JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

October 5th, 2023

Chairman Jason Smith
House Committee on Ways and Means
Washington, DC

Submitted electronically to WMAccessRFI@mail.house.gov

Re: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Justice in Aging appreciates the opportunity to respond to the request for information on addressing chronic disparities in access to health care in rural and underserved communities. 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.

Congressional action is urgently needed to address barriers that impede access to care for older adults and people with disabilities. While older adults nationwide face challenges in accessing healthcare, rural older adults encounter obstacles, such as limited numbers of providers, direct care workforce shortages, and high poverty rates, that result in delayed or inaccessible care.[1] The challenges in rural areas are further intensified by a heightened demand for services, as these communities often have a larger proportion of older adults compared to urban settings.[2]

To increase access to care for older adults and people with disabilities in rural areas, we recommend Congress 1) strengthen the underlying benefits within both Medicare and Medicaid to meet the health and social needs of enrollees; 2) eradicate institutional biases and expand programs that support aging at home and in community; 3) expand financial assistance to support full access to comprehensive services; 4) address barriers and enable timely access to services; 5) strengthen the direct care workforce; and 6) leverage lessons learned from innovative models to improve existing benefits for older adults and people with disabilities.

I. Geographic Payment Differences; Sustainable Provider and Facility Financing

Medicare and Medicaid cover many essential services and supports and are the only source of health and LTSS coverage for older adults with limited income and wealth. Yet, gaps in scope, availability, and affordability of this coverage mean that many older adults – particularly older adults in rural communities - cannot live in their own homes if they need help with activities of daily living or get basic care like dental, vision and hearing, or access skilled nursing facility care when they need it. Congress should take the following steps to strengthen Medicare and Medicaid to address payment inequities and ensure sustainable funding for providers in underserved communities.

A. Add comprehensive dental, vision, and hearing benefits to Original Medicare.

Today, Original Medicare does not include dental, vision or hearing benefits. This substantial gap in coverage poses one of the most significant barriers to rural health access. These services are expensive,

[1] *See e.g.,* Nielsen et al., "Addressing Rural Health Challenges Head On," October 2017, Missouri Medicine.
[2] CMS, "Strengthening the Direct Service Workforce in Rural Areas."

so it is not surprising that those without coverage or even those with limited coverage cite cost as the biggest barrier to accessing care.[3] Older adults in rural areas are less likely than their counterparts in urban and suburban areas to have visited a dentist in the past year despite having poorer oral health, for example.[4] Similarly, those with hearing loss also cite lack of insurance coverage and cost as the biggest barriers to obtaining treatment.[5] The lack of Medicare coverage for these benefits also exacerbates the low provider-to-population ratios for these services in rural areas since fewer people are able to pay for services.[6]

The inability to obtain oral, vision, and hearing care significantly impacts older adults' overall health and quality of life. For example, periodontitis (gum disease) is strongly associated with diabetes – a condition disproportionately impacting individuals residing in rural regions.[7] This association is bidirectional meaning that periodontitis is a risk factor for poor metabolic control of diabetes and poor metabolic control increases the prevalence and severity of periodontitis.[8] Most recently, poor oral health, hearing loss, and vision loss have been associated with increased risk for Alzheimer's disease and dementia.[9]

Accordingly, **we strongly urge Congress to add comprehensive dental, vision, and hearing benefits to Medicare Part B.[10]** We also ask Congress to continue to support the Centers for Medicare & Medicaid Services (CMS) to increase awareness among rural health care providers and Medicare enrollees regarding Medicare's coverage of dental services when they are inextricably linked and substantially related to an underlying medical condition.[11]

B. Expand and align eligibility for Medicare Savings Programs and the Part D Low-Income Subsidy so that all Medicare enrollees with limited income can get help with premiums and cost-sharing necessary to access their benefits.

Senior poverty is increasing[12] and fewer older adults can afford health care and other basic needs. One in five Medicare enrollees have income below $20,000.[13] And in rural regions, an even higher percentage of older adults have very low income–$20,100 is the annual average Social Security benefit–making it very difficult to afford Medicare premiums and pay for care out of pocket.[14] The Medicare Savings Programs (MSPs) and Part D Low-Income Subsidy (LIS) are critical sources of support, but outdated and overly strict asset and income limits prevent many people from accessing them.[15] The result, unfortunately, is that many older adults hit an affordability cliff when they turn 65 and lose eligibility for Marketplace subsidies or Medicaid. We appreciate the recent expansion of the full LIS to

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[3] Vujicic, et al., "Dental Care Presents the Highest Level of Financial Barriers, Compared to Other Types of Health Care Services," (December 2016), Health Affairs.
[4] United Health Foundation, "America's Health Rankings Senior Report," (2018).
[5] Powell, et al., "Rural Adult Perspectives on Impact of Hearing Loss and Barriers to Care," (2019).
[6] NIH, "Oral Health in America," (2021) ("Every region of the country has shortage areas, but rural areas account for more than two-thirds of these, and only about half of dental needs are being met for people in these areas.")
[7] Dugani, et al., "Burden and Management of Type 2 Diabetes in Rural United States," (2020).
[8] Paunica, et al., "The Bidirectional Relationship Between Periodontal Disease and Diabetes Mellitus – A Review," (2023).
[9] Dominy, et al., "Porphyromonas gingivalis in Alzheimer's disease brains: Evidence for disease causation and treatment with small molecule inhibitors," (2019); Loughrey et al., "Association of age-related hearing loss with cognitive function, cognitive impairment, and dementia: a systematic review and meta-analysis," (2018).
[10] Justice in Aging, Creating an Oral Health Benefits in Medicare: A Statutory Analysis (January 2019).
[11] See the response to this RFI submitted by the Oral Health Consortium.
[12] U.S. Census Bureau, Poverty in the United States: 2022 (Sept. 2023)
[13] KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (2023).
[14] U.S. Census Bureau, Older Population in Rural America 2012-201, (Sept. 2019).
[15] Justice in Aging, Expanding Health Care Affordability for Older Adults and People with Disabilities (March 2022).

people with incomes under 150%[16] and strongly urge Congress to eliminate the asset tests for MSPs and LIS, and increase and align income eligibility for these programs so that more low-income rural adults can afford to use their Medicare coverage.[17]

C. Eliminate the Lesser of Policy to Increase Provider Access for People Dually Eligible for Medicare and Medicaid.

Congress must also target barriers that threaten the long-term financial health of medical providers and discourage providers from servicing low-income older adults, especially since provider access in rural communities is already limited. The Qualified Medicare Beneficiary (QMB) program, one of four MSPs, is a required Medicaid program in every state. QMB covers Medicare premiums, deductibles, and copayments, effectively eliminating patient costs while preserving access to care.[18] However, providers are less willing to serve QMBs, a population of approximately 8 million low-income Medicare enrollees, because of the "lesser of" policy, which permits states to pay providers for this population's Medicare-covered service at Medicaid rates.[19]

The Medicare program covers 80% of Medicare-approved charges, while Medicare beneficiaries must pay the remaining 20% of the Medicare-approved fee. Providers cannot bill QMBs for the 20% cost sharing, but can bill the state Medicaid programs. However, under the Balanced Budget Act of 1997, states are not required to pay the remaining 20%. Instead, the statute explicitly permits states to pay the "lesser of" the Medicare rate or the amount that would be payable under the state's Medicaid program for the same service.[20] Because state Medicaid rates are typically below 80% of the Medicare rate, providers often receive nothing from Medicaid for the coinsurance under this policy.

Though optional, 42 states have adopted this "lesser-of" policy for physician services.[21] As a result, many providers refuse to accept QMBs as patients and QMBs frequently go without needed care because they cannot access providers willing to serve them. This problem is particularly prevalent among primary care providers and mental health professionals.[22] A recent Congressional Budget Office analysis found that "lesser-of policies were associated with a 5 percent reduction in the number of new primary care visits and a 7 percent reduction in the likelihood of such visits among QMBs. Both the number and the likelihood of total and established patients' primary care visits fell by about 3 percent."[23]

To ensure that QMBs have full access to Medicare providers, Congress should eliminate the "lesser of" policy and set QMB reimbursement rates at the full authorized Medicare amount for all Medicare-covered services. Reimbursement at the Medicare-approved amount is critical so as not to cement a deprecated payment system, and consequential access challenge, for people dually eligible. This

[16] Justice in Aging, How Medicare Prescription Drug Reforms in the Inflation Reduction Act Help Low-Income Older Adults (2022).
[17] See, e.g., Lowering Medicare Premiums & Prescription Drugs Cost Act (S. 1844).
[18] 42 U.S.C. § 1396a (a)(10)(E).
[19] National Council on Aging, Medicare Savings Program Enrollment 2007-June 2022, (August 2023).
[20] 42 U.S.C § 1396a(n).
[21] Roberts et al., New evidence of state variation in Medicaid payment policies for dual Medicare-Medicaid enrollees (Sept. 2020).
[22] Mitchell et al., "State Payment Limitations on Medicare Cost-Sharing Impacts on Dually Eligible Beneficiaries and Their Providers," (Nov.2004), The Journal of Health Care Organization, Provision, and Financing.
[23] CBO, "Lesser-of" Payment Policies and the Use of Physicians' Services Among Dual-Eligible Beneficiaries (Jan. 2023).

recommendation is supported by existing precedent, as the Affordable Care Act required Medicaid programs to pay primary care providers at Medicare rates from 2013 to 2014.[24]

Eliminating the lesser of policy would not only increase access to these services for QMBs but also support the providers that serve rural and other low-income communities. By paying providers the full Medicare-approved amounts, these providers will have the financial security needed to continue serving underserved communities.[25]

D. Support older adults in rural communities to age in place.

While the vast majority of older adults prefer to age at home, those living in rural areas are even more likely to express this preference.[26] Accessing necessary at-home support can be challenging regardless of where an individual lives, and especially difficult for residents in rural and underserved communities. Medicaid is the largest payer of long-term services and supports (LTSS), but over 90% of people with LTSS needs in the community rely on unpaid family caregivers.[27] In fact, only 13% of people with LTSS needs received any form of paid assistance at home. To address the enormous and growing gaps in our home care infrastructure, Congress needs to strengthen both Medicare and Medicaid.

a) Medicare Home Health

Medicare can and should be playing a bigger role in helping older adults access personal care and other support with daily activities at home. To strengthen the Medicare home-health benefit and ensure enrollees can access the full scope of the benefit they are entitled to under the law, Congress should take the following actions.

i. Enforce the law to ensure access to Medicare-covered Home Health Aides[28]

Access to Medicare covered home health aide services is declining due to a combination of discriminatory policies, home health agency (HHA) business decisions, and poor oversight. Advocates report that home health agencies often refuse to take on Medicare enrollees who are more in need of "non-skilled" aide services and tell enrollees that aide services are not available at all or do not cover anything beyond bathing.[29] Instead of providing home health aides, agencies refer patients to their non-Medicare, private pay "affiliates" for related services, cost-shift home health aides for patients dually enrolled in Medicare and Medicaid to Medicaid, or force individuals to rely on family caregivers.

Denying access to Medicare-covered home health aides for help with activities of daily living as critical as bathing, toileting, grooming, skin care, walking, transferring, and assistance with medications, puts enrollees at risk of being hospitalized or entering a nursing facility because they do not get the support they need to stay safely at home. These practices are detrimental to the enrollee's health and well-being and costlier for Medicare. It also pushes costs onto Medicaid, straining limited home- and community-based services (HCBS) dollars and contributing to unmet need.

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[24] 42 U.S.C. § 1396a(a)(13)(C).
[25] Justice in Aging, Improving the Qualified Medicare Benefit Program for Dual Eligibles, (Nov. 2011).
[26] AARP, "2018 Home and Community Preferences Survey: A National Survey of Adults Age 18-Plus a Look at Rural Communities," 2019.
[27] Community Living Policy Center, Reducing Costs for Families and States by Increasing Access to Home- and Community-Based Services (March 2022).
[28] Justice in Aging, Statement for the Record: September 19, 2023, Senate Finance Subcommittee on Health Care Hearing on "Aging in Place: The Vital Role of Home Health in Access to Care."
[29] Center For Medicare Advocacy, Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved (Dec. 2021).

Insufficient accountability allows home health agencies to sidestep their obligation to offer home health aide services to Medicare beneficiaries. Agencies exploit this gap by understaffing aides in their Medicare operations and prioritizing clients who can pay privately, thereby maximizing profits at the expense of Medicare-covered individuals. Oversight entities such as the Office of Inspector General (OIG) and Medicare contractors exacerbate this issue by neglecting to conduct audits on agencies that underserve enrollees. Instead, these entities apply incorrect standards and focus audits on agencies "overserving" patients, thereby missing the critical issue of inadequate and potentially discriminatory service delivery to patients with chronic conditions.

Robust oversight is needed to ensure that home health agencies provide necessary care. It is not the *need* for aide services that is declining, but rather the access that is being inappropriately denied. **Therefore, we strongly urge Congress to direct CMS to ensure that Medicare home health agencies serve enrollees who require Medicare-covered home health aide services up to the statutorily defined limit of 28-35 hours a week.**

ii. Eliminate Medicare's statutory "home bound" eligibility restriction for home health care and urge CMS to remove the "in the home" restriction on durable medical equipment.

These discriminatory policies prevent people with Medicare from participating in their community and put unnecessary burden on Medicaid programs to serve people with chronic conditions who need longer-term care. The "in the home" restriction on durable medical equipment[30] can be particularly limiting for people in rural communities where they have to travel farther and do not have access to public transportation. For example, a person might need a power scooter to grocery shop, go to a family picnic, or attend a community event, but Medicare would not cover a scooter if they do not need it to get around their home.

b) Medicaid Home & Community Based Services

To ensure older adults and people with disabilities in rural areas have access to the full range of supports they need to age in place, Congress must also strengthen Medicaid HCBS. We recommend the following actions.

i. Eliminate Medicaid's bias towards institutional care

Federal Medicaid law mandates states to cover nursing facilities, while coverage HCBS is optional. This institutional bias, coupled with insufficient funding, has resulted in fragmented and inconsistent availability of HCBS across states. Congressional action is urgently needed to correct the institutional bias and adequately fund these crucial services to enable comprehensive and equitable access to HCBS nationwide. **We encourage Congress to pursue opportunities, such as the HCBS Access Act (H.R. 1493), to expand access to HCBS, identify and address disparities in access, and bolster the HCBS workforce.**[31]

ii. Increase Timely Access to HCBS[32]

Congress should pursue legislation to ensure that rural older adults can access LTSS immediately, in the setting of their choice, instead of being forced to enter a nursing facility. Unfortunately, under federal Medicaid policy, people cannot rely on retroactive coverage of HCBS while their Medicaid application is being processed like they can for nursing facility care. In practice, this means that people who need LTSS can enter a nursing facility immediately and worry about Medicaid coverage later, but cannot start HCBS

[30] CMS, Durable Medical Equipment (DME) coverage.
[31] Justice in Aging, The HCBS Access Act (June 2023).
[32] Justice in Aging, Medicaid's Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today (Sept. 2021).

until Medicaid coverage and the service plan is approved. This lack of retroactive HCBS coverage disproportionately affects low-income, uninsured, and underinsured older adults and people with disabilities, who often face unexpected health emergencies or high-cost healthcare needs that make planning for services difficult. Without the financial safety net of retroactive coverage, many have no choice but to either forego essential services or opt for less desired, more expensive nursing facility care. This policy ultimately robs individuals of their agency to choose where they receive care and funnels them into costlier institutional settings. To increase prompt access to HCBS, **Congress should revise the statute to clearly authorize retroactive coverage of HCBS on par with nursing facility coverage.**[33]

iii. Eliminate Medicaid Estate Recovery[34]

The fear of Medicaid estate recovery is a significant deterrent to accessing HCBS or any long-term services and supports. This federal policy requires states to seek repayment of specific Medicaid benefits, including nursing facility services and HCBS provided to recipients ages 55 and older, from the estates of deceased beneficiaries. In many cases, the enrollee's home—often their only substantial asset—is the main source of recovery, putting surviving family members in the difficult position of having to sell the family home or incur personal debt to settle the Medicaid claim. This not only disrupts the living arrangements of surviving family members and leads to increased rates of homelessness among these populations, but also perpetuates intergenerational poverty and exacerbates inequities for communities of color. Estate recovery thus serves as a barrier to HCBS access, discouraging individuals from seeking services due to the potential financial and emotional burden on their families. Notably, no other public benefit program requires that correctly paid benefits be recouped from a deceased family member's estate.[35]

The primary rationale of estate recovery is to recuperate funds supporting state Medicaid programs. Despite this financial justification, a 2021 MACPAC evaluation of estate recovery demonstrated that the policy is ineffective, recovering only 0.55 percent of total fee-for-service long-term care spending.[36]

Congress should eliminate Medicaid estate recovery so that low-income families are better able to retain wealth and pass it on to future generations. **We urge Congress to pass the *Stop Unfair Medicaid Recoveries Act* which would eliminate all Medicaid estate recovery claims, except in cases where benefits were incorrectly paid.**[37] Eliminating estate recovery will eradicate the inequitable effect of this policy on low-income families and communities of color, affording them increased financial and housing stability.

At a minimum, as MACPAC suggests, Congress should amend federal law to make estate recovery claims voluntary for states.[38] For example, although West Virginia previously attempted to eliminate and reduce the negative impacts of estate recovery, the state was unsuccessful due to current federal law.[39] States like Georgia, for example, utilize policy measures to make recovery less punitive by setting high

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[33] *Id.* (explaining that Congress could address this issue by adding language at the end of Section 1902(a)(34) of the Social Security Act).
[34] Justice in Aging et al., Medicaid Estate Claims: Perpetuating Poverty and Inequality for a Minimal Return (Apr. 2021).
[35] *Id.*
[36] MACPAC, Chapter 3: Medicaid Estate Recovery: Improving Policy and Promoting Equity (March 2021).
[37] Stop Unfair Medicaid Recoveries Act, H.R. 6698, 2022.
[38] MACPAC, Chapter 3: Medicaid Estate Recovery: Improving Policy and Promoting Equity.
[39] *See* Medicaid Estate Claims: Perpetuating Poverty and Inequality for a Minimal Return, *supra*.

cost-effectiveness thresholds to discourage pursuit of estate recovery.[40] If a state believes that estate claims are counterproductive, the state should not be forced to pursue them.

E. Fix observation status barrier to skilled nursing facility care.

We urge Congress to pass the bipartisan Improving Access to Medicare Coverage Act of 2023 (H.R. 5138) to ensure older adults are not prevented from getting coverage of necessary skilled nursing facility care because their hospital stay is classified as outpatient observation rather than inpatient.

II. Health Care Workforce

We appreciate the Committee's focus on the health care workforce. **When addressing health care workforce shortages, Congress must include direct care workers providing critical personal care and other support to people receiving LTSS.** As we discuss in the next section, states have used enhanced HCBS funding to increase compensation for direct care workers. Without this continued federal financial support in the HCBS system, job quality and the worker shortage will worsen while the need for HCBS is growing. As a result, fewer older adults and people with disabilities will be able to live at home, family caregivers will be further strained, and states will have to spend more money on institutional care.

In response to the request for feedback about the impact of nursing home staffing mandates on healthcare workforce availability in other settings, we would like to highlight the positive effects that such mandates can bring. Rather than viewing these mandates as a constraint on workforce availability, they should be seen as an essential step toward professionalizing the workforce. **The introduction of staffing mandates can act as a catalyst for policy measures designed to elevate job quality for direct care workers, making the field more appealing to potential new entrants and enabling increased retention of workers.** As the direct care workforce is comprised primarily of women of color, investments in job quality will also advance equity for this population.

To achieve staffing standards, providers must address job quality concerns that contribute to high rates of turnover and insufficient numbers of new entrants. According to research from PHI, the median annual turnover of nursing assistants in nursing facilities was nearly 100 percent in 2017-2018, a trend largely attributed to poor job quality.[41] Analysis of data from 2019 shows that in all 50 states and the District of Columbia, the direct care workforce median wage was lower than the median wage for occupations with similar entry-level requirements; this research demonstrates that direct care jobs are not competitive, contributing to workforce attrition.[42]

Strategies to improve job quality, like increasing worker compensation to provide livable and family-sustaining wages, implementing training systems that offer portable and stackable credentials for career progression, and actively seeking the valuable input of direct care workers through surveys to better understand their experiences and suggestions for job quality improvement, will make these positions more attractive to workers, therefore increasing the overall availability of workers. By fostering a more professional and better-supported workforce, nursing facility staffing mandates will likely attract, rather than deter, individuals to the healthcare field.

III. Innovative Models and Technology

We appreciate the opportunity to uplift innovative models that offer promise to increase access to services for rural communities. The Federal Financial Alignment Initiative (FAI) was a pilot program

[40] MACPAC, Chapter 3: Medicaid Estate Recovery: Improving Policy and Promoting Equity.
[41] PHI, Understanding the Direct Care Workforce.
[42] PHI, "Competitive Disadvantage: Direct Care Wages are Lagging Behind," 2020.

across participating states to trial innovations to better integrate Medicare and Medicaid programs. Some successful and scalable aspects of the FAI, including care coordination across benefit programs, unified appeals processes, unified communications, and consumer advisory committees, are now regulatory requirements for at least some categories of Dual Eligible Special Needs Plans (D-SNPs). **We encourage policymakers to leverage lessons learned from existing integration models to achieve improved outcomes for individuals in rural and underserved communities.**

In response to the COVID-19 pandemic, Congress provided states with additional funding through the American Rescue Plan Act to bolster access to HCBS. These funds enabled states to maintain access to services in the community at a time when the virus presented a grave risk to residents in nursing facilities. Every state took up the funding to increase, for example, pay for direct care workers, utilization of self-directed services, support for family caregivers, and use of technology services.[43] The success of these temporary flexibilities makes a strong case for their long-term adoption and expansion to enhance access to HCBS. **As the ARPA funds will soon expire, we urge Congress to pass new enhanced funding to continue these successful investments across states.**

We also strongly encourage innovative approaches to expand beyond solely medical offerings in Medicare and Medicaid to holistically address enrollees' health related social needs, including caregiver supports. We advocate for targeted innovations in care delivery to serve populations disproportionately affected by systemic barriers—such as individuals with dementia, communities of color, LGBTQ+ individuals, and those with limited English proficiency. Due to systemic discrimination, these groups often experience inequities leading to poorer health outcomes and heightened risk of institutionalization, underscoring the need for tailored and innovative solutions.

We support innovative efforts to expand access to Medicare and Medicaid for people leaving incarceration. In particular, **we recommend Congress work with CMS to change Medicare's custody definition to align with the Medicaid and Marketplace definitions and ensure access to health insurance coverage for older adults who are living in the community while under parole, probation, bail, or supervised release.**[44]

IV. Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Natalie Kean, Director of Federal Health Advocacy, at nkean@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director of Health Advocacy

[43] NASHP, "Most States Plan to Continue Medicaid Home and Community-Based Flexibilities Implemented during the Public Health Emergency," (June 2023).
[44] *See* Justice in Aging, Medicare Special Enrollment Period for Formerly Incarcerated Individuals: What Advocates Need to Know (July 2023).