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Chairman
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Ways and Means Committee
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Washington, DC 2015

The Honorable Danny Davis
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Re: Rural and Underserved Health Communities Health Task Force Request for Information

LeadingAge, an association of not-for-profit aging services providers, appreciates the opportunity to respond to Chairman Neal and Ranking Member Brady as well as to the Co-Chairs of the Rural and Underserved Communities Health Task Force (Task Force) regarding their request for information. The mission of LeadingAge is to be the trusted voice for aging. Our 6,000+ members and partners include nonprofit organizations representing the entire field of aging services, including affordable housing, assisted living, home care, life plan communities, and nursing homes. LeadingAge partners with 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research. As part of our efforts, we have a Center for Workforce Development, a Center for Aging Services Technology, and a Center for Managed Care Solutions all of which develop targeted resources for and about our members that intersect with the questions that the Task Force poses in this RFI. Since we have such a broad continuum of members, we wanted to highlight some issues that we see across our members to provide background that informs our answers to the questions posed in the Request for Information.

Closures: Rural nursing homes are closing at about the same rate as urban and suburban nursing homes, but their closures have more impact in rural areas where there are few alternative long-term care providers. For example, the *New York Times* reported earlier this year on the impact of closures of rural nursing homes in South Dakota. In addition to the impact on residents, who may have to find care in a nursing home much farther from their families and friends, closures of rural nursing homes can hurt communities where they were a large, stable employer.

Lack of access: LeadingAge represents many rural long-term services and supports providers who do an outstanding job in caring for their residents and clients. Residents of rural areas need and deserve the

highest quality of long-term services and supports. But the challenges of financial and human resources that generally prevail in the long-term services and supports field are magnified in rural and frontier areas where the working-age population is declining, the aging population is growing, and health, long-term care, and human resources are few and far between. This is a concern not only for us as providers but also for those representing individuals and families who need long-term services and supports. Residents of rural areas have less access to hospice services and have uneven access to home health services.[1]

Workforce: The US has a significant shortage of, and a growing demand for, qualified workers who are capable of managing, supervising and providing high-quality services and supports for older adults and this shortage is endemic in the rural and underserved areas. The population of adults age 65 and older will increase from nearly 50 million in 2015 to 88 million in 2050 – an 84% increase. Among those currently reaching retirement age, more than half (52%) will require long-term services and supports at some point, and for an average of two years. By 2050, the number of individuals using paid long-term services in any setting will likely double from the 13 million who used services in 2000, to 27 million people. Thus, the nation will need 2.5 million workers of all different types by 2030 to keep up with the growth of America's aging population.[2]

Unfortunately, current recruitment and retention of workers of all kinds is an ongoing challenge for a number of reasons, including inadequate funding under public programs and the physical and emotional demands of the work. While LeadingAge and its members continue efforts to improve our field's workplace culture, changes in public policy are needed to ensure adequate numbers of well-trained and qualified caregivers now and in the future. In the questions below, we discuss some successful recruitment models and our International Migration of Aging and Geriatric Workers in Response to the Needs of Elders (IMAGINE) proposal which looks a number of options for engaging qualified foreign workers through targeted visa programs.

We want to take this opportunity to thank the Committee for the work that has already occurred this Congress that will help support rural and underserved communities. Some examples of bills that the House has already passed that will support these communities are the *Palliative Care Education and Training Act*, *The Dignity in Aging Act*, *and the EMPOWER for Health Act of 2019*. We also want to thank Chairman Neal, Ranking Member Brady, and the Co-Chairs for convening this Task Force to tackle these pressing and timely issues that impact all our members and provide our answers to the questions posed by the Task Force below.

What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Rural and underserved communities often lack the means to pay for needed services, means to reach and use the services, poor health literacy, lack of trust in providers, workforce shortages, and lack of

[1] http://medpac.gov/docs/default-source/reports/mar19_medpac_ch12_sec.pdf?sfvrsn=0 and http://medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec_rev.pdf?sfvrsn=0

[2] https://www.leadingage.org/sites/default/files/LA_Workforce_Survey_Whitepaper_v5.pdf.

belief they will receive quality care.[3] All of these issues impact our members – but one factor we want to highlight is transportation.

Lack of adequate public transportation remains a critical problem. In rural areas, there may be none and in underserved areas, it may be inadequate or unreliable. This issue affects the ability to provide care, whether prohibiting home health, hospice, home and community-based services to get to patients in a cost-effective and timely manner or delaying workers in residential care facilities from getting to their jobs. This lack of reliable transportation impacts the ability to retain workers and the ability to hire in states that limit where prospective employees can get their fingerprints taken for background checks.[4] Additionally, for workers that are providing care in the home, windshield time is a major expense.

This lack of transportation infrastructure also impacts patients and families. Older adults, wherever they call home, often require accessible transportation that their families cannot provide. Rural and frontier areas lack the infrastructure for subsidized para-transit systems and in underserved areas, even the subsidized rates for these programs can be a financial burden.

We recommend allocating funding for rural post-acute care providers and home care providers including home and community-based service providers and hospices, along with allowing transportation as a reimbursable expense. Additionally, the Committee should look at ways to fund para-transit systems including through public-private partnerships.

What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

The housing plus services model, championed by LeadingAge through advocacy and applied research by the LeadingAge LTSS Center at UMass Boston (LTSS Center), shows promising results in improving health outcomes in both rural and underserved communities related to multiple chronic conditions and social determinants of health.[5]

Studies by the LTSS Center show that HUD-assisted residents are more likely to be dually eligible and thus high utilizers and in need of supports[6] and that the presence of a service coordinator decreased the residents' odds of having a hospital stay.[7] A enhanced service coordinator case study in rural Ohio notes that a management tool for assessing and meeting the residents' needs, a partnership with a preferred

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[3] https://www.healthinnovation.org/resources/publications/body/In-Their-Words-Consumers-Vision-for-a-Person-Centered-Primary-Care-System.pdf
https://www.ruralhealthinfo.org/topics/healthcare-access

[4] https://phinational.org/wp-content/uploads/2017/07/home-help-provider-survey.pdf

[5] Millions of older adult renters and homeowners face excessive housing costs, live in housing with serious physical problems, or in housing that is not adapted to their needs as they age. An increasing proportion of older adults experience multiple chronic illnesses and deteriorating physical and cognitive functioning are often what impede the ability of older adults from living independently in their communities.

[6] http://www.ltsscenter.org/resource-library/Housing_Services_Policy_Brief.pdf

[7] https://www.ltsscenter.org/housing-plus-services/#1565718559492-c93bf23d-97b5

provider, and a focus on social determinants of health are keys to making this type of intervention successful.[8]

The LTSS Center is also a partner in evaluating the Support and Services at Home (SASH) intervention through which a housing-based wellness nurse and a SASH care coordinator work in concert with a variety of community-based organizations to support older Vermont residents who choose to live at home.[9]

Housing plus services are showing success but are not scalable without annual appropriations sufficient to cover the costs of preserving, maintaining, and operating existing affordable housing projects and building new ones and expanded funding for the service coordinators and other staff who assist residents in accessing the supportive services they need.

What should the Committee consider with respect to patient volume adequacy in rural areas?

The Committee should consider the following options related to reimbursement to balance challenges with patient volume adequacy:

- ✓ Create reimbursement parity between critical access hospitals (CAHs) and other post-acute providers providing the same services.[10]

- ✓ Make the rural add-on payment for home health permanent and explore add-ons for other providers such as SNFs, hospices, and adult day providers.

- ✓ Explore the creation of a disproportionate share program or a Federally Qualified Health Center (FQHC)-like reimbursement for new categories of providers in rural or underserved communities.

- ✓ Expand the wage index[11] geographic reclassification board[12] to include non-hospital providers. Of concern is that a hospital may secure a geographic reclassification for application of the wage index by establishing that said hospital draws on an employment pool that is different from the geographical area to which it would otherwise be assigned. As a result, a hospital competing for the same employees as home health and hospice providers may be receiving more Medicare monies and thus have more funds to pay staff.

- ✓ Expand the wage index protections offered to hospitals to other Medicare providers. For example, a home health or hospice's wage index can be below the "rural floor" for their state; this cannot be the case for a hospital.

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[8] https://www.ltsscenter.org/bringing-service-coordination-home-in-rural-ohio/

[9] https://www.ltsscenter.org/4-year-evaluation-shows-sash-continues-to-slow-medicare-growth/

[10] Post-acute care has changed significantly since the establishment of the CAH program and many rural nursing homes have transitional care units that can get the same outcomes at a lower cost to the federal budget.

[11] CMS made some substantial updates to the wage index in the 2020 IPPS Final rule but we do not anticipate that these changes will address the problems outlined here.

[12] Medicare home health and hospice providers payments are adjusted to reflect varying wage levels across the nation using a wage index; however the wage index utilized by CMS is based on the reporting of hospital wages that explicitly excludes any home health or hospice specific service costs.

The Committee should also consider a process by which providers in rural and underserved communities could apply for some of the waivers allowed for in the Center for Medicare and Medicaid Innovation (CMMI) demonstrations like the homebound requirement in home health, the 3-day requirement for SNF stays, and others to increase volume.

If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

Through our Center for Aging Services Technology (CAST), LeadingAge supports our members in expediting the development, evaluation, and adoption of emerging technologies that can improve the aging experience. Through CAST, LeadingAge produces resources that states, regional network, or other entities can use to identify challenges with a variety of technology challenges from EHRS to medication management tools to care planning tools.

Both LeadingAge and CAST responded to the Congressional Telehealth Caucus' Request for Information that led to the development of the CONNECT for HEALTH Act (H.R. 4932). This legislation would be a critical step forward in expanding evidence for and access to telehealth:

- ✓ The waiver in this legislation that would allow for more flexibility around telehealth use in high-need professional shortage areas could have an immediate impact on workforce shortages.
- ✓ We are also very supportive of the MedPAC study and demonstration proposals in the legislation that would allow for testing of how telehealth is most effective and what sufficient reimbursement looks like for a variety of telehealth services.
- ✓ Allowing hospices to provide the face-to-face recertification via telehealth would also alleviate burdens particularly on rural hospice providers.
- ✓ The use of telehealth for mental health and emergency care would help all our providers in rural and underserved areas where having access to these services via telehealth may prevent a hospitalization (and a long ambulance trip).

What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

LeadingAge outlines alternatives to expand options for utilizing foreign born workers to mitigate our workforce crisis through our International Migration of Aging and Geriatric Workers in Response to the Needs of Elders (IMAGINE) paper. Our members in both rural and underserved areas have taken the following approaches:

- ✓ Developing employment agencies and/or recruitment programs to assist with helping to bring in registered nurses (RNs) from the Philippines to the U.S. The Filipino government trains more RNs and other medical professionals than are needed in the Philippines and have a national strategy for outbound migration of these skilled workers. A Filipino nurse applicant must go through

approximately 23 steps of competency in order to immigrate to the U.S. and the immigration process can take from 18 months to 3.5 years so creating a pipeline is critical.[13]

- ✓ Our members who have managed to create that pipeline are beginning to close the gaps in their own workforce shortages. One member in Chicago even has more RNs coming through the agency than they need internally, and they have chosen to work with selected nonprofit organizations to match their trained nurses with the employment needs of colleague organizations, many of which are in rural or other underserved areas.

- ✓ Since implementing these programs, members have seen improvement in state surveys and CMS star ratings and more than 90% of the recruited nurses have stayed in the jobs beyond their contractual commitments.[14]

- ✓ Other members work with refugees to work toward full employment in their member communities.

Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Specialized Staff Training: At Garden Village in Yakima, Washington, most of the residents have severe behavioral health needs and 92% of the facility's payments come from Medicaid. Residents with behavioral health diagnoses need staff with specialized training and supports that require different policies. Staff is specially trained from day one to interact with residents who are behaviorally challenged. The Committee should look at how to adjust reimbursement and oversight to support this type of nursing home – what makes for a good community for those with behavioral challenges does not necessarily fit into a surveyor's checkbox.[15]

Supporting Communities: Hospice providers are required to provide grief counseling as a part of the Medicare Hospice Benefit. Many nonprofit hospice providers extend those benefits into their communities at large, offering grief and bereavement support to those who need it regardless of whether they have received care from the hospice provider – these services are philanthropically funded. In response to increased deaths from substance abuse disorders, especially related to opioids, nonprofit hospices have been utilizing their grief counselors to address issues related to treating adults and children affected by an unintended overdose death. These efforts are stretching the abilities of the hospice programs to continue these services and the impact is causing many to discuss the viability of the maintaining services at this level. These services give tremendous support and guidance for individuals, many of whom already live in destructive environments. The Committee could consider funding opportunities not only for preventive efforts but supportive efforts like these so that families can begin to recover.

The availability of post-acute care and long-term services and supports is limited across the nation but can be particularly challenging in rural and underserved areas facing disproportionately large burdens

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[13] https://www.leadingage.org/nursing-shortages-require-international-solutions
[14] https://www.leadingage.org/recruiting-rns-philippines
[15] https://www.leadingage.org/catalysts/september-2019-leadingage-catalyst

of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

LeadingAge has members working on both addressing gaps in care delivery and social isolation though both remain challenges across our care continuum. One approach to address social isolation is intergenerational programming. For example, one of our nursing home members entered into a joint venture with a daycare provider to build a daycare center that is attached to the nursing home in rural Minnesota. The daycare center's children have regular interactions with their "grandpals" as a condition of the joint venture between the nursing home and daycare center which is beneficial to both parties. It also supports the nursing home staff since they have a source of childcare.[16]

Communities have also had to figure out how to provide different types of care other than their "core business," utilize under-reimbursed services that enhance care quality, and utilize beds for new purposes in order to enhance services in their communities. Avera Health in South Dakota[17] is a prime example of this – they are in a rural area and have adapted to utilize more telehealth (with foundation support), more behavioral health, bariatric care, expanded their hospice program, and other adjustments from their original mission in order to better service their community. They have opened a transitional care unit that houses patients who may have a high acuity condition or may not have a payer source. The Committee should consider why there was a need in this community for that type of unit and how to create more flexible payment options for these types of patients.

Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

- ✓ *Improving Access to Medicare Coverage Act of 2019 (H.R. 1682)* deems an individual receiving outpatient observation services in a hospital an inpatient for the purposes of satisfying the 3-day rule for SNF coverage. This bill would be particularly important in rural and underserved communities – the 3-day stay rule is cited as one of the biggest barriers to patient access to nursing home care in rural areas.[18]

- ✓ *The Nursing Home Workforce Quality Act (HR 4468)* restores a nursing home's authority to train staff as soon as the nursing home comes back into compliance with all federal regulations. The current policy which results in the loss of nurse aide training authority is an obstacle to quality improvement for nursing homes that need to increase their staffing levels and exacerbates the severe workforce shortage in long-term care especially in rural areas where there often are no alternative training sites.

- ✓ *Home Health Payment Innovation Act (H.R. 2573)* will ensure payment adequacy for home health providers and expand flexibilities in the home health benefit.

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[16] http://www.blcada.org/child_care written up at https://www.ruralhealthinfo.org/project-examples/883. Other examples of intergenerational partnerships can be found at https://leadingage.org/magazine/septemberoctober-2016/all-ages-making-difference-benefits-intergenerational-partnerships and through our toolkit at https://leadingage.org/press-release/intergenerational-programming-resource-and-toolkit-debuts-0

[17] https://www.leadingage.org/catalysts/january-2019s-leadingage-catalyst

[18] http://rhrc.umn.edu/wp-content/files_mf/1493905594SNFbarriers.pdf

- ✓ *The Home Health Planning Improvement Act (H.R. 2150)* expands the providers that can order home health services beyond a physician and thus expand the ability of home health to be offered in rural and underserved areas.

- ✓ *The Rural Access to Hospice Act (HR. 2594)* allows RHCs and FQHCs to receive payment for physicians' services while acting as attending physicians for their patients in hospice care.

LeadingAge thanks the Committee and the Task Force for the opportunity to provide feedback on this Request for Information and looks forward to partnering to ensure access to high quality care for older adults in rural and underserved communities.

Please contact Ruth Katz, Senior Vice President for Policy and Advocacy, LeadingAge, with any followup questions or comments at rkatz@leadingage.org