October 5, 2023

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

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

Dear Chairman Smith:

As President and CEO of Lutheran Services in America, I appreciate the opportunity to submit comments on the Committee's recent Request for Information on "Improving Access to Health Care in Rural and Underserved Areas."

Lutheran Services in America is a national network of 300 faith-based health and human services organizations that reaches one in 50 people in America each year. Recognized by The Chronicle of Philanthropy and Forbes as one of the nation's top nonprofit organizations, the Lutheran Services in America network operates with more than $23 billion in combined annual revenue and reaches one in 50 Americans every year. Headquartered in Washington, D.C., Lutheran Services in America leads innovative collaborations with partners in philanthropy, academia, and healthcare, among others, to address the most critical challenges in over 1,400 communities and empower people to lead their best lives.

We are dedicated to advancing innovative solutions that improve health and opportunity for millions of people in America. In collaboration with key partners, we lead programs that inform and advance policy, system, and practice changes to improve the health and wellbeing of all people in America. We leverage our national network of providers to catalyze trends and opportunities that can be scaled for greater success. Our work includes piloting promising practices, evaluating progress and lessons learned, and sharing our work and findings with stakeholders across the health and human services sector to accelerate change. Based on our tenured experience, we offer the following comments.

HEALTH CARE WORKFORCE

We are well placed to comment on challenges and existing barriers to health care access caused by staffing shortages in the health care workforce as our network of member providers works with people across the spectrum of age, need, and geography. While the shortage of health care staff has been acute across the board, it has been especially problematic in rural areas, particularly in providing long-term care for older adults.

Rural Issues

Aging in rural communities presents unique challenges to empowering older adults so they can maintain their health and independence. Key challenges include limited infrastructure and private investment in medical and nonmedical services and supports (including housing and transportation) at the same time demand for services is increasing. A shrinking workforce due, in part, to the out migration of young people and a rapidly aging population driving increasing demand create a complex terrain in need of long-term, sustainable solutions. Some specific ways to help address rural concerns include expanding reimbursement mechanisms for community-based organizations to address health-related social needs (HRSNs) with limited healthcare infrastructure and preserving recently expanded approval for Medicare reimbursement for telehealth services and Medicaid telehealth flexibilities by state. Home and community-based workforce retention efforts could also be strengthened by directing CMS to fairly compensate rural care providers for distance traveled to older adults receiving home- and community-based services under Medicaid.

SNF Minimum Staffing Rule Impact

Long-term, skilled nursing care has also been dramatically affected by the longstanding shortage of direct care workers. The current CMS proposed rule Instituting a mandate for minimum staffing requirements at skilled nursing facilities (SNFs) with no additional funding support will only exacerbate the current workforce crisis, further reducing access to essential health care.

The workforce shortage is acute across the board (nurses, behavioral health, food service) but is most serious in positions like Certified Nursing Assistants (CNAs) and Direct Service Professionals (DSPs.) In a survey of our providers who provide skilled nursing care, 80% of respondents report staffing vacancies of 11% or more, with over 16% having vacancies greater than 31%. As a result, 90% of respondents say that since March 2020, they have had to reduce

services, close a location, or reduce the number of people served because they don't have enough staff—or they anticipate doing so.

The critical workforce shortage has led to long waiting lists for skilled nursing with older adults languishing in hospitals because of the lack of skilled nursing beds, leaving vulnerable older adults without any access to quality care. For example, because of the reduction in the number of SNF beds resulting from workforce shortages, more patients are unable to be discharged from hospitals to post-acute facilities and are now spending nearly 24% more time in hospitals awaiting discharge than they did in 2019. With the inability to meet existing needs given reasons outlined above, we see that nationwide, more than 575 facilities have closed since 2020 and 54 percent of nursing home providers say they are limiting new admissions due to staffing shortages. As such, the current proposed rule will only make access more difficult in rural areas.

Nonprofit providers, especially faith-based providers, consistently receive the highest star ratings. On average, nonprofit and similar mission-minded nursing homes provide 42 more minutes of care each day compared to nursing homes generally. They simply do not accept new patients or residents if they do not have the staff to support them. Therefore, when they are forced to reduce services or close, it means that higher-quality providers are further limited in their ability to serve their communities and older adults will not be able to find care.

Nonprofit facilities, which rely most heavily on state Medicaid payments and cannot simply charge consumers more for services, require additional funding to meet current challenges and offset the increased costs and inflation that have grown out of the pandemic. The system is not sustainable. It cannot serve all those in need of care.

While an increased minimum staffing standard may benefit a few residents at select facilities operating below that threshold, many more residents, especially in nonprofit facilities, will face disruption or displacement as their current home is sold or entire wings of facilities are shuttered. A minimum staffing standard which fails to consider the individual nuances of each state and community only further exacerbates these financial challenges and will lead to additional closures and a reduction of beds available to serve our nation's older adult population. In fact, per a report by accounting and

consulting firm CliftonLarsonAllen, 18% (or 205,000+) of nursing home residents would be at risk for displacement, as facilities would be forced to reduce their census to meet a minimum staffing ratio.

In just one example from a rural provider in our network, a facility which was licensed pre-pandemic for 100 beds now has a multi-step plan to reduce licensure to 44 beds if they cannot find sufficient additional staff. Currently, they have 31 people actively waiting for placement in the nursing home. In a town of just over 3,000, that's the equivalent of 1% of the population waiting for a spot in this nursing home.

The proposed application of a uniform minimum staffing requirement will have a larger impact on underserved and rural communities where the workforce crisis is most acute, resulting in less access to care in these communities. A one-size-fits-all approach will have unintended consequences. Not only is this an access to care issue, but this is a health equity issue. CMS defines health equity as the attainment of the highest level of health for all people, whereby every person has a fair and just opportunity to attain their optimal health regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, and geography—including whether they live in a rural or other underserved community. Reduction in access to quality care in these communities will result in continued health disparities for their residents.

Revitalizing the Workforce

Many factors have affected our providers' ability to recruit workers, including the demand for healthcare professionals in other settings; competition with for-profit businesses; the long-standing inadequacy of Medicaid reimbursements; and the drastically diminishing labor pool caused by the departure of Baby Boomers from the workforce with too few new workers to take their places. Overall, the most significant factor is that it is hard to attract workers due to the low reimbursement rates that Medicaid provides.

Put simply, there are fewer and fewer people entering the healthcare field, and our providers cannot recruit against other employers given current funding levels. As the primary payer of long-term care, Medicaid has not fully met the costs of care for years, much less the significantly increased costs of care today with rising workforce and operating costs. The Medicaid and CHIP Payment and Access Commission has reported that current basic Medicaid

reimbursement rates only cover 86% of nursing home costs today. Providers need higher reimbursements to support a family sustaining wage for caregivers and maintain quality and access for residents.

For example, a SNF in Kansas received $230.52 per resident per day in Medicaid reimbursement for the first half of this year, while it cost them $321 a day to provide services. This means that this provider lost over $90 a day on each Medicaid resident—60% of the people in their facility—which is unsustainable and leaves them unable to offer competitive wages.

Solutions

To begin to solve these complex challenges, we have identified several specific actions that would begin to address the workforce shortage. First, improve Medicaid reimbursement levels for the full range of covered services to address current funding inadequacy, maintain quality and access, and support fair wages for caregivers. Second, update immigration and refugee policies to increase availability of people from these communities to enter the direct care workforce. One immediate option would be to ease the pathway to securing work visas. Allowing special visas to fill CNA positions along with instituting a waiver process for immigrants and refugees to the United States who want to work in direct care and who already have foreign licenses/degrees can ease workforce challenges we face across the country.

We also urge lawmakers to support the Healthcare Workforce Resilience Act. The bill with broad bipartisan support in the 117th Congress is planned to be reintroduce soon. The measure would help increase the healthcare workforce in the following ways: award visas for direct healthcare workers with emphasis on registered nurses (RNs) and CNAs; remove the green card freeze impacting international nurses; and recapture unused visas from previous fiscal years for nurses and their families.

Finally, additional focus on building an internal recruitment/training/retention pipeline is also needed. Allowing greater flexibility for SNFs to provide onsite training for new hires and existing employees, especially CNAs, would foster stronger recruitment and retention as SNFs develop their own workforce. Loan forgiveness, tax credits, and other incentives for new and existing staff are also needed.

INNOVATIVE MODELS AND TECHNOLOGY

We also see great promise in policies and programs to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas.

An important factor is recognizing that rural communities have different, unique service needs and one size does not fit all. This is especially true given how the lack of population density impacts investment from private stakeholders and the availability of services. For example, the health care needs of rural Americans could be better met if the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS) funded rural-specific research about effective payment and service delivery models, including reinstating the Community Health Access and Rural Transformation (CHART) program and developing an Accountable Health Communities (AHC)Model for rural communities.

Addressing health-related social needs such as housing would also improve health care and outcomes for these populations. We urge stakeholders to increase investment in the U.S. Department of Agriculture's (USDA) Rural Housing Services (RHS) program in partnership with the Department of Housing and Urban Development (HUD) in the reauthorization of the Farm Bill and related appropriations bills.

Within our own experience, we are witnessing the importance of addressing social determinants of health (SDOHs) to prevent acute episodes or hospitalizations. Our Rural Aging Action Network (RAAN) is seeding investment in community-led approaches to aging in rural and frontier communities that center the voices of older adults. The RAAN approach broadens the circle of partners in aging, recognizing that unlike urban areas, rural environments with less infrastructure demand creative and inclusive approaches to mobilize whole communities to support older adults. RAAN partners are innovatively addressing gaps in care by listening to the needs of older adults through strengths-based one on one assessments utilizing the CMS AHC Health Related Social Needs Screening Tool and mobilizing community partners to address unmet SDOH needs. This holistic approach builds trusting relationships and elevates the voice of older adults while providing choice and independence to age in place.

CONCLUSION

We appreciate the opportunity to share our experience and thoughts with the Committee. We would welcome the chance to speak with Committee members or staff further on any of these issues or connect you with our network providers across the country for their expertise.

Sincerely,

Alesia Frerichs
President and CEO