Center for Medicare Advocacy
MedicareAdvocacy.org

October 22, 2025

Annabelle Huffman
Legislative Clerk
Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Submitted via email to: [redacted]

Re: Response to Questions for the Record from September 18, 2025 Hearing Titled "Examining Policies to Enhance Seniors' Access to Breakthrough Medical Technologies"

Thank you, again, for the opportunity to testify before the Committee at the above-referenced hearing. Per the Committee's request, attached please find responses to questions for the record. If you need any additional information, please contact me at [redacted] or [redacted].

Sincerely,

David Lipschutz
Co-Director/Attorney

Attachment

Attachment

Responses from the Center for Medicare Advocacy to Additional Questions for the Record from Hearing Titled "Examining Policies to Enhance Seniors' Access to Breakthrough Medical Technologies" (September 18, 2025)

The Honorable Mariannette Miller-Meeks (R-IA)

1. **Even when a breakthrough medical technology is FDA-cleared or approved, patients in rural communities often wait years for coverage and access — especially when those technologies are not traditional drugs or devices, but software-driven innovations like autonomous artificial intelligence systems that bring specialist-level diagnostic care directly into primary care and other frontline settings.**

    a. **What do you believe are the most effective steps Congress and CMS can take to ensure that these kinds of diagnostic and preventive innovations reach rural and aging populations more quickly — particularly when they improve chronic disease management, close care gaps, support earlier detection of disease, and reduce pressure on limited specialist capacity?**

The significant barriers to accessing care in rural areas are well documented, but there are pathways to making improvements, including through increased access to technology. As discussed in an *American Journal of Medicine* article titled "Bridging the Health Care Gap in Rural Populations: Challenges, Innovations, and Solutions" by Ayesha Javed, MD, (May 2025)[1], there are complex health care challenges faced by rural populations. The author suggests expansion of telemedicine, mobile health clinics, "leveraging technology to improve remote monitoring of chronic conditions like diabetes and hypertension [that] can allow for more effective management without requiring frequent in-person visits," programs that combat workforce shortages, including offering financial incentives, and "addressing the economic barriers through policy changes—such as expanding insurance coverage and offering subsidies for transportation—could make health care more affordable." Dr. Javed concludes: "Ultimately, it is through collective action, driven by evidence-based strategies and a steadfast commitment to equity, that we can improve health outcomes and ensure that rural populations have access to the care and resources necessary to thrive."

Similarly, the National Rural Health Association (NRHA) published a blog post titled "Diagnostic advancements create opportunities for rural health" (July 16, 2025) which was adapted from a Mayo Clinic piece by Dr. William Morice II.[2] The post notes that "[i]nnovations in diagnostics have the potential to significantly transform rural health care by bringing more care to patients in their communities and even their homes. Wearable devices, telehealth, and point-of-care diagnostics are three specific areas where advancements have the potential to enable new approaches to health care delivery that overcome unique rural barriers." Dr. Morice concludes:

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[1]Volume 138, Issue 5, p761-762, available at: https://www.amjmed.com/article/S0002-9343(25)00039-7/fulltext

[2] National Rural Health Association, available at: https://www.ruralhealth.us/blogs/2025/07/diagnostic-advancements-create-opportunities-for-rural-health.

> Fully realizing the potential of these technologies requires rethinking how care is provided. Simply incorporating new technology into existing health care delivery models will limit what is possible. This transformation requires a shift toward more flexible and adaptive health care systems that can seamlessly integrate new diagnostic tools and telehealth services. By taking advantage of technological advances, rural health care can offer comprehensive, high-quality care that better meets the needs of rural communities.

As you are likely aware, the National Academies of Sciences, Engineering, and Medicine recently conducted a public workshop to explore opportunities to improve diagnosis in rural areas in the United States. On October 14, 2025, the National Academies hosted a public workshop titled "Advancing Diagnostic Excellence in Rural Areas: A Workshop,"[3] Among the topics considered was "[t]he role of technologies and diagnostic innovations in improving diagnosis, including artificial intelligence and machine learning tools, digital health, telehealth, mobile units, remote diagnostics, and other mechanisms to routinely collect high-quality data and communicate patient information to clinicians in real time." While the proceedings-in-brief of this workshop has not yet been released, it is likely that it will include valuable expert opinions on this subject that can help inform policymakers.

Congress can invest funds in ensuring that such technology is made available to and specifically targets rural areas, and can work to ensure access regardless of an individual's health coverage (e.g., through both traditional Medicare and Medicare Advantage, Medicaid, Affordable Care Act plans, etc.). In addition, Congress should further invest in our nation's federal public health and research infrastructure, rather than accept recent efforts to slash funding, staffing and otherwise diminish these agencies, which will most certainly have negative consequences nationwide.[4] Many of such agencies work to address barriers to care in rural areas. For example, the CDC has been engaged in efforts to "improve rural health through funding, research, surveillance, and telehealth"[5], NIH's National Center for Advancing Translational Sciences (NCATS) supports the Clinical and Translational Science Awards (CTSA) rural health initiatives[6] and SAMHSA has a Rural Recovery Innovations project.[7]

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[3] See https://www.nationalacademies.org/event/45238_10-2025_advancing-diagnostic-excellence-in-rural-areas-a-workshop.

[4] See, e.g., Economic Policy Institute, "Trump's gutting of public health institutions is setting the stage for our next crisis" by Kyle K.. Moore (April 21, 2025), available at: https://www.epi.org/blog/trumps-gutting-of-public-health-institutions-is-setting-the-stage-for-our-next-crisis/.

[5] See https://www.cdc.gov/health-equity-chronic-disease/health-equity-rural-communities/index.html.

[6] See https://ncats nih.gov/research/research-activities/ctsa/projects/rural-health.

[7] See https://library.samhsa.gov/product/rural-recovery-innovations/pep24-08-010.

The Honorable Debbie Dingell (D-MI)

1. **In your testimony, you spoke about ensuring equitable access to care for Medicare beneficiaries, and the need to strengthen Traditional Medicare. Can you speak to the strain that healthcare cuts broadly will have on access to care for Medicare beneficiaries?**

On July 4, 2025, President Trump signed into law H.R. 1 – One Big Beautiful Bill Act (OBBB).[8] This bill makes unprecedented and wide-ranging cuts to a number of safety-net programs, including over $1 trillion in cuts to health programs, which will result in an estimated 10 million people losing insurance coverage.[9] The bulk of health care cuts, which will be implemented over a number of years, are directed at the Medicaid program and aimed at reducing the number people covered. These changes include: new "community engagement" (work requirements) for certain individuals to maintain coverage; more frequent eligibility redeterminations; rescission of eligibility for certain groups of lawfully present immigrants (similar to the Medicare-specific provision described below); and reduced ability for states to raise additional Medicaid funds through provider taxes. There are also significant changes for Affordable Care Act marketplace enrollees, including non-renewal of financial assistance for qualifying individuals.

Many of the cuts to Medicaid will impact people who have both Medicare and Medicaid (dual eligibles). As outlined in joint publications by the Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst,[10]

- One in five Medicare enrollees relies on Medicaid to help pay Medicare premiums and cost sharing;
- Nearly 30% of Medicaid funding goes to people with Medicare;
- Medicaid is the primary payer for 63% of nursing facility residents; and
- Without Medicaid, over 12 million Medicare enrollees would experience gaps in care that jeopardize their health and well-being.

As noted in an April 2025 *Health Affairs* article,[11] cuts to Medicaid will have significant impacts on older adults and individuals with disabilities:

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[8] Pub. Law No: 119-21.
[9] Congressional Budget Office (CBO), "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate" (July 21, 2025), available at: https://www.cbo.gov/publication/61569.
[10] Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst, "A Cut to Medicaid is a Cut to Medicare" (March 2025) – Fact Sheet: https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-fact-sheet.pdf; Issue Brief: https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-Issue-Brief.pdf.
[11] *Health Affairs Forefront*, "History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People" by Jessica Schubel, Alison Barkoff, H. Stephen Kaye, Marc A. Cohen and Jane Tavares (April 16, 2025), available at: https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.

Cutting federal Medicaid spending would have such negative consequences on older adults and people with disabilities because reductions in Federal reimbursements to states would leave states with tough choices: use more state dollars to pay for Medicaid (hard to do if the use of provider taxes is eliminated or severely cut), or cut Medicaid spending. If they cut Medicaid spending, that means covering fewer people, reducing covered benefits, cutting provider payment rates, or a combination of these. For each of these choices, Home and Community Based Services (HCBS) is a highly threatened area, despite assurances otherwise […].

There are also provisions of the OBBB that will directly impact Medicare beneficiaries, including:

- *Limiting eligibility and terminating coverage of certain lawfully present non-citizens* – Upon enactment, §71201 restricts Medicare eligibility to citizens or nationals of the U.S., lawful permanent residents (green card holders), certain Cuban/Haitian entrants and Compacts of Free Association (COFA) migrants (rescinding eligibility for all other lawfully present immigrants, including asylees, refugees, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and individuals granted humanitarian parole for a period of at least 1 year). Not later than one year after enactment (July 4, 2026), the Commissioner of the Social Security Administration is directed to identify individuals with Medicare coverage who do not meet the new criteria, and notify such individuals "as soon as practicable after such identification and in a manner designed to ensure such individual's comprehension of such notification" that their coverage will be terminated as of 18 months after enactment (approximately January 2027). Note: Undocumented individuals have never been eligible for Medicare coverage, but, until enactment of the OBBB, lawfully present individuals who meet the requisite work history requirements through SSA have been eligible for Medicare coverage.
- *Ending implementation of a rule streamlining eligibility and enrollment in Medicare Savings Programs (MSPs)* – §71101 prohibits the Secretary of Health & Human Services from implementing (for 9 years) certain provisions of the final rule published by CMS on September 21, 2023 (88 Fed. Reg. 65230), which was aimed at making it easier for Medicare beneficiaries to enroll in and qualify for MSPs, which can cover some Medicare premiums and costs for lower income beneficiaries. The Congressional Budget Office (CBO) estimates that this will save over $66 billion over 10 years due to fewer people enrolling in MSPs; more than 1.3 million dually eligible individuals are expected to lose assistance through MSPs.
- *Prohibiting implementation of a final staffing rule for nursing facilities* - §71111 prohibits CMS from implementing a final rule issued in 2024 (89 Fed Reg 408706) which established national minimum staffing requirements for nursing facilities to promote quality care (note that provisions of this rule were vacated by a federal court, but the Trump Administration continues to defend the rule). Researchers at the University of Pennsylvania have estimated that the staffing rule would save 13,000 residents' lives each year.[12]

[12]Letter (Jul. 8, 2024) from Rachel M. Werner, Professor, Health Care Management and Economics, Professor, Medicine, University of Pennsylvania, Norma B. Code, Director of Research, LDI, Professor, Medical Ethics and Health Policy, University of Pennsylvania, to Senator Elizabeth Warren, available at: https://www.warren.senate.gov/imo/media/doc/letter_from_researchers_to_sen_warren_070824.pdf. Also see, e.g., Center for Medicare Advocacy, *CMA Alert*: "Reconciliation Bill will Cause Nursing Home Residents to Suffer" (June 5, 2025), available at: https://medicareadvocacy.org/bill-will-cause-nursing-home-residents-to-suffer/.

- *Restricting the Medicare program's ability to negotiate the price of certain drugs* – the Inflation Reduction Act of 2022 (Pub. Law No: 117-169) gave the Secretary authority to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, with negotiated prices first effective in 2026. Section 71203 of the OBBB carves out certain "orphan drugs" (medications developed to treat rare diseases) from Medicare drug price negotiation. CBO has recently estimated that the 10-year cost of this section will be $8.8 billion.[13]

Finally, unless Congress acts, the bill threatens Medicare's sustainability by triggering massive future cuts to the program. Nearly $500 billion in Medicare cuts would be required,[14] with an estimated $45 billion occurring as soon as fiscal year 2026.

In addition to the Medicaid cuts that will impact individuals dually eligible for Medicare and Medicaid, terminating lawfully present individuals from Medicare, halting changes that would make it easer to qualify for financial assistance, prohibiting implementation of a nurse-staffing rule that would have better protected nursing home residents, and further restricting the ability of the Medicare program to negotiate the costs of certain prescription drugs will combine to have a significant, negative impact on the Medicare program.

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[13] CBO, "Revised Estimate of Changes Under the 2025 Reconciliation Act for Exemptions From Medicare Price Negotiations for Orphan Drugs" (Oct. 20, 2025), available at: https://www.cbo.gov/publication/61818.

[14] See, e.g., Congressional Budget Office (CBO) "Potential Statutory Pay-As-You-Go Effects of a Bill to Provide Reconciliation Pursuant to H. Con. Res. 14, the One Big Beautiful Bill Act" (May 20, 2025), available at: https://www.cbo.gov/publication/61423.