Medical-Legal Partnerships Support Patients' Health

BY KATHRYN DEMOTT
Senior Editor

Dr. Colleen Cagno recalls a patient who urgently needed help renewing his public housing.

She and a lawyer who works down the hall documented how his medical condition qualified him for public housing, and expedited the process to prevent an eviction that would have taken a toll on the patient's health, said Dr. Cagno, associate residency program director in the department of family and community medicine at the University of Arizona, Tucson.

In October 2005, the faculty and residents started offering such services to low-income patients and families under a medical-legal partnership known as the Tucson Family Advocacy Program. Now, two lawyers are available in the teaching clinic for a total of 40 hours per week. Since opening its doors, TFAP has assisted more than 370 patients with more than 770 legal matters affecting health, including disability benefits, Medicaid, Medicare, housing conditions, public benefits, advance directives, and domestic violence.

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The program is one of more than 70 medical-legal partnerships operating or soon-to-be operating across the country, explained Anne M. Ryan, J.D., director of TFAP. Across the country, medical-legal partnerships are found in a variety of settings, from universities to legal aid offices, hospitals, and law schools, Ms. Ryan added.

A wealth of literature indicates that "if we don't address our patients' [basic nonmedical] needs, we [as physicians] end up spending more time in other ways," Dr. Cagno added.

These are the patients who often come in again and again. At first glance, they might appear to have a difficult time complying with their medication regimen, but often at the root of that problem is a social or financial obstacle.

With half of her clinic's patients on Medicaid, Dr. Cagno noted that it's not unusual for them to struggle with basic needs such as housing and food, so paying for medications becomes a second-tier priority.

Patients with asthma have needed legal assistance dealing with landlords who are slow to eradicate a roach or mold infestation problem. Others are living with domestic violence, a situation in which having the clinic's legal and social services on hand makes all the difference.

In another case, a 46-year-old man who was used to living from paycheck to paycheck from his store clerk job worried about providing for his family after he was diagnosed with advanced cancer and was no longer able to work. In conjunction with his physician, TFAP helped him obtain temporary state assistance and expedited Social Security disability benefits, enabling the family to keep its home and car. Without the coordination of medical and legal services, his family would have needed to wait 6 months for disability benefits to begin, Ms. Ryan noted.

"It's providing that kind of patient-centered holistic care that really gets to the concept of the medical home," Dr. Cagno added.

Funding for TFAP comes from a variety of sources, including the Arizona Foundation for Legal Services and Education, Southern Arizona Legal Aid, the United Way of Tucson and Southern Arizona, and the University of Arizona Foundation. In addition, the university's department of family and community medicine pays for the staff time of the physicians who are involved in the partnership, and the clinic provides the office space for the lawyers, a social worker, and interns.

Physicians practicing outside of academic medicine may lack the backing of such funding sources, Dr. Cagno and Ms. Ryan acknowledged. But they both insist that there are resources out there. To start, every state has legal aid offices, which provide free legal services to individuals with limited income. In addition, there are free legal service providers in every state that help disabled individuals, Ms. Ryan said. And in many communities, lawyers volunteer their services to those in need either pro bono or on a sliding scale.

Physicians frequently get discouraged because they don't have the time to find services for their patients who are in need, Dr. Cagno said. But in every community there are at least one or two key social service providers who will do the digging to help patients find services.

Screening patients for social or financial problems is a good first step, Dr. Cagno and Ms. Ryan agreed. Ms. Ryan suggested asking just a few open-ended questions, such as "Every family has fights. Tell me about fights in your home." Or "Have you ever cut your medicine dose in half or skipped it because you couldn't afford it?" Many patients do not want to apply for public assistance. The key is to destigmatize the need by having their physicians ask questions that validate their needs, she said.

Screening by physicians is crucial. Of patients referred to the TFAP last year, 94% had not previously sought legal help for their problems. All, however, had discussed their concerns with their family health care providers.

According to Ms. Ryan, "This statistic supports a fundamental principle of medical-legal partnerships like TFAP: Providing multidisciplinary legal services in a trusted health care setting is an effective way to identify and help people access the benefits and services they need. We believe that lawyers, physicians, social workers, and patients can work together to prevent or overcome many nonmedical problems that impact health." ■

POLICY & PRACTICE

Part B Premiums Same for 2009

Medicare beneficiaries won't have to reach any deeper into their wallets to pay their Part B premiums and deductibles next year. Officials at the Centers for Medicare and Medicaid Services announced that the 2009 standard Part B monthly premiums will be the same as in 2008—$96.40. This is the first time since 2000 that the standard premium has not increased over the previous year, according to CMS. The Part B deductible also remains the same at $135. Part B expenditures, which cover physician services and outpatient hospital services, continue to rise, but government officials were able to keep premiums from increasing because of a surplus in the Part B account of the Supplementary Medical Insurance trust fund. However, premiums are likely to go up in 2010, Richard Foster, CMS actuary, said during a briefing. For Medicare Part A, the deductible—which covers the first 60 days of Medicare beneficiary's hospital stay, will rise to $1,068 next year, an increase of $44.

Part D Marketing Rules Finalized

CMS officials have finalized new Medicare Advantage and Part D prescription drug plan marketing regulations that prohibit plans from telemarketing to seniors and making other unsolicited sales contacts. Under the new regulations, plans cannot provide meals to beneficiaries as part of marketing activities, and cannot conduct sales presentations or distribute or accept applications in places where health care is delivered. The rules also ban financial incentives that could encourage agents and brokers to maximize commissions by inappropriately moving, or "churning," beneficiaries from one plan to another. CMS is requiring plans to be in compliance with the provisions as they begin their marketing for the 2009 plan year. CMS also said it will increase marketplace surveillance, which includes "secret shopper" activities in which a Medicare official poses as a prospective enrollee.

Part D Premiums Up $3 a Month

Medicare Part D prescription drug plan premiums will average $28 per month next year, up $3 from $25 per month this year, CMS Acting Administrator Kerry Weems said. In addition, some beneficiaries may see coverage changes, such as reduced coverage in the Part D "doughnut hole," Mr. Weems said during a press briefing. Some plans had been providing full coverage of generic medications through the doughnut hole, but that coverage is "decreasing somewhat," Mr. Weems said. Still, approximately 97% of beneficiaries currently enrolled in a stand-alone drug plan will have access to Part D and Medicare Advantage plans next year with premiums at the same cost or lower than their coverage this year, though they might have to switch plans to do so, Mr. Weems said, adding that CMS is encouraging beneficiaries to examine their options and review their plans before making a decision for next year.

Retail Clinics Reach Underserved

Retail clinics reach patients who don't have a regular primary care physician, but there is no evidence that the clinics reduce overall health care costs, according to two studies published in the journal Health Affairs. Ten clinical problems, including sinusitis and immunizations, encompass 90% of all retail clinic visits, the first study found. These same 10 clinical problems make up 13% of adult primary care physician visits, 30% of pediatric primary care visits, and 12% of emergency department visits. Although 81% of adults and children nationwide report having a primary care physician, fewer than 40% of the patients surveyed as part of the study reported having one. The second study compared costs over 4 years at the Minnesota locations of MinuteClinics, retail clinics owned by CVS Pharmacy, to those at a physician's office. It found that getting treated at a MinuteClinic costs an average of $104, $55 less than treatment at a physician's office. However, the study said, retail clinic visits accounted for only 6% of all provider visits, and costs rose substantially at all locations over the course of the study.

CMS Alters Overpayment Policy

CMS officials are changing the procedures for recovering certain overpayments made to physicians. CMS will no longer seek payment from a physician for an overpayment while the physician is seeking a reconsideration of the overpayment determination by a qualified independent contractor. Under the new policy, which was mandated by the 2003 Medicare Modernization Act, CMS can only seek to recoup the payment after a decision has been made on the reconsideration. The changes, which went into effect Sept. 29, will apply to all Part A and Part B claims for which a demand letter has been issued. However, a number of claims have been excluded, including Part A cost reports, Hospice Caps calculations, provider-initiated adjustments, Home Health Agency Requests for Anticipated Payment, Accelerated/Advance Payments, and certain other claims adjustments. The changes do not affect the appeal process or the normal debt collection and referral process, according to CMS.

NIH Director Zerhouni Steps Down

Dr. Elias Zerhouni, director of the National Institutes of Health since May 2002, announced that he will step down at the end of October to pursue writing projects and explore other professional opportunities. During his tenure, he worked to lower barriers between disciplines of science and to encourage trans-NIH collaborations, such as the NIH Roadmap for Medical Research, which brought together all 27 NIH institutes and centers to fund research initiatives that single institutes couldn't tackle alone.

—Jane Anderson