Chairman Jason Smith
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

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

Dear Chairman Smith,

Thank you for the opportunity to respond to this request for information on improving access in rural and underserved communities. The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 mission driven aging services providers that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

First and foremost, we recommend that the Congress instruct the White House to create an Office on Aging that can take a whole of government approach to the problems facing our aging population that would include the challenges facing rural and underserved populations. Sustainable long term care financing must be a part of this conversation as well.

Definitions

As the Committee makes new policy, we recommend that they ask GAO or a similar body to study all the existing definitions of "rural" and "underserved" used across government and ask for stakeholder feedback on the applicability of each definition. We know, for example, that CMS is using the Census definition of rural for the purposes of the proposed nursing home staffing standard and that Health Resources and Services Administration (HRSA) uses a different definition for their programs (e.g., the distribution of American Rescue Plan rural funds). It would behoove future policymaking for everyone to be operating under the same framework. This comment is amplified when referring to the term "underserved" – stakeholders operate with different frameworks for this phrase and it would make for better policymaking going forward if everyone were working from the same playbook.

Payment

The Committee asked for feedback on payment in a few different areas – geographic payment differences, sustainable provider and facility financing, and aligning sites of service. Across our nonprofit and mission driven providers, we hear similar themes – that reimbursement is not keeping up with the cost of providing care. The pandemic only exacerbated these issues – between inflation, introduction of new costs, and the increased cost of staff due to the severe workforce shortage – our members are struggling. We appreciate that the Committee is considering ways to enhance sustainability because we have serious concerns about whether our members are going to survive if there are not significant changes in how we think about paying for services.

Wage Index

This response will touch a few places where the wage index produces inequities. We know this is an issue that the Medicare Payment Advisory Commission (MedPAC) has looked at recently and that the

Committee has expressed interest in examining in more detail. We agree that there are flaws in the way that the wage index is designed. In particular, the ability for hospitals to reclassify creates disparities between their reimbursement and that of our members, many of whom receive payment based on a pre-reclassified, pre-floor index. If the wage index is going to be reformed, we ask for the following principles to be considered:

- *Post Acute Care Must Be on Equal Footing with Acute Care:* Our members compete with hospitals for staff. Currently, they lose. Whatever changes are made to the wage index must ensure that our members are able to compete for staff with their hospital counterparts. The MedPAC proposal, as it stands, recommends different inputs for hospitals and for SNFs. This concerns us because the reality of each market is that hospitals set the prevailing wage. The MedPAC proposal does not contemplate home health or hospice, but we would have the same concerns.
- *Data Inputs Must Include All Relevant Competitors:* The MedPAC proposal suggests some new data sources to create the wage index. As one Commissioner commented during a MedPAC session on the proposal, health care does not only compete with other health care providers for staff. Our members compete with Target and Amazon for certified nursing assistants and home health aides. They compete with fast food for dining staff. They compete with health plans for nurses. A detailed analysis of all industries that attract the variety of professionals needed to provide comprehensive post-acute and long-term care must be undertaken for consideration for input into a future wage index. A "national wage index" would make sense to consider as one option.
- *Consider the Role of Non-Clinical Staff*: Our members report staffing challenges for a wide variety of disciplines. For example, shortages exist in social work and given the focus on care navigation and social determinants of health, we anticipate the demand for these services will increase over time. Members need dining, janitorial, and other staff that are non-clinical yet operationally critical. Our members report challenges recruiting managers – both clinical and non-clinical. All of these professionals are important to functioning post-acute care. If the wage index is to be re-examined, an evaluation of whose wages matter for the purpose of the index should also be evaluated.

Medicare Advantage and Medicaid

On the issue of ensuring adequate payments to providers in rural and underserved areas, one must address the growing penetration of Medicare Advantage (MA) nationally – though this phenomenon is newer in rural communities then in the rest of the country. What we have seen among our members in underserved areas that will seep into rural areas is the negative impact Medicare Advantage has on provider payment rates, which ultimately, impacts beneficiaries' access to providers.

MA plans can be attractive to beneficiaries given their low or no premiums (69% of rural MA enrollees are in a $0 premium plan) and inclusion of supplemental benefits such as vision, dental and hearing. However, as recent OIG reports[i], Congressional investigations (1, 2) and media accounts (1, 2)have shown, these plans do not always work well for beneficiaries when they need post-acute care services, often denying Medicare covered services. From a post-acute provider perspective, MA plans are typically paying skilled nursing facilities (SNFs) and home health agencies (HHA) providers less than Medicare FFS (often 60-80% of Medicare FFS rates) while imposing a significantly greater administrative burden. As MA enrollment rises, these providers lose any leverage to "negotiate" better rates with these MA plans with providers often signing contracts that initiate a financial death spiral because their choice is between providing services at a low rate or receiving no referrals at all. The result is lower revenues for these providers via not only lower per unit cost but also fewer units of service, and increased costs to hire additional FTEs to manage the costs associated with submitting prior authorizations and claims to the

various MA plans. 91% of Medicare Advantage enrollees must get prior authorization to receive home health services and 99% must get prior authorization to receive SNF services.[ii] While plans indicate they are reducing health care expenditures, it is on the backs of post-acute care providers and beneficiaries who are wrongfully denied Medicare covered services based upon an artificial intelligence algorithm.

Considering Medicare fee for service payment in a vacuum is simply not an option in this environment. We need Congress and its advisors (i.e. MedPAC) to recognize that provider margins cannot be examined in siloes. For example, in home health, while the current proposed CMS payment cuts are only in Medicare fee for service, the reality is that the impacts of cuts in Medicare fee for service have ripple effects. In both the home health and SNF settings, MedPAC claims that payment must be adequate because providers accept contracts from Medicare Advantage – this interpretation does not reflect that providers must accept Medicare Advantage contracts to stay competitive in the market. Often our members must choose whether to limit access for Medicare Advantage patients due to the administrative and financial burdens of accepting MA – but this pattern limits access for patients. This pattern is even more alarming if you look at agencies that take Medicaid patients. Our members have no leverage to negotiate rates in either Medicare Advantage or in Medicaid.

It is not ideal that Medicare FFS is acting as a financial counterbalance to Medicare Advantage and Medicaid. The government needs to work on ensuring rate adequacy across all payers before disrupting overall access to care through further cuts to fee for service Medicare. If policy options that ensure rate adequacy in both Medicare Advantage and Medicaid, smoothing of costs across payers might be appropriate. But in the current environment, continued reductions in Medicare fee for service payment will simply result in reduction in access.

Medicare Advantage plans have gotten increases from CMS year over year – an 8.5% increase in CY2023 and a CY2024 increase of 3.32%– and rarely is any of that increase passed along to providers. In considering where money can be shifted within the Medicare program to boost reimbursement to deal with the challenges of providing care in rural and underserved areas, the Medicare Advantage program must be a part of that conversation. In addition, Congress should consider eliminating the non-interference clause (Sec 1854 (6)(b)(iii) of the Social Security Act) in the Medicare Advantage law that prohibits CMS from intervening to set a Medicare FFS as the rate floor or to instruct plans to contract with providers through value-based arrangements that reward providers for delivering high quality outcomes. CMS should be permitted to ensure continued access to health care providers in rural and underserved areas through these types of measures but are currently handcuffed.

We also recommend an enhanced federal medical assistance percentage (FMAP) should be considered to enhance funding for the direct care workforce in both home and community-based services and in nursing homes. The Committee would need to be closely engaged on this effort because an increase in Medicaid funding for workforce needs to be considered holistically with any changes to Medicare funding based on workforce. We have heard from members in the past that payment boosts that are not in sync can detrimentally impact the ability to hire staff.

Rural

While long-term care leaders are eager to employ local talent, they report that it can often be difficult to recruit and retain staff with the necessary specialized training in rural communities and it is often cost prohibitive to relocate a staffer from an urban center.[iii] A LeadingAge member from the Midwest, that has typically provided services in rural communities recently reported, “it is no longer financially viable

to enter markets with populations under 50,000 people not because there isn't an aging population to be served but because there is no workforce to hire to serve them." Additional LeadingAge members commented that there is no longer a pay differential between urban and rural communities as "providers are competing for the same talent pool as urban workers especially for non-medical role, that can work remotely."

Our rural providers report that competition for workforce is no longer limited to rural city limits and that luring workers to more rural areas is challenging even if cost of living is lower. Rural providers often must match the salary of the health systems in the closest urban area in which they compete. In hospice, the rural floor was eliminated, and there are areas where the wage index falls below the rural floor. These types of dynamics, in combination with market pressures, do indicate that we must look at how we compensate for the challenges of serving a rural community. Initiatives like loan forgiveness, and housing and transportation assistance should also be considered.

The Committee could look at targeted add on payments to cover specific challenges faced by rural providers. In home health and hospice, the windshield time is often cited as a barrier to providing care. Productivity cannot be the same as it in denser areas. Gas and the wear and tear on cars are also huge cost factors. Our members are often thinking about how to either compensate for the gas utilized or how to afford to provide staff with company cars. Payment adjustments for these types of expenses along with consideration of the reality of competing for rural staff are examples of areas we believe that the Committee should explore. In home health, the phasing out of the rural add on payment will be extremely detrimental for a service that is already underutilized, in large part due to a lack of availability – this policy should be continued.[iv]

Underserved

Underserved populations span both rural and urban locations. There are challenges serving populations with high levels of social need, who lack a caregiver, who lack resources and competency to navigate the health system, and sundry other factors. From our members who deliver care at home for underserved populations, we hear challenges with medical complexity, social complexity, and safety.

Examples include our members taking a higher proportion of patients out of safety net hospitals where they are likely to have high levels of complex medical needs (e.g., complex wounds in home health) and also a variety of social needs (e.g.' unstable housing, lack of a stable caregiver, food insecurity). We also have members who send a "buddy" to each home visit due to safety concerns which costs extra capital. On the nursing home side, a more traditional definition of "safety net" might be able to be applied based on mix of patients and payer. We recommend that, in addition to working with GAO on a standard definition of "underserved," Congress instruct both MedPAC and GAO to study the complexity of beneficiaries served in post-acute care to help inform a potential safety net definition. We know that MedPAC started this work, but their conclusions do not align with on the ground experience. We ask that the work continue with the opportunity for stakeholder feedback on methodology and results.

Serving beneficiaries who have a mental or behavioral health challenge could be a new consideration for a safety net definition. Increasingly, nursing home residents and those receiving care in the home and community require comprehensive mental health treatment and services, which has become a particularly common challenge for rural health care providers due to a lack of basic mental health

infrastructure and significant shortages of mental health professionals equipped to work with older adults.[v]

Value Based Care
Post-acute care has mostly been seen as a source of savings for value-based care rather than a partner. Congress should look at how to incentivize partnerships with post-acute care and letting post-acute care lead in value-based care. They also should invest in helping those who are smaller or serve rural or underserved populations to get more financial help in the transition to value. Technology, data collection, scale – these elements are tricky for providers who are targeting the populations the Committee is trying to assist via this RFI. For example, all home health agencies are moving to home health value-based purchasing. Even though the cohorts are based on size, they are not based on geography so a rural agency may be compared to a suburban agency based on size but will not be comparable in terms of challenges serving their unique populations.

PACE
The Program for All Inclusive Care for the Elderly (PACE) is the standard bearer for what coordinated community based long term care can look like. There are many barriers to expanding PACE in rural areas. HRSA recently did an examination of these barriers and made a number of recommendations – we concur with them and encourage the Committee to implement them.

Relationship of Post-Acute Care to Critical Access Hospitals (CAHs)
The Committee should examine the incentives between critical access hospitals and post-acute care to ensure payment incentives are aligned such that post-acute care can survive independent of the CAH. We hear from our SNF members that since swing beds in CAHs receive a substantially higher reimbursement rate, the incentives are for CAHs (or health systems more broadly) to open swing beds and hoard referrals. This makes it harder for rural nursing homes to survive and costs the taxpayer more money for the same service. In hospice care, CAHs must carve out hospice from cost reporting which lowers the hospital's cost-based reporting reimbursement rate. This acts as a regulatory barrier for CAHs to contract with hospice providers to offers services locally to hospice eligible beneficiaries in their service areas – the Committee should explore providing the Secretary with greater flexibility in cost reporting to encourage more hospice-CAH collaboration which would result in savings at the end of life and higher quality care. This cost-based reporting barrier is also a barrier for exploring CAH-PACE partnerships.

Regulatory Burden

While not directly related to payment, reducing the regulatory burden on rural and underserved providers would free up resources to focus on beneficiary care, staff, and other critical aspects of operations. Oversight -- both for quality and for fraud and abuse – are important but in their current form, these tools are not having the desired impacts. We recommend the Committee look at ways to reduce burden and increase the efficacy of existing safety, quality, and oversight tools.

Congress should promote transparency and efficiency amongst CMS' audit contractors to shift the focus of current audit and recovery practices from obtaining large initial "overpayment" recoveries to halting billing practices and patterns that clearly reflect failure to comply with fundamental requirements of the program. We recommend:

- Re-focusing its audit contractors on patterns and practices characteristic of providers that aim to minimize or avoid therapeutic care and supportive services that are required under relevant Medicare programs;
- Placing emphasis on the education of providers rather than recovery of payments and ensuring there are clear definitions and standards communicated effectively to providers and that are applied uniformly in the audit process;
- Requiring substantive education and training for all auditors that is consistent with the education given to providers to minimize inconsistencies;
- Modifying the audit, recovery, and appeals processes to reduce the need for lengthy adjudication and reduce the burden for typically compliant providers. Included in this should be a procedure for centrally monitoring audits across all contractors to ensure a high bar for why a provider must go through multiple audits simultaneously. Additionally, there should be an opportunity for mediation with the MAC to explain the provider's justification for the billing and correct auditor errors before denial or recovery of claims are initiated; and
- Increasing transparency of CMS contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, and top denial reasons.

While we hear about this burden most frequently from our hospice members, we strongly recommend that the Committee consider implementing more transparency and accountability measures on audit contractors to ensure taxpayer dollars are being directed toward the right targets.

Health Care Workforce

The US Healthcare system is navigating a new and unfamiliar landscape in the wake of the COVID-19 Public Health Emergency (PHE). Three years of sustained stress and increasing workloads have caused a dramatic shift in staffing patterns and an alarming rise in burnout across health professions. While shortages were projected prior to the pandemic, they have reached a crisis point in its wake. According to the *United States Registered Nurse Workforce Report Card and Shortage Forecast of 2019*, a shortage of registered nurses is projected to spread across the country through 2030. While 30 states are likely to experience a shortage, those in the Western, and more rural, region of the US will likely experience acute nursing shortages.[vi] This shortage will have a devastating impact on aging services writ large and we need more training, education, supply, and incentives specifically for nurses to enter aging services.

In a Senate hearing on September 19th, witness Carrie Edwards noted that she had lost nursing staff because they were not sure about the sustainability of her home health agency.[vii] She and other witnesses also noted a challenge that we hear from our members across the home-based care space – providing care in the home is a specific and challenging skillset. Nurses, therapists, and aides must balance the complexities of each individual client and be autonomous. Our home health and hospice members used to only hire staff with home-based care experience – that standard is no longer feasible. However, the Committee must examine ways to accommodate the enhanced training needs for care to be provided in the home.

Impact of the Proposed Staffing Standard on Rural Nursing Homes

The mission driven members of LeadingAge have fought valiantly throughout COVID-19 to protect the most vulnerable, older Americans, while acting as critical partners in their local health delivery systems.

Our members' efforts to care for those after in-patient treatment for COVID-19 prevented acute care hospitals from reaching capacity and ensuring doctors and nurses were able to continue to provide lifesaving care across generations. However, as the long-term care community emerges from a deadly pandemic and seeks to find the "new normal" we are met with a renewed push for unrealistic staffing mandates. According to the federal Bureau of Labor Statistics, the nursing home and other care facilities' workforce shrunk 410,000 workers nationally between March 2020 and November 2021. While it began to rebound in February 2022, these nursing homes and other residential care facilities still have more than a 200,000-person deficit in their workforce. At the same time, the 65+ population grows by more than 10,000 individuals per day. The ultimate trajectory if we don't address the health care workforce shortage is more working adults will need to leave the broader workforce to care for their loved ones at home. This isn't just a health care problem. Federal action on staffing mandates must be realistic for all communities, particularly those with limited access to health care providers.

There is no funding to hire and retain the 90,000 new staff CMS estimates will be needed. CMS estimates the cost of meeting the proposed rule's staffing levels is $40.6 billion over 10 years with an average annual cost of $4.06 billion. Independent estimates of the cost impacts are even greater, including the analysis by LeadingAge using CMS administrative data estimating the annual cost at $7.1 billion. The costs of delivering quality care in nursing homes already far exceed Medicaid reimbursement levels[viii], and this unrealistic mandate will force nursing homes to consider limiting admissions or even closing their doors for good, depriving older adults and their families care in their communities. This impact would trickle down to other settings – home health and hospice are also experiencing high levels of referral rejection and a staffing mandate would make these trends worse.[ix]

There simply aren't enough people to hire. As is true for most retail, food service, and hospitality businesses, a mandate will not solve the long-standing workforce shortages impacting nursing homes and the rest of long-term care continuum, particularly in rural and underserved areas. A 2020 study by the University of Washington found that the supply of primary care providers per capita is lower in rural areas compared to urban areas.[x] CMS estimates that approximately 75% of nursing homes will need to hire additional registered nurses (RNs) and certified nurse aides (CNAs) to meet the proposed staffing requirements. Many nursing homes have already been forced to utilize staffing agencies at prohibitive and unsustainable costs (this is true across our continuum and would get worse if the mandate were implemented as proposed).

Mandating staffing requirements could decrease access to care across the continuum. Both the acute and post-acute care sectors are seeing workers exit the profession, leaving a void that cannot be filled without bold action. Nursing homes have already reported increasing demands on their staffing resources, often leading to closures, which affect rural areas disproportionately. The existing workforce shortages are resulting in backlogs at acute care hospitals, which are unable to discharge patients due to reduced capacity in post-acute, long-term care facilities. Further, home health, hospice providers, and PACE providers – already navigating workforce challenges – will be short of even more workers if they move to nursing homes. Shuffling the relatively small number of care workers available between settings won't solve the problem.

Workforce Recommendations

LeadingAge suggests the following actions on workforce:

- Enact *the Protecting Rural Seniors Access to Care Act* (H.R.5796)
- Enact *the Expanding Care in the Home Act (H.R. 2853)* – of note is section 8 that looks at the future of the home-based care workforce with a focus on home-based nursing and grants to develop the home-based care workforce. The grant recipients should be expanded to include hospices.
- Enact the *Improving Care and Access to Nursing Care Act (H.R. 2713)* which would expand the authority of advance practice nurses.
- Enact the *Preserving Access to Home Health Care Act (H.R. 5159)* to ensure continued access to home health services.
- The Department of Health and Human Services (HHS) should establish and fully fund a national technical assistance center to support health and long-term care employees dealing with chronic workforce shortages.
- Direct HHS to create a standardized online training and testing program for Certified Nurse Aides (CNAs) and other allied health professionals.
- Direct HHS to review, and report to Congress, the current barriers for students seeking to complete training in long-term care and home and community-based settings. This should include masters and doctoral students completing required shadowing, training hours or internship placement.
- Direct HHS to provide a report to Congress outlining the role of Licensed Vocational/Practical Nurses across home and community-based care including home health, hospice, and PACE and congregate settings.
- Direct HHS to review opportunities to incentivize Graduate Medical Education (GME) slots for medical students who are completing training in geriatric medicine with rural healthcare providers.

Innovative Models and Technology

What we hear from both rural and underserved areas is that funding and flexibility to bring community partners together is one of the keys to promoting innovative practice. It involves putting older adults and their families at the center of the system. Our system as currently constructed does not reimburse for the time needed to form the relationships that lead to effective interventions nor to provide services like transportation, maintenance in the home, care coordination, socialization and others that have proven effective in keeping people in the setting of their choice for longer.

We recommend the Committee explore ways to reimburse for these aspects of providing services and supports. One example where this type of approach is working is the Connected Communities Grant Project being run by our state partner, LeadingAge Minnesota. Each Connected Community pilot includes the area hospital(s) and/or health system(s), nursing homes, home health agencies, assisted living providers, local area agencies on agency and tribal agencies, home and community-based service providers, social services, physicians, local public health, and area health plans (the payers). What is unique, is that the effort is coordinated by an aging service provider that has proximity to consumers, clinical providers, and community systems. It really is a whole system, person-centered approach. While the details are community-informed, each pilot agrees to address to include community planning, care coordination, quality improvement, and social engagement as part of their initiatives. To date, the program is seeing the development of deeper relationships across the participating partners resulting in shared problem solving and resources to meet community needs, greater identification and interaction with community individuals before they need care, and the creation of a comprehensive inventory of available services and supports in the community.

This type of approach is local but there are aspects that are replicable including creating a local coalition to lead this community-based work and break down barriers across sectors, completing a comprehensive review, taking a population health approach, engaging older adults in healthy aging, and building a community-specific care management model that can address needs unique to that geographic area, especially in rural areas. To enhance programs like Connected Communities and other initiatives that follow similar principles, Congress must provide upfront planning and implementation funding, create new payment structures for longitudinal population health management, and create sustainable funding streams for services that help people stay in the community.

Technology

LeadingAge supports the enactment of the *CONNECT for Health Act of 2023* (H.R. 4189) which would make permanent and build on the innovations in technology that occurred during the pandemic. Congress should authorize funding for long-term and post-acute care (LTPAC) providers to adopt interoperable Health IT with a focus on patient care and safety, including infection control and prevention and the other recommendations of the LTPAC Health IT Collaborative. We also ask that the Congress look at updating the *Home Health Emergency Access to Telehealth Act* (H.R. 3371 from the 117th Congress) to allow for home health agencies to receive reimbursement for telehealth services.

OUTSIDE THE COMMITTEE'S JURISDICTION

While we recognize that the Committee has specific jurisdiction, it is not feasible to solve the problems outlined in the RFI without consideration of a holistic picture of aging services – and we recommend that the Chairman work with his colleagues on all of government solutions.

Workforce

In addition to our recommendations for the Committee, we have the following recommendations:

- Congress should direct the United States Citizen and Immigration Services to review the current use of 'retrogression" and its impact on the recruitment of nurses and caregivers seeking to enter the country to work in long-term and home and community-based services.
- Congress should pass the Citizenship for Essential Workers Act, which would allow undocumented persons working as essential workers during the COVID-19 pandemic to be eligible for a path to citizenship.
- Congress should also enact the U.S. Citizenship Act of 2021 to provide a pathway to citizenship for approximately one million undocumented immigrants, including direct care workers.
- The U.S. Department of State should work with the Department of Health and Human Services create a special "caregiver visa" for direct care workers.

Rural Affordable Housing Need

Housing is one of the major social determinants of health, which have been shown to have a greater influence on health than either genetic factors or access to healthcare services.[xi] Trying to reform medical care without considering housing is not going to be effective.

There is a severe shortage of affordable housing across the United States, in rural, suburban, and urban areas. In 2021, more than 2.3 million very low-income older adult renter households spent more than half of their income for rent, one million older adult households more than in 2009.[xii] None of these households have housing assistance. Only one of every three eligible older adults receives housing assistance because the programs are too small to meet the need.[xiii] Between 2019 and 2021, the nation has experienced an increase of 10,000 more older adults relying on homeless shelters for their

housing.[xiv] Nearly a third of households age 65 and over live in low-density communities. This number is expected to continue to increase as older adult homeowners and renters age into rural areas or move to them, resulting in a concentration of older adults in low-density areas that is likely to continue for decades.[xv]

Affordable housing programs like the USDA's Section 515 Rural Rental Housing Program (and associated rental assistance from the USDA Section 521 Rental Assistance program) and HUD programs, including the Section 202 Supportive Housing for the Elderly and Section 8 Project-Based Rental Assistance programs, provide housing assistance to fewer and fewer older adults each year as federal assistance contracts with some private owners expire or are prepaid and funding to expand the supply of these homes is minimal for some programs and nonexistent for others. According to the Housing Assistance Council, 921 Section 515 properties serving more than 21,000 households left the program between 2016 and 2021.[xvi] More than 34% of Section 515 exclusively serve older adults and, of course, older adults also live in non-elderly Section 515 communities. Two-thirds of Section 515 residents are older adults or persons with disabilities.

Of the more than 5.1 households served by HUD programs in rural, suburban, and urban communities, 3.1 million are older adult households. Overall, the split of HUD-assisted housing between metropolitan and nonmetropolitan areas in 2019 was similar to that of all renter households and all renter households with very low incomes.[xvii] About half of HUD-assisted senior housing properties have a service coordinator, a critical lynchpin to helping residents access the health and wellness services and supports they need to successfully age in community.

LeadingAge urges Congress to:

- Fully fund the preservation of existing affordable USDA and HUD housing programs in annual appropriations bills.
- Expand the supply of housing affordable to households with very low incomes in annual appropriations bills.
- Enact the Rural Housing Service Reform Act, which has been introduced in the Senate (S. 2790) and would decouple rental assistance from maturing mortgages and permanently establish the Multifamily Housing Preservation and Revitalization Demonstration (MPR).
- Enact the Expanding Service Coordinators Act, HR 5177, to expand the number of service coordinators in HUD-assisted housing and authorize funding for service coordinators in Low Income Housing Tax Credit housing.
- Support funding for service coordinators in USDA Section 515 Rural Rental Housing.

Thank you for your consideration. Please reach out to Mollie Gurian, mgurian@leadingage.org with any questions or to discuss any of ideas in this RFI.

[i] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

[ii] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

[iii] Henning-Smith, C., Cross, D. A., & Rahman, A. (2021). Challenges to Admitting Residents: Perspectives from Rural Nursing Home Administrators and Staff. *Inquiry*, *58*, 004695802110051. https://doi.org/10.1177/00469580211005191

[iv] https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2021/03/RHRC_PBMAR2012_MROZ.pdf

[v] According to a 2022 report from the Rural Policy Research Institute (RUPI), residents of nursing homes in "noncore counties" are less likely to have functional limitations but are more likely to have behavioral/mental health needs mirroring earlier findings that suggest an increase in the number of nursing home residents with severe mental illness including diagnosis for depression, schizophrenia, and dementia. See more on nursing homes at Henning-Smith PhD., C., Casey MS, M., Prasad MBBS, MPH, S., & Kozhimannil PhD, K. (2017, May). *Medical Barriers to Nursing Home Care for Rural Residents*. University of Minnesota Rural Health Research Center. https://rhrc.umn.edu/wp-content/files_mf/1493905594SNFbarriers.pdf

[vi] Juraschek, S. P., Zhang, X., Ranganathan, V. K., & Lin, V. W. (2019b). Republished: United States Registered Nurse Workforce Report Card and Shortage forecast. *American Journal of Medical Quality*, *34*(5), 473–481. https://doi.org/10.1177/1062860619873217

[vii] https://www.finance.senate.gov/hearings/aging-in-place-the-vital-role-of-home-health-in-access-to-care

[viii] MACPAC. (2023, January 6). *Estimates of Medicaid Nursing Facility Payments Relative to Costs : MACPAC*. https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/

[ix] https://homehealthcarenews.com/2023/07/referral-rejection-rates-patient-complexity-in-home-health-care-reaching-all-time-highs/ and https://hospicenews.com/2022/02/18/referral-rejection-rate-for-hospice-reaches-all-time-high-of-41/

[x] Larson EH, Andrilla CHA, Garberson LA. Supply and Distribution of the Primary Care Workforce in Rural America: 2019. Policy Brief #167. WWAMI Rural Health Research Center, University of Washington; June 2020.

[xi] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

[xii] https://www.huduser.gov/portal/publications/Worst-Case-Housing-Needs-2023.html

[xiii] https://www.huduser.gov/portal/publications/Worst-Case-Housing-Needs-2023.html

[xiv] https://www.huduser.gov/portal/sites/default/files/pdf/2021-AHAR-Part-2.pdf

[xv] https://www.jchs.harvard.edu/housing-americas-older-adults-2019

[xvi] https://ruralhome.org/update-maturing-mortgages-usda-section-515-rural-rental-housing-program/

[xvii] https://www.huduser.gov/portal/sites/default/files/pdf/2019-Characteristics-Report.pdf