, ethnicity, sexual orientation and gender identity to determine who is and isn't currently being served. A scan can also identify what services are easily available in what neighborhoods, as well as how many services are accessible to people with disabilities. An environmental scan examining disparities will help ACL, states and plans to focus on addressing those disparities as they develop new initiatives.

Attention to the needs of those CBOs serving the most underserved communities also is critical. These CBOs may themselves be the most under-resourced and need the most assistance with business practices and with dealings with health plans. If ACL and states are going to assist in linking CBOs with managed care plans, it is important that they ensure that those partnerships address current disparities

[1] An example of the threat to these programs is the initial California Medicaid budget proposed this spring. It would have eliminated funding for the Community Based Adult Services (CBAS) program and Multi-Purpose Senior Service Program (MSSP), and would have made cuts to the In-Home Supportive Services (IHSS) program -- the largest long-term services and supports program in the state. Under the proposal 44,000 individuals would have lost services entirely and 625,000 individuals would have seen their hours reduced by seven percent – the majority of those impacted would have been people of color. The programs were ultimately saved in the state's final budget.

in health and in service access. Health plans may be more comfortable working with the longest-established and largest CBOs, yet those may not necessarily be the ones that reach the most vulnerable and disadvantaged populations or that have the reservoir of cultural competence to facilitate person-centered planning.

Medical Model and Social Determinants of Health

The Framework (p.4) notes that 60% of the factors that influence health are non-medical social, behavioral and environmental factors and that CBOs are pivotal in addressing these needs. We ask that ACL, both in the Framework and its work, be more explicit in discussing the gap –sometimes more like a chasm-- between the medical model of health plans and the approach of CBOs addressing SDOH. The approach of health plans to assessments, service delivery, even forms and terminology can easily dominate and lead to medicalization of person-centered care. As health plans embrace the opportunity to provide non-medical services on both the Medicare and Medicaid side, ACL and the states can play an important role in ensuring that they do so in a way that recognizes the prominent role of SDOH in addressing the needs of low income high-need older adults. Requiring plans to partner with trusted CBOs rather than bring services in-house is an important step in preventing medicalization of whole person care. ACL and states also can take other steps to address the need for a cultural shift in health plans and the practical steps to make that shift a reality.

Meaningful Consumer Participation in Systems Design and Implementation

Many of the innovative programs highlighted in the Framework include robust consumer involvement both in planning and ongoing operation of coordinated systems. In the FAI, as well, ongoing meaningful consumer participation such as the Implementation Councils in the Massachusetts FAI have added significant value.[2] Additional avenues, such as use of focus groups to review consumer communications and provide input to program evaluations, have made a difference in program success. The FAI also brought much learning on how to effectively empower consumer voices and support consumer participation.

Particularly now, when issues of equity and disparate impact have come so painfully to the fore, it is critical to very intentionally incorporate consumers in the kind of planning needed for the improved coordination envisioned in the Framework and to ensure that programs are working to reach those who are most in need of services. We suggest that the Framework more directly call out the need for consumer participation, both by advocates and, importantly, by consumers themselves, and discuss with more specificity how to maximize the impact of consumer participation.

Evaluation, Accountability and Transparency

When looking at CBO utilization by plans and its impact on beneficiaries, the role of data is critical to determine whether innovations are meeting their goals. The Framework (p. 8) notes this work in Virginia's VAAACares project. In the FAI in California, the CalMediConnect (CMC) performance dashboard provided important information on the extent to which each CMC plan used specific CBO

[2] See, e.g., Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report (April 2019), pp. 22-24. available at innovation.cms.gov/files/reports/fai-ma-thirdevalrpt.pdf.

services and helped inform policy analysis moving forward. These kinds of data driven, publicly available analyses need to be baked into all the activities discussed in the Framework. Transparency is essential and issues of proprietary data must be addressed at the beginning. As the inequities throughout our healthcare system have become more glaring, it is particularly important that data collection include breakdowns by race, ethnicity, sexual orientation and gender identity. Though we believe all these concerns are implicit in the Framework, we suggest more direct discussion of their importance.

Section 1: Opportunities for Aging and Disability Networks

CIHNs: We appreciate ACL's leadership and thoughtful work on Community Integrated Health Networks (CIHNs). As managed care has expanded in state Medicaid programs and enrollment has grown in Medicare plans serving dual eligibles, the need for coordinated and streamlined contracting with health plans has intensified. Coordination both in contracting and in delivery of services can reduce administrative burdens and help level the playing field between large plans and CBOs. Standardization of business practices across CBOs and across plans is important and we appreciate that ACL is devoting efforts to make that happen.

As advocates, we see time and time again that many of the problems in beneficiary access to benefits are the result of failures of systems to talk to each other, interoperability issues, etc. We note for example that in the Ohio FAI demonstration, differences in time reporting requirements when home aide services were subsumed into managed care brought delays in provider payment and created a chaotic period when many beneficiaries lost access to critically needed services.[3] Issues that may appear to be purely back office business matters can have very tangible impact on beneficiary wellbeing.

Policy levers—Medicaid and D-SNP contracts: As noted in the Framework, state contracts with Medicaid managed care plans and with Dual-Eligible Special Needs Plans (D-SNPs) are particularly powerful levers. Our experience with D-SNPs is that most states have imposed minimal requirements in their contracts to date. Now that Congress has permanently authorized the D-SNP model, however, there is an opportunity for more comprehensive and specific state requirements that would promote optimal utilization of existing community resources.

We note the valuable tool prepared by the Integrated Care Resource Center with model D-SNP contract language for statutorily required elements as well as for some optional requirements. Something similar with model language for both Medicaid and D-SNP plan contracts related to requirements for contracting with CBOs, developed either by or for ACL, could be very helpful to states.

State contract terms and requirements are only effective levers, however, if states exercise oversight to monitor progress and ensure compliance. States wanting to achieve transformative change in their delivery systems for dual eligibles need to dedicate personnel to ongoing engagement with CBOs and plans to identify problems early and determine successes. In the FAI, CMS/state contract management teams met periodically with plans and, as appropriate, with other partners. There also was informal ongoing review, such as review of small samples of care management files, not for purposes of compliance actions but rather so that regulators could get a sense of strengths and weakness that could

[3] See Financial Alignment Initiative My Care Ohio (April 2019), p. 119, available at innovation.cms.gov/files/reports/fai-oh-firstevalrpt.pdf.

be addressed by training or other means. This level of involvement is resource-intensive for states but essential. ACL could play a very useful role in developing best practices for states and facilitating state sharing of oversight challenges.

Policy levers—MSP enrollment: We share ACL's view that CBOs play an important role in maintaining continuity of enrollment of dual eligibles as well as increasing access to Medicare Savings Programs (MSPs), the Part D Low-Income Subsidy (LIS) and other programs. We also note that there are significant opportunities for states to address chronic under-enrollment in MSP programs. ACL may wish to highlight an innovation recently adopted by New York State that uses a batch enrollment process for QMB and SLMB enrollment. The process eliminates enrollment complexity for beneficiaries and provides administrative simplification. States can simplify and expand eligibility and improve their handling of the MIPPA process in which SSA sends LIS data to the states for purposes of initiating an MSP application.

State Roadmap and Addendum

The State Roadmap portion of the Framework and Addendum 1 offer very practical guidance and a deep dive into core benefit areas. We appreciate this wealth of information, both in the Roadmap and in the detailed Addendum. Our comments on this section suggest some additional areas for discussion and offer additional thoughts on transportation and nutrition.

Role of Legal Services: The Roadmap does not discuss legal services programs, which are themselves CBOs and an important component of the ecosystem supporting access to health and other services for older adults. Strong connections between legal services and other CBOs are essential to address enrollment, retention and access to services faced by older adults, particularly because older adults often first come to a social worker, care coordinator or health care provider in a CBO with a problem that requires legal assistance. Legal services programs also are well situated to identify systemic issues in programs serving the community. Legal services programs, including those funded by OAA, frequently are central players in initiatives and redesign efforts on issues like transportation, nutrition and housing, all of which are discussed in the Roadmap. Though in some communities the connections between legal services and other CBOs are strong, there are others where ACL leadership could encourage broader collaboration.

Disaster Preparedness: We suggest that the state Roadmap include discussion of disaster preparedness. The pandemic, as well as recent hurricanes and fires have demonstrated that older adults are those most at risk and least able to fend for themselves in times of crisis.[4] Planning ahead for a coordinated response of CBOs and plans is essential. The role of CBOs is central because of their ongoing relationship with the most vulnerable and isolated seniors and their knowledge of the particular needs of individuals.

Elder Justice: CBOs are on the front lines in identifying physical, psychological and financial elder abuse among their clients. Research shows that older adults in communities of color experience abuse in distinctly different ways, but elder abuse among these communities is underreported and under-

[4] The US Fire Administration estimates that older adults are nearly twice as likely as the general population to die in a fire. Indeed, the overwhelming majority of deaths in California's devastating Paradise fire were over 65. In hurricanes, nearly half individual who died in Hurricane Katrina were over 75, half of those who died in Hurricane Sandy were over 65.

researched.[5] CBOs, with their deep cultural competence and their trusted relationships, are uniquely situated to spot instances of elder abuse and also support older adults in the aftermath. ACL and states can work with CBOs to develop common protocols, collect data, and share best practices, particularly educating each other on cultural norms that may affect underreporting.

Transportation: Access to safe and reliable transportation is most certainly a key element in ensuring that older adults can live safely in the community with access to needed services. The Medicaid Non-Emergency Medical Transportation (NEMT) benefit is an important component in a community's transportation mix. The currently dominant model in which states contract with national transportation brokers, however, has not been conducive to engaging these national players at the local level. Experience suggests that significant challenges will arise when trying to include NEMT in the kind of coordination and integration envisioned in the Roadmap. To partially address this issue, we suggest that state broker contracts impose very specific requirements with respect to broker participation in transportation partnerships and coordination with CBOs and state and local entities.

Nutrition: We appreciate that the Roadmap highlights the need of many older adults for medically tailored meals. As D-SNPs and other Medicare Advantage plans introduce meals as SSBLI benefits, it will be important that, from the beginning, they ensure the availability of medically tailored meals. Plans have an obligation not to discriminate among plan members and failure to offer tailored meals would make a nutrition benefit unavailable or at least unusable to many plan members.

An additional issue with nutrition benefits that was not highlighted in the Framework is cultural competence in meal design. Especially for older adults, a nutrition program will be successful only if individuals are provided with meals that are consistent with their cultural preferences. CBOs focused on serving particular populations can be important partners in developing a robust meal program that effectively reaches the whole community.

Conclusion

Thank you for the opportunity to review the Framework. We look forward to continuing to work with ACL to improve person-centered services to older adults. If any questions arise concerning this submission, please contact Georgia Burke, Directing Attorney, at gburke@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director

[5] For example, Black older adults are significantly more likely to be victims of financial exploitation and psychological mistreatment, while Asian American older adults are more likely to view elder abuse as existing only within the family, making the risk of abuse from outside actors higher.