

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

September 11, 2023

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services

Submitted electronically via [regulations.gov](https://www.regulations.gov).

**Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS–1784–P)**

Justice in Aging appreciates the opportunity to respond to proposed changes to the CY 2024 Physician Fee Schedule and other Part B Payment and Coverage Policies. 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 healthcare, economic security, and the courts for older adults with limited resources. We focus our efforts primarily on those who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency. Justice in Aging has decades of experience with Medicare and Medicaid and improving both programs and integration for people dually eligible.

Given our focus on the impact of health care programs on low-income older adults, our comments discuss the effect the rule would have on people dually eligible for Medicare and Medicaid and health inequities and disparities. We primarily address the proposals on Medicare payment of dental services inextricably linked to covered services; caregiver training services; and health-related social needs including community health integration.

[Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services \(II.K.\)](#)

*Medicare Payment for Dental Services; Proposed Additions to Current Policies Permitting Payment for Dental Services Inextricably Linked to Other Covered Services (K.1. – K.2)*

Justice in Aging applauds CMS for its continued recognition that oral health is essential in maintaining overall health and addressing health disparities. CMS's CY 2023 Medicare Physician Fee Schedule included a significant clarification of CMS's authority under the Medicare statute to cover "medically necessary" dental care in the Medicare program when dental services are inextricably linked to other covered services. In this rule making, we are very pleased that CMS has identified additional instances in which Medicare will cover medically necessary dental care. This proposal will help to improve equitable access to dental services, improve health outcomes, and help to address health disparities for Medicare enrollees.

Accordingly, **we strongly support the proposal to pay for dental services that are inextricably linked to the use of chemotherapy, CAR T-cell therapy, and high-dose bone-modifying agents including**

*Washington, DC*



*Los Angeles, CA*



*Oakland, CA*

**payment for dental or oral examinations, medically necessary diagnostic and treatment services, and ancillary services, such as x-rays and anesthesia when treating any type of cancer.**

We also strongly support the proposal to cover these services whether offered inpatient or outpatient and whether they are needed *prior to* or *during* cancer treatment. We have heard from advocates that Medicare enrollees are unable to start cancer treatment or have to stop treatment because they could not access necessary oral health services. Delays in cancer treatment result in worse prognoses and perpetuate disparities. Today, for example, Black individuals with cancers of *any type* experience higher death rates than any other racial or ethnic group.<sup>1</sup> For cancers of the oral cavity and pharynx, 47% of Black men have a five-year survival rate compared to 69% of white men.<sup>2</sup> If finalized and effectively implemented, this proposal would improve cancer prognoses and address disparities in cancer outcomes.

*Request for Information on Dental Services Integral to Covered Cardiac Interventions; Request for Comment on Dental Services Integral to Specific Covered Services to Treat Sickle Cell Disease (SCD) and Hemophilia; Request for Comment Regarding Dental Services Possibly Inextricably Linked to Other Medicare-Covered Services (K.3. – K.5)*

We are encouraged that CMS is seeking evidence regarding circumstances in which dental services are inextricably linked to cardiac interventions, treatments for sickle cell, hemophilia, and treatments for people with auto-immune conditions. As Families USA notes, there is clinical consensus from medical experts and professional associations regarding the importance of oral health treatment for these medical treatments.<sup>3</sup> Additionally, there are significant racial disparities in the incidence and severity of these health conditions that coverage of dental services would improve.

While Justice in Aging cannot provide clinical evidence, with regard to auto-immune disorders in particular, we have heard directly from advocates working with older adults that they are unable to begin chemotherapy because their poor oral health place them at too high of risk for infection considering the immunosuppressive impact of chemotherapy.<sup>4</sup> Similar to the use of chemotherapy for the treatment of cancer, delays in the use of chemotherapy for treatment of auto-immune disorders result in poorer prognosis and health outcomes and perpetuate health disparities.

We strongly urge CMS to use evidence submitted for this and future proposed rules and to continue to partner with researchers to obtain additional evidence to permit payment for dental and oral health treatments and ancillary services that improve the affordability, access, and outcomes of cardiac interventions, treatments for sickle cell, hemophilia, and treatments for people with auto-immune conditions.

*Request for Information on Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services (K.6.)*

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<sup>1</sup> National Institutes of Health, National Cancer Institute, "[Trends in Cancer Mortality Among Black Individuals in the US From 1999 to 2019](#)," (2022).

<sup>2</sup> National Institutes of Health, National Institute of Dental and Craniofacial Research, "[Oral Health in America: Advances and Challenges](#)," [Section 3-B: Oral Health Across the Lifespan: Older Adults](#) (2021).

<sup>3</sup> Santa Fe Group, "[Clinical Consensus on Medically Necessary Dental Care](#)," (2020).

<sup>4</sup> Justice in Aging, "[Dental Coverage for Older Adults Should be Coordinated and Evidence-Based](#)," (2017).

We appreciate that CMS is seeking comments and best practices on the implementation of the medically necessary policies, including on coordination between providers and whether CMS should provide further guidance to other dental benefit payers. Without effective implementation, the goals of improving access to oral health care, improving health outcomes, and addressing health disparities cannot be realized.

As the Center for Medicare Advocacy outlined in their comments, very few Medicare medical providers or dental providers know that Medicare will pay for dental services inextricably linked to other Medicare covered services. Of those few providers who do know about the coverage, they have questions about when the coverage applies and how they code and obtain reimbursement for rendering services. We urge CMS to develop and disseminate additional guidance and engage in robust and targeted outreach to both Medicare medical providers as well as oral health providers to disseminate this guidance and provide technical assistance. For example, CMS should issue more comprehensive guidance through Medicare Learning Network (MLN) resources and consider ways to leverage care coordinators and Principal Illness Navigators in education efforts. Additionally, CMS should be providing guidance to Medicare Advantage plans to ensure the plans and frontline staff understand this coverage and importantly how it should be coordinated with any supplemental dental coverage these plans are offering. The explanation of this coverage should be integrated into the evidence of coverage and described in MA Member Handbooks and MA provider directories should include dental providers.

As advocates for low-income older adults, **we strongly urge CMS to issue guidance on how this coverage interacts with Medicaid coverage.** More often than not, when Medicare coverage differs and overlaps with Medicaid coverage, dually-eligible individuals face significant barriers in obtaining any services at all despite dual coverage. Coordination of dental coverage may be especially complex for some dually eligible individuals enrolled in Medicare Advantage because they may have three types of dental coverage: Medicare coverage of inextricably linked dental care, MA supplemental dental benefits, as well as Medicaid coverage. We urge CMS to issue guidance on Medicare payment of dental services through State Medicaid Director letters; offer technical assistance; share best practices; and provide model educational materials for states to use in their outreach efforts. In addition to general Medicare Advantage materials noted previously, CMS should also issue specific guidance to integrated Medicare products including Dual Eligible Special Needs Plans (D-SNPs), Medicare-Medicaid plans, and PACE. While these plans are mandated to better integrate and coordinate care for individuals dually eligible, we continue to see barriers to accessing covered services for overlapping covered services.

We encourage CMS to look at best practices in other areas of overlapping coverage in which the Medicare standard or coverage is different or more restrictive than Medicaid, such as durable medical equipment (DME), that can be modified for medically necessary dental coverage. In Connecticut, for example, the state's pre-authorization process for DME in Medicaid addresses the requirement for a Medicare rejection before Medicaid review while California lists out DME services that are never covered by Medicare and accordingly do not require a rejection.<sup>5</sup>

CMS should also consider how to support enrollment of dental providers in Medicare with specific strategies to enroll dental providers already contracted with Medicaid. We hear frequent reports about

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<sup>5</sup> CT Administrative Agencies, §§ 17b-262-672 – 682; California Department of Health Care Services, "[Medicare Non-Covered Services: HCPCS Codes](#)," (Aug. 2023).

how dental providers contracted with Medicare Advantage plans are not contracted with Medicaid. As a result, dually eligible individuals have to see two different providers and often end up getting improperly billed for covered services. For this reason, we also support the coverage of inextricably linked dental services provided in federally qualified health centers (FQHCs) since this is a setting that already accepts Medicaid in which dual eligibles receive both their medical and oral health care.

**Lastly, we strongly urge CMS to track these implementation efforts by analyzing Medicare claims data for dental covered services across fee-for-service and managed care paired with demographic characteristics of those receiving services (e.g., race, ethnicity, age, disability, dual eligible status, etc.) and publicly reporting this data in future rule making and on CMS data dashboards.**

#### Payment for Caregiver Training Services (II.E.4.(26))

**Justice in Aging supports the proposal to allow Medicare reimbursement for caregiver training services.** We commend CMS for taking this concrete action to support family caregivers who are providing the majority of at-home care for people with Medicare. We want to emphasize that while Caregiver Training Services (CTS) is an important support, Medicare enrollees with complex care needs and their caregivers need paid at-home care as well. We strongly urge CMS to fully enforce the Medicare home health benefit to ensure individuals can get both skilled care and paid personal care that they are entitled to.<sup>6</sup>

Despite taking on complex tasks such as providing injections, changing catheters, and tube feeding, only seven percent of family caregivers report receiving any training related to tasks they perform.<sup>7</sup> Facilitating training will particularly help Black and Latino caregivers who perform medical/nursing tasks more often than white caregivers.<sup>8</sup> Most importantly, Medicare reimbursing for CTS has the potential to greatly improve outcomes for Medicare enrollees as research shows that when older adults' caregivers receive training and other supports, nursing home placement is delayed and hospitalizations decrease.<sup>9</sup>

We agree that the definition of caregiver eligible for CTS should be broad. However, we are concerned that the proposed definition will exclude family caregivers who are paid by Medicaid. As discussed below, these family caregivers receive minimal if any training and so it would be in the best interest of Medicare enrollees to permit them to receive CTS through Medicare. To avoid excluding any family caregivers, **we recommend CMS align the definition of caregiver for CTS with existing statutes and initiatives that define caregivers**, specifically the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act definition.<sup>10</sup> In the final rule, we also urge CMS to reiterate that CTS supports person-centered treatment planning and that the examples of circumstances where CTS may be

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<sup>6</sup> See [Justice in Aging's response to CMS Request for Information on Access to Medicare Home Health Aide Services](#) (Aug. 28, 2023).

<sup>7</sup> Burgdorf J, et al., Factors Associated With Receipt of Training Among Caregivers of Older Adults, *JAMA Intern Med.* (2019), <https://doi.org/10.1001/jamainternmed.2018.8694>; AARP & NAC, [Caregiving in the U.S.](#) (May 2020).

<sup>8</sup> *Id.*

<sup>9</sup> Nat'l Academies of Sciences, Engineering, & Medicine, *Families Caring for an Aging America*, p. 216, (2016), <https://doi.org/10.17226/23606>.

<sup>10</sup> In the RAISE Family Caregivers Act, "The term 'family caregiver' means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation." 42 U.S. Code § 3030s, Statutory Note.

reasonable and necessary are not meant to be an exhaustive list. We recommend CMS provide ongoing education to providers, Medicare enrollees, and family caregivers about CTS by discussing examples of conditions and circumstances where CTS may be appropriate.

CMS asks whether Medicaid programs typically cover training that would duplicate the proposed CTS. In our experience, the CTS would not be duplicative. As of 2020, less than half of state Medicaid programs offered training to family caregivers, and that training is limited to people enrolled in specific home- and community-based services (HCBS) programs.<sup>11</sup> There are many older adults dually eligible for Medicaid who are not enrolled in HCBS who could benefit from Medicare CTS. Some states also restrict who is eligible for training services based on their relationship to the enrollee or whether or not they are paid.<sup>12</sup> In addition, Medicaid covered training may not be available when the need arises as part of a treatment plan following acute care. Therefore, **we agree with CMS that the specificity of the proposed CTS would not duplicate Medicaid training. Rather, Medicare CTS would complement any available Medicaid caregiver training.**

**We recommend CMS also permit CTS by telehealth and remote delivery methods.** Each Medicare enrollee's circumstances are different and generalized training in a non-home environment may not be effective to help a caregiver carry out the treatment plan in the enrollee's home. In addition, an enrollee's caregiving needs are likely to evolve over time and CMS should build in flexibility to enable providers and caregivers to maximize the benefit of CTS for the enrollee. Allowing CTS to occur via telehealth is also consistent with Medicaid authority that states adopted during the COVID-19 pandemic.

[Services Addressing Health-Related Social Needs \(Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services\) \(II.E.4.\(27\)\)](#)

#### *Community Health Integration (CHI) Services*

**Justice in Aging strongly supports allowing for reimbursement for community health integration (CHI) services.** CHI services could fill critical gaps for low-income Medicare enrollees and help address health disparities, recognizing that a diagnosis and treatment alone may not resolve the underlying cause or be accessible without additional social supports. We commend CMS for the particular recognition of the role that community-based organizations (CBOs) and community health workers, care navigators, and peer support specialists can play in delivering effective, culturally appropriate, in-language CHI services. This peer-led workforce has unique and critical connections to underserved communities. We urge CMS to ensure the final rule encourage providers to contract with CBOs.

CMS asks whether Medicaid programs typically cover services similar to CHI. While some states do cover some of these services for certain Medicaid populations (e.g., home- and community-based services for people with functional limitations) or in certain circumstances (e.g., non-emergency medical transportation), we do not believe CHI would be duplicative. There are many more Medicare beneficiaries who could benefit from these services than are eligible for Medicaid. Moreover, the home-

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<sup>11</sup> NASHP, [State Approaches to Family Caregiver Education, Training, and Counseling](#) (2020).

<sup>12</sup> *Id.*

and community-based services programs that do cover some of these services have very limited enrollment and cannot be accessed immediately when the need arises.

**We urge CMS to require providers to obtain informed consent for CHI services.** Informed consent is a fundamental principle of person-centered care. As with health services, CHI services involve very intimate aspects of an individual’s life and they should have the right to decline those services. Obtaining consent from individuals who have experienced discrimination in the health care or social services systems is especially important to building trust. Informed consent would also help ensure individuals are appropriately counseled on options to address their needs and any associated costs with the CHI services themselves or the solutions. We do not see any reason to distinguish these services from case management, which does require consent, as many CHI services may be conducted remotely and involve time not spent directly with the Medicare enrollee. We support allowing verbal consent where services are delivered remotely.

**We recommend CMS allow for concurrent billing of CHI services and skilled home health plan of care.** The home health benefit both in design and in practice is not sufficient to address complex health-related social needs (HRSNs). Even if an individual receiving Medicare home health needs social supports, those supports are short-term and may not be provided at all. Allowing for concurrent CHI services would avoid disruptions in social services and avoid forcing individuals to choose between getting home health skilled care and social services.

#### Principal Illness Navigation (PIN) services

We strongly support the proposal to reimburse for principal illness navigation services (PIN) and to allow concurrent billing for PIN and other care management services. One of the greatest challenges people with high health care needs face is navigating their care. PIN services will be especially beneficial for people who are dually eligible for Medicare and Medicaid, as they are more likely than Medicare-only enrollees to have dementia, mental health conditions and multiple chronic conditions; need assistance with activities of daily living; be in fair or poor health; and experience preventable hospitalizations.<sup>13</sup>

In addressing these navigation needs, we appreciate CMS recognizes the role of CBOs, peer support specialists and care navigators who have lived experience and deep knowledge of their communities and resources. We recommend CMS clarify that social workers, marriage and family therapists, and mental health counselors can provide PIN services and receive reimbursement equitable to that of non-physician medical service providers.

**We recommend CMS require providers to obtain informed consent before providing PIN services** for the same reasons discussed above with respect to CHI. To minimize burden and ensure timely access to services, verbal consent prior to initiating PIN should be permitted.

#### Comment Solicitation on Expanding Access to Behavioral Health Services (II.J.7.)

Justice in Aging supports the Legal Action Center’s comments and recommendations with respect to improving access to substance use disorder and mental health treatment for people with Medicare, including aligning terminology across federal programs by removing use of the term “behavioral health.”

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<sup>13</sup> KFF, [A Profile of Medicare-Medicaid Enrollees \(Dual Eligibles\)](#) (2023); Oh et al, [The association between primary care use and potentially-preventable hospitalization among dual eligibles age 65 and over](#) (July 19, 2022).

To maximize the benefit of the proposed changes throughout this rulemaking, **we strongly recommend CMS amend 42 C.F.R. § 411.4(b) to allow individuals who are not incarcerated to be eligible to enroll in Medicare and receive health care, dental care, substance use disorder and mental health treatment, CHI, PIN, and other critical services that they need.** Medicare regulation bars provider payments for any Medicare-covered services for individuals who are “under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule.”<sup>14</sup> This definition of custody is inconsistent with CMS’s policies that eliminated similar exclusions in Medicaid and Federally-Facilitated Marketplace (FFM) plans in 2016,<sup>15</sup> as well as the administration’s health equity and reentry initiatives.

This is a growing issue for the Medicare program: the proportion of older adults in prison in the U.S. is rapidly growing and is projected to increase to more than 30% by 2030.<sup>16</sup> Older adults in prison report a high incidence of chronic conditions and physical and mental disabilities.<sup>17</sup> Because the Medicare restrictions on payments for people leaving incarceration are overly broad and imprecise, many of these older individuals returning to the community cannot access Medicare providers due to conditions of their release, and those who do not qualify for Medicaid face significant health care costs and may forgo care. Changing the Medicare definition to harmonize with the Medicaid definition would improve access and prevent confusion among providers, enrollees, and those who are working to connect them to needed health services. It would also relieve Medicaid programs from costs for services that Medicare would otherwise cover, providing health care savings for states.

## Conclusion

Thank you for the opportunity to comment. If any questions arise concerning this submission, please contact Natalie Kean, Director of Federal Health Advocacy, at [nkean@justiceinaging.org](mailto:nkean@justiceinaging.org).

Sincerely,



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Managing Director of Health Advocacy

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<sup>14</sup> 42 CFR 411(b).

<sup>15</sup> Centers for Medicare & Medicaid Services, “[SHO # 16-007 Re: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities](#),” Q2 and Q3 (April 28, 2016); Centers for Medicare & Medicaid Services, “[Incarceration and the Marketplace: Frequently Asked Questions](#)” (May 3, 2016)..

<sup>16</sup> U.S. Dep’t of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), “[Aging, Reentry, and Health Coverage: Barriers to Medicare and Medicaid for Older Reentrants](#),” (March 2018).

<sup>17</sup> Lisa C. Berry et al., “[Disability in Prison Activities of Daily Living and Likelihood of Depression and Suicidal Ideation in Older Prisoners](#).” *Int. J Geriatric Psychiatry*. 2017 October; 32(10): 1141–1149.