JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

October 26, 2017

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
200 Independence Avenue, SW, Room 415F
Washington DC 20201

Submitted via e-mail at HHSPlan@hhs.gov

Re: Draft HHS Strategic Plan FY 2018-2022

Justice in Aging appreciates the opportunity to comment on the draft HHS Strategic Plan, FY 2018-2022.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging uses 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.

I. Overview

Our comments are informed by the needs of the populations for whom we advocate. They are built around some major themes that are important to meeting the needs of low income older adults:

- Affordability: Older adults with low incomes need comprehensive coverage from the Medicare and Medicaid programs because they do not have the resources to pay for additional services that are not covered. We urge that the Strategic Plan include actions to ensure that the full spectrum of necessary health care services, including oral health, vision and hearing services and long-term services and supports are both available and affordable to all who need them.

- Care coordination and integration of community supports: Developing more person-centered approaches to health care and providing better coordination of services are important goals across the American healthcare system. The need is particularly acute for low income older adults, who disproportionately have multiple chronic conditions and who often need additional community supports to live safely in the community. We welcome ongoing efforts to better coordinate delivery systems and provide person-centered care. We also appreciate the recognition in the Strategic Plan of the need to

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better integrate non-medical supports such as housing into health care planning and delivery.

- ❖ Oversight: We have concerns that throughout the Strategic Plan there are very limited references to the agency's oversight function. While we recognize that HHS should and must work collaboratively with the provider, health insurer and research communities to foster improvement and innovation, it is equally important that the agency engage in robust oversight to ensure that consumers are protected from harm, that quality standards are upheld, and that improvements are implemented. All Americans, but most especially the older adults and persons with disabilities who rely on Medicare and Medicaid, count on HHS to carefully monitor the performance of the providers and health plans under its jurisdiction. With the increasing number of consumers in Medicare and Medicaid managed care and in Marketplace plans subject to HHS jurisdiction, it is particularly important that HHS ensure that plans deliver what they promise.

- ❖ Health equity: We appreciate that the Strategic Plan seeks to address inequities in health care delivery and in health outcomes among Americans. Cultural competence across the health care delivery system, including within HHS, is critically important in effectively delivering health care. Cultural competence includes a need to provide information in languages and formats that consumers can understand. We believe the Strategic Plan could be strengthened by more explicitly recognizing the link between discrimination protections and improving health equity and by a more explicit commitment to enforce anti-discrimination statutes and regulations.

II. Specific Comments and Suggested Edits

Goal 1: Reform, strengthen, and modernize the nation's health care system

Objective 1.1 Promote affordable health care, while balancing spending on premiums, deductibles and out-of-pocket costs

Strategy: Promote preventive care to reduce future medical costs (Line 141)

As discussed in our general comments, affordability is a central element in accessibility. In the Medicare and Medicaid programs, as well as private insurance, HHS has recognized that co-insurance for preventive services has been a deterrent for uptake and made ongoing efforts to expand the scope of preventive services that are available to consumers with no cost-sharing. We ask that there be an explicit commitment to ensuring affordability of preventive care by the following revisions:

Line 147:

- Reduce avoidable costs by increasing use of and <u>ensuring affordability</u> <u>of</u> primary and secondary preventive health services.

Line 151:

- Support availability and affordability of preventive health services such as screenings, immunizations by healthcare providers and community partners.

Strategy: Strengthen informed consumer decision-making and transparency about the cost of care (Line 158)

We support efforts to strengthen informed consumer decision-making and transparency about the cost of care. For older adults and people with disabilities, navigating choices can be particularly daunting and confusing and many use in-person assistance when making decisions about their health care coverage. Many older adults are not comfortable with computer programs, and those with low incomes often do not have access to internet-based assistance and may not have the ability to receive, maintain and effectively use printed information. For these individuals especially and for people with limited health literacy or limited English proficiency, personal one-on-one assistance is critical for informed consumer decision-making.

To make informed decisions on health insurance choices, consumers need confidence that the information on which they are making their choices accurately describes the coverage they will receive. For example, health plan provider networks must actually be available as described. But recent CMS surveys of Medicare Advantage and Medicaid Managed Care plans found an alarming percent of providers listed in plan directories either were not listed at current addresses, were not taking new patients, or had died or disappeared. Important questions have also arisen with respect to whether providers listed as accessible to persons with disabilities actually can provide accessible services. Similar concerns exist for Qualified Health Plans in the Marketplace. These examples demonstrate the importance of HHS exercising its oversight responsibilities to ensure that consumers can confidently make choices based on accurate information.

We propose the following additional bullets to address these concerns:

- Ensure that consumers have access to free, unbiased in-person assistance in understanding health care choices, and that such assistance is accessible to people with disabilities and those with limited English proficiency.

- Exercising the agency's oversight role, ensure that information upon which consumers make coverage choices is accurate and that consumers have full access to the coverage they have chosen.

Strategy: Reduce disparities in quality and safety (Line 283)

We strongly support the inclusion of this strategy as it is critical to ensure that our health care system is accessible to all individuals, regardless of race, ethnicity, language,

immigration status, sex, gender identity, sexual orientation, age and/or disability. We believe all of these strategies must be kept and indeed should be expanded upon.

We also recommend that to the extent HHS recognizes the need for providing materials in non-English languages that it also recognize the need for providing materials in formats that will be accessible to individuals with disabilities who have communication needs. This would include large print format and audio or video recordings for those who cannot access written materials. We recommend amending the relevant bullet as follows:

Line 294:

- Increase available information in cultural- and health literacy-appropriate levels, and in alternate formats, — such as in languages other than English, large print, or audio and video versions — to improve access to health information

Objective 1.3 Improve Americans' access to healthcare and expand choices of care and service options.

Strategy: Expand Coverage Options (Line 325)

We appreciate the reference in this section to consumer choice in Medicare. Since an important option for Medicare consumers is fee-for-service, we propose edits to the first bullet that recognize the need to strengthen that option as well. Further, we think it important not to emphasize reducing regulatory burden on plans over ensuring that consumers have access to quality, affordable coverage and care. While we recognize that there are opportunities to avoid duplicative reporting requirements and otherwise streamline requirements, it is important that HHS be careful to maintain a regulatory regime that includes robust oversight over plan quality and performance. Audits conducted by CMS have shown significant failures of plans to comply with core requirements. Audits repeatedly identified plans that imposed unauthorized utilization management requirements on prescription drugs, that routinely failed to handle appeals of denial of coverage in a timely or appropriate fashion and that engaged in other conduct that put the health and safety of their members at risk. Medicare beneficiaries rely on HHS to identify areas of poor performance and protect them from the harm that ensues. This activity is a core responsibility of the agency.

We also appreciate the bullet regarding improved access for dual eligible beneficiaries to integrated physical and behavioral care options. Much is being learned from the current dual eligible financial alignment demonstrations about integrating care for duals and we urge HHS to continue to analyze which interventions are most effective and what coverage vehicles work best for different subsets of the dual eligible population. We also note that effective integrated care options must be person-centered and, for dual eligible beneficiaries, must include the long-term services and supports that their Medicaid benefit provides.

We propose the following edits:

Line 326:

- Expand ~~plan~~ choice in Medicare by strengthening the quality of all coverage options, including Medicare fee-for-service, Medicare Advantage and Medicare Part D. Protect the integrity and soundness of these programs by exercising robust oversight while reducing administrative, regulatory, and operational burdens, but only to the extent that such reduction does not weaken consumer protections for Medicare beneficiaries.

Line 335:

- Improve access of dual Medicare-Medicaid beneficiaries to care options that prove effective in providing person-centered coordination of care. These options can include those that fully integrate physical and behavioral care and long-term services and supports.

Strategy: Reduce Disparities in Access to Health Care (Line 380)

We strongly support the emphasis in this section and elsewhere on reducing disparities to access to health care. Addressing disparities is one of the great challenges in health care and the agency's commitment to tackle the problem is well placed. We recommend HHS include a broad definition of health care disparities in its strategic plan that includes not only racial and ethnic health disparities but also disparities based on language, age, sex, sexual orientation, gender identity, and disability.

We have several thoughts on how to strengthen this important section in particular. Looking at the first bullet, we fully endorse the proposal to test models of care with strong evidence-based evaluation. We have supported the rigorous evaluation component in the demonstrations undertaken by the Medicare-Medicaid Coordination Office and urge in-depth evaluation with demonstrations going forward. Though it may appear to be a small point, we also urge that, when talking about models of care, the agency use the term "person-centered" rather than patient-centered (we note that "person-centered" is used in Goal 3). Person-centered planning takes into account all of the individual's wishes and goals, and is not limited to the purely medical elements. Particularly for older adults and persons with disabilities who require both medical and non-medical supports to live safely in the community, this distinction is an important one.

Looking at the second bullet, we are unclear about its focus. Specifically, it is unclear to us whether the bullet is addressing enrollment and retention of beneficiaries or providers. We believe that simplification on both fronts is important and, for clarity, propose that each be addressed separately. We particularly see opportunities for HHS to work with states for simplification and retention of enrollment of individuals in Medicaid, including Medicaid Savings Programs. Much of the simplification in the enrollment process for the Medicare Part D Low Income Subsidy could easily transfer to state Medicaid programs. These include

limiting the requirements to produce paperwork by assuming a burial set-aside without requiring a separate account, by not requiring determining the cash value of small life insurance policies, and by not counting in-kind support in income calculations. The Part D continuing eligibility for a calendar year and, starting in July, for the next calendar year also is an efficient way to maintain eligibility for a population that overwhelmingly has very small variances in income.

We appreciate the references in the third bullet on oral health and vision services. We would add hearing services, with particular emphasis on the current lack of Medicare coverage for hearing aids. We also note that research on access to the services identified is not the real issue. There already is abundant evidence that current access and affordability are limited and that those limits are negatively affecting overall health, particularly among older adults. Rather, developing funding mechanisms so that those services can be better integrated into the Medicare and Medicaid programs is a primary concern.

Another important element in addressing disparities that is not directly discussed in the current strategy is communication. A recent study released by CMS, Understanding Communication and Language Needs of Medicare Beneficiaries,[1] discussed the language needs of the over four million Medicare beneficiaries who have limited English proficiency. We urge that the strategic plan more specifically address those needs.

Persons with disabilities, including many older adults also need physical access to services including providers that have accessible offices and equipment, accessible and reliable transportation to provider facilities, home visits by providers, etc. It is important that CMS monitor the providers, plans and entities it regulates to ensure that disparities in access to care are corrected.

More generally, people who are frail, and those with low health literacy, including many living in poverty find health programs such as Medicare and Medicaid very difficult to navigate alone. We have seen that robust ombuds programs, such as those in the Medicare-Medicaid financial alignment initiative, can contribute significantly to alleviating problems and improving access.

To address these concerns, we recommend the following:

Line 381:

- Test ~~patient~~ person-centered models of care, including ~~patient~~ person-centered medical home recognition and care integration, and support the adoption and evolution of such models <u>that improve quality of care and reduce expenditures.</u>

[1] Available at cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf . See also a discussion of the American Community Survey numbers and the needs of Limited English proficient older adults in AARP Public Policy Inst., Improving Access to Care Among Medicare Beneficiaries with Limited English Proficiency: Can Medicare Do More?, available at assets.aarp.org/rgcenter/health/i6_medicare.pdf.

Line 384:

- Simplify enrollment of healthcare providers, eliminate barriers to retention of healthcare providers, and address shortages of healthcare providers who accept Medicare or Medicaid or providers who offer specialized care.
- Simplify enrollment of beneficiaries in Medicare and Medicaid. Explore ways to smooth enrollment in Medicare when individuals turn 65 or otherwise become eligible for Medicare. Work with states to simplify enrollment and retention in Medicaid, including adoption of techniques used in the Medicare Part D Low Income Subsidy program.

Line 386:

- ~~Support research to provide evidence on how~~ Work to ensure access to affordable, physical, oral, vision, hearing, behavioral, and mental health insurance coverage for children and adults, especially those with low incomes.

Add the following bullets:

- Take appropriate actions to ensure that HHS itself and the health plans and providers it regulates comply with the requirements of Title VI of the Civil Rights Act of 1964, Executive Order 13166, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act and other civil rights statutes and regulations that address disparities.

- Through data collection, consumer focus groups and other mechanisms, monitor the performance of health plans and providers to identify and address disparities in access to services.

- Maintain and support ombuds programs to assist individuals in accessing services and to identify systemic problems of access or quality.

Objective 1.4: Strengthen and expand the healthcare workforce to meet America's diverse needs

We agree that strengthening and expanding the healthcare workforce is critical to address health disparities and believe that a key component of this effort must be to ensure that healthcare providers do not discriminate. For frail older adults, the effects of discrimination can be especially troubling. For example, in a survey of LGBT seniors reported in our publication, Stories from the Field, there were numerous cases where LGBT seniors in care facilities were denied baths or other basic assistance and were treated without dignity or respect.[2] Therefore, we recommend the following change:

[2] LGBT Older Adults in Long-Term Care Facilities, Stories from the Filed (2015), available at justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf .

Line 435:

- Remove ~~any~~ barriers to, and promote, full participation in the health care workforce by persons and/or organizations with religious beliefs or moral convictions, while ensuring that health care providers, whatever their religious beliefs or moral convictions, adhere to the medical and health-related standard of care and do not discriminate.

Goal 2: Protect the Health of Americans where they live, learn, work, and play

Objective 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support

Strategy: Build capacity and promote collaboration among states, tribes, and communities (Line 698)

We appreciate the explicit recognition of promoting the health and independence of older adults who have or are at risk for behavioral health conditions and believe that providing integrated behavioral health services is critical to ensuring older adults can live safely and independently in the community. Therefore, we recommend the following change:

Line 708:

- Promote the health and independence of older adults with or at risk for behavioral health conditions (i.e., mental illness, substance use disorders, suicide) through improved collaboration with federal and non-federal stakeholders and through increasing access to and availability of home and community-based long term supports and services that provide full support to allow individuals to live and fully participate integrated settings.

Objective 2.4: Prepare for and respond to public health emergencies

Strategy: Promote emergency preparedness and improve response capacity (Line 761)

Recent disasters have highlighted the fact that older adults are among those most at risk in health emergencies. The majority of the deaths in California's wildfires have been older adults.[3] The shocking nursing home deaths in Florida are another example of how vulnerable older adults need to be prioritized.[4] With these factors in mind, we recommend adding a new bullet:

[3] See San Francisco Chronicle, The Lives Lost in the Wine Country Fires, available at sfchronicle.com/news/article/The-lives-lost-in-the-Wine-Country-fires-12271338.php

[4] See, e.g., New York Times, Nursing Home Deaths in Florida Heighten Scrutiny of Disaster Planning, available at nytimes.com/2017/09/14/us/nursing-home-deaths-irma.html .

- Exercising the agency's regulatory authority, ensure that institutions and health care facilities, particularly those serving older adults, people with disabilities, and other vulnerable groups, have emergency procedures in place to ensure the safety of those they serve.

Strategy: Support timely, coordinated, and effective response and recovery activities (Line 778)

With communications easily meaning the difference between life and death, it is also critically important in disasters to reach all members of the community, including those who do not speak English well. We suggest the following edit:

Line 786:

- Ensure that the needs of disadvantaged and at-risk populations are met in emergencies, through effective integration of traditionally underserved populations into planning, response, and recovery efforts and through use of communications strategies that are culturally competent and reach all community members, including those who have limited proficiency in English and those needing communications in alternate formats.

Strategy: Strengthen and protect the emergency preparedness and response workforce (Line 808)

We propose calling out especially the needs of older adults and people with disabilities.

Line 822:

- Increase capacity of emergency providers, healthcare and human services providers, and public health professionals to address needs of at-risk individuals, including older adults and people with disabilities, in disaster and public health emergency preparedness, response, mitigation and recovery.

Goal 3: Strengthen the economic and social well-being of Americans across the lifespan

Objective 3.4: Maximize the independence, well-being and health of older adults, people with disabilities, and their families and caregivers

We appreciate the emphasis in this section on person-centered care and on improving Home and Community-Based Services (HCBS) and opportunities for aging in the community. Among the strategies proposed, we suggest clearer emphasis not only on opportunities to remain in the community but also on opportunities for persons living in institutional settings to transition into community living.

Strategy: Strengthen supports for community living (Line 1066)

We believe that this strategy can be strengthened by more explicit recognition of the need to support to older adults and people with disabilities to not only to live in their communities but fully participate in them as well, and by ensuring that these individuals are protected from discrimination.

We see affordability as a missing piece in the strategy. With the median income of Medicare beneficiaries well below $30,000, it is critical that needed health care be available at costs that older adults can afford. For the lowest income individuals, it is imperative that Medicaid coverage be robust and comprehensive. On the Medicare side, the skyrocketing cost of prescription drugs alone is leading many beneficiaries to drop needed prescriptions, skip doses, or make painful choices between food and needed medications.

A closely related issue is the gap in coverage of whole categories of services that older adults need to live in health and safety in the community. The lack of Medicare coverage for oral health, most vision services, and hearing aids puts these important services out of reach for many. Medicaid coverage of these services, because it is optional, varies significantly from state to state. Further, oral health has not been well integrated in coordinated care.

We propose the following edits:

Line 1067:

- Develop age-and dementia-friendly livable communities to improve quality of life for older adults, families, caregivers, people with disabilities, and the larger community and develop funding mechanisms that make these communities accessible to people with low incomes.

Line 1069:

- Promote independence of older adults and people with disabilities through improved federal collaboration, including with faith-based and community organizations, to ensure opportunities to live and receive services in ~~the community~~ their own homes and communities, in the most integrated setting appropriate to their needs, including integrated opportunities for active community participation in all areas of life.

Lines 1072:

- Foster culture change through inclusion and accessibility for children and adults with disabilities and older adults by removing physical and other barriers and through robust implementation and enforcement of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act.

Add the following bullet:

- Develop programs and policies that integrate oral health with primary care, that increase access to oral health care, and that increase access to vision and hearing services for all Medicare and Medicaid beneficiaries.

Strategy: Support improved care transitions and care coordination. (Line 1078)

We appreciate that HHS has raised the visibility of care transitions. We ask that this strategy explicitly address the unique challenges in transitions for individuals who have been residing in long term care facilities and wish to return to the community. We propose the following change:

Line 1083:

- Pursue initiatives and programs to provide support to older adults, people with disabilities and their families and caregivers as individuals move between institutional settings and ~~home~~ more integrated settings. Develop programs and supports that provide opportunities for those in long-term care facilities to safely return to the community with needed supports and funding in place to allow active community participation in all areas of life.

Strategy: Strengthen supports for caregivers (Line 1109)

We appreciate the emphasis on support for caregivers. We ask, however, that this section more explicitly acknowledge the limits to what unpaid caregivers can be expected to do and the importance of affordable access to paid caregivers. Additionally, under the Affordable Care Act many family and paid caregivers gained access to health coverage through Medicaid and the Marketplaces, and we believe this section should explicitly recognize the need to ensure all caregivers have access to affordable, comprehensive health coverage. We propose the following additional bullets:

Add the following bullets:

- Expand the availability and affordability of a workforce of trained, culturally competent paid caregivers.
- Ensure that all caregivers have access to affordable and comprehensive health coverage.

Goal 4: Foster sound sustained advances in the sciences

Everyone working to support beneficiaries dealing with dementia, cancers, heart disease and the many diseases that disproportionately affect older adults want, as much as anything, that answers are found to stop or slow these diseases that destroy lives and burden the health system. The constellation of dementia-related conditions particularly burdens families, communities, and the health care system. HHS support of basic research has been critical for major breakthroughs in the past. We are hopeful that such support will continue and yield benefits in the future. We strongly support the agency's efforts.

Goal 5: Promote effective and efficient management and stewardship

Objective 5.3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals

Strategy: Modernize information technology systems. (Line 1598)

As advocates, we see that a very significant percent of the problems that Medicare and Medicaid beneficiaries face arise from data errors affecting eligibility and enrollment, slow updates in status that cause denials of services or benefits, etc. In many cases, there are compatibility issues between HHS systems with SSA systems and with state Medicaid systems. Thoughtful investments in systems upgrades and especially in improving compatibility and efficiency in communications among agencies would solve many recurring problems and free administrative time needed to untangle errors and delays.

Thank you again for the opportunity to comment. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org.

Sincerely,

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