Leadership Council of Aging Organizations

Max Richtman, Chair

December 9, 2020

Majority Leader Mitch McConnell
Minority Leader Chuck Schumer
United States Senate
Washington, DC 20150

Speaker Nancy Pelosi
Minority Leader Kevin McCarthy
United States House of Representatives
Washington, DC 20515

Dear Leader McConnell, Leader Schumer, Speaker Pelosi, and Leader McCarthy:

The Leadership Council of Aging Organizations (LCAO) is a coalition of national nonprofit organizations concerned about the well-being of America's older population and committed to representing their interests in the policymaking arena. We, the undersigned LCAO members, write to urge you to include the following important Medicare and Medicaid provisions in the health extenders legislative package that is expected to be considered by December 11:

- Make permanent, within any Medicaid-funded Home and Community-Based Services (HCBS) program, protections against spousal impoverishment.
- Make permanent the Medicaid HCBS Money Follows the Person Program.
- Extend—preferably with permanent, increased funding—support outreach and enrollment activities for Medicare beneficiaries with low incomes.
- Prevent cuts to the Medicaid Disproportionate Share Hospital program.
- Extend funding for Community Health Centers.
- Exercise flexibility regarding implementation of electronic visit verification for Medicaid-funded personal care services and home health services.

Additional details on each provision follow.

Making Permanent Programs That Help Medicaid Enrollees Remain in Their Communities
As COVID-19 has raged through nursing homes and other institutional settings, the need for publicly supported HCBS has become increasingly urgent. To that end, we urge you to extend funding for—and, ideally, make permanent—two critical and expiring HCBS programs: Money Follows the Person (MFP) and spousal impoverishment protections.

The MFP program provides enhanced funding to assist transition from institutional settings back to their communities. These costs include identifying and coordinating affordable and accessible housing and providing additional services and supports to make successful transitions. Between its inception in 2008 and the end of 2019, the program helped more than 101,500 older adults and people with disabilities

111 K Street, NE #700 • Washington, DC 20002
(202) 216-8383– Direct Line • (800) 966-1935 – Reception Line
Email: LCAO@ncpssm.org • Website: www.LCAO.org

move from institutional settings back to their communities. Moreover, the program is cost effective: According to the Centers for Medicare & Medicaid Services (CMS), in its first year MFP realized an average cost savings of $22,080 per older adult participant, $21,396 per person with physical disabilities, and $48,156 per person with intellectual disabilities. However, uncertainties regarding previous, short-term extensions have caused some states to drop the program. Consequently, making the program permanent—or instituting at least a 5-year extension—is critical to helping people living in institutional settings transition safely back into their communities.

Medicaid's "spousal impoverishment protections" make it possible for an individual who needs a nursing home level of care to qualify for Medicaid while allowing the person's spouse to retain a modest amount of income and resources. Since 1988, federal Medicaid law has required states to apply these protections to spouses of individuals receiving institutional long-term services and supports (LTSS). Effective in 2014, Congress extended this protection to eligibility for HCBS in all states and the District of Columbia, thereby ensuring that married couples have the same financial protections whether a person uses LTSS in a facility or in the community. Allowing the policy to expire could force people whose needs warrant a nursing facility level of care and who now receive HCBS to move into more costly institutional care against their wishes. Furthermore, failure to extend—or, optimally, make permanent—these protections could stall or even reverse progress states and the District have made in helping older adults and people with disabilities remain in their homes and communities.

Continuing Medicare Low-Income Outreach and Enrollment Assistance

We urge that Congress also included in its health extenders package a provision to continue funding for Medicare outreach and enrollment efforts to beneficiaries with low incomes, many of whom are dually eligible for Medicaid. Such funding supports community-based efforts not only through State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, but also through the National Center on Benefits Outreach and Enrollment, which provides grants to a network of 80 local Benefits Enrollment Centers in 43 states. These efforts, extended nine times since 2008, enable Medicare beneficiaries with the fewest resources to access assistance for prescription drug coverage and other essential Medicare benefits for which they are eligible. We urge you to extend funding for as long as possible—ideally, making the program permanent—and to include a modest funding increase from $37.5 to $50 million to help address growing needs.

The following data exemplify the need for this low-income outreach and enrollment assistance. Almost 3 million beneficiaries are eligible for but not enrolled in the prescription drug low-income subsidy program (LIS, also known as Extra Help). Improving enrollment in this program is critical to reducing out-of-pocket prescription drug costs for beneficiaries who can least afford them. Many of these beneficiaries live in rural and other historically underserved communities. Low-income outreach and enrollment activities have also helped many Medicare beneficiaries with low incomes enroll in Medicare Savings Programs (MSPs), which help pay for Part A and Part B premiums, deductibles, coinsurance,

copayments, or some combination thereof. Thanks to low-income outreach and enrollment activities, the number of Medicare beneficiaries enrolled in MSPs increased from 7.9 million in 2008 to 10.9 million as of December 2019.

Supporting Safety Net Providers

COVID-19 has created an unprecedented strain on the United States health care system and poses a serious threat to the viability of safety net providers, many of whom faced financial challenges even before the pandemic. These providers, known as Disproportionate Share Hospital (DSH), serve high numbers of Medicaid enrollees and people without health insurance. Although coverage gains under the Affordable Care Act have helped cushion the strain of such uncompensated care, these hospitals continue to face budgetary challenges, which have been aggravated by the COVID-19 pandemic. The pandemic has also pushed the budgets of states, territories, and the District of Columbia to the brink, raising the possibility of reductions in Medicaid payment rates. Therefore, we urge Congress to prevent Medicaid DSH funding cuts. Such cuts would be especially problematic in areas in which hospitals serve both as an economic engine, providing jobs in the local economy, and as the primary care provider because the community lacks sufficient physicians and health care facilities. Allowing DSH cuts to take effect in this time of uncertainty would decrease access to health care for people who are least able to afford it and threaten the financial viability of many hospitals.

In addition, we urge Congress to extend funding for Community Health Centers (CHCs), which provide vital primary and preventative care to underserved populations and reduce health disparities. COVID-19 has created unique challenges for CHCs, forcing many to reimagine how they provide care, particularly in helping people at high risk manage chronic conditions and prevent serious illness. At the same time, CHCs are facing new costs and serious financial challenges. Cuts to CHC funding could eliminate health care lifelines in many communities.

Electronic Visit Verification

Finally, we urge Congress to delay further implementation of electronic visit verification (EVV) for Medicaid personal care services and home health services. Alternately, we urge you to provide the Secretary of Health and Human Services with greater authority to accommodate states, workers, and consumers, who currently face unprecedented challenges in providing and accessing care. EVV was signed into law as part of the 21st Century Cures Act and was scheduled with a one-time, statutorily permitted administrative action for implementation as of January 1, 2021. States, territories, and the District of Columbia were already struggling to meet EVV requirements; COVID-19 has only worsened a difficult situation.

Put simply, most states and other jurisdictions are not ready to implement the law, even as some continue good-faith efforts to comply. EVV implementation has been chaotic, at best, from the top

down, with shifting (and sometimes seemingly contradictory) federal guidance. States and other jurisdictions have been at the forefront of combatting the pandemic, and resources are spread extremely thinly. This budget pressure may force states and other jurisdictions to cut Medicaid funding—which, in past fiscal crises, resulted in significant cuts to HCBS. Penalizing states and other jurisdictions that cannot comply with EVV at this time by reducing Medicaid funding could, as noted previously, diminish consumer access to HCBS and increase the need for more costly and risky nursing home care. Furthermore, pushing states and other jurisdictions to rush EVV implementation would present significant risks to older adults, people with disabilities, and workers. Not only could rushed implementation jeopardize worker and consumer privacy, but many unintended consequences could also result. For example, a poorly functioning system could contribute to consumers losing access to services. It could also inappropriately reduce hours and compensation for workers, who already live paycheck to paycheck.

We recognize the difficult fiscal constraints under which Congress is operating at this time. Yet, we respectfully urge you to recognize the importance of the aforementioned provisions to the health and well-being of older adults and people with disabilities. Indeed, these investments are critical to our communities as a whole because we all depend on one another.

Thank you for your consideration of our recommendations. We look forward to working with you to ensure sustained investment in the Medicare and Medicaid programs.

Sincerely,

Alzheimer's Association
Alliance for Retired Americans, Eva Dominguez
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Geriatrics Society
American Postal Workers Union Retirees Department
American Society on Aging
Association of Jewish Aging Services
Center for Medicare Advocacy
Families USA
Gerontological Society of America
Jewish Federations of North America
Justice in Aging
LeadingAge
Medicare Rights Center
National Academy of Elder Law Attorneys
National Adult Day Services Association
National Association of Area Agencies on Aging

National Association for Home Care and Hospice
National Association of Nutrition and Aging Services Programs
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Committee to Preserve Social Security and Medicare
National Council on Aging
National Consumer Voice for Quality Long-Term Care
National Senior Corps Association
Volunteers of America
Women's Institute for a Secure Retirement (WISER)

Cc: The Honorable Charles Grassley
Chairman, Senate Committee on Finance

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance

The Honorable Frank Pallone
Chairman, House Committee on Energy and Commerce

The Honorable Greg Walden
Ranking Member, House Committee on Energy and Commerce

The Honorable Richard Neal
Chairman, House Committee on Ways and Means

The Honorable Kevin Brady
Ranking Member, House Committee on Ways and Means