

Testimony of Robert Blancato
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House Ways and Means Committee, “Caring for Aging Americans”
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Chairman Neal, members of the Committee:

Thank you for the invitation to testify. I especially thank the Chairman for his advocacy on behalf of nursing home and hospice residents and their rights, shown in the convening of this hearing and the five very strong and clear letters sent to the Administration over the past few months on these issues.

I have been working on aging issues for several decades. Aging Americans and their families and caregivers continue to face many challenges, whether in skilled nursing facilities or independently in their homes and communities. Affordability of long-term care is a huge concern in all settings, as are abuse, neglect, and exploitation. Rural older Americans, LGBTQ older Americans, and those who are food insecure also have unique challenges. As a result, many older adults and their families and caregivers can face an uncertain future.

The Affordability of Quality Care

Achieving quality care for older adults is one thing. However, affording it is entirely different. These issues are intertwined; without adequate Medicaid and private funding to pay professional home health aides and nursing home workers decent wages, turnover is high, leading to inexperienced, overworked aides who may not be able to provide quality care.

Overall, we know that the cost associated with long-term care/long-term services and supports is the biggest unfunded liability facing the boomer generation, which now ranges in age between 55 and 73.¹ Genworth’s “Cost of Care” estimates show that the median national cost of a year’s care in a nursing home (semi-private room) exceeds \$90,000.² Home health care costs exceed \$50,000 per year and assisted living costs currently exceed \$48,000.³

However, future Medicaid funding is uncertain. Many older adults rely on Medicaid to fund their long-term care needs. However, states are increasingly considering waivers that would block-grant Medicaid, which could lead to individual caps on care funding. Further, Medicaid reimbursement rates are currently very low for nursing home and home health aides, also leading to their low wages.

¹ Sam Baker, “Aging baby boomers raise the risk of a long-term-care crisis that the US isn’t remotely ready for,” *Business Insider*, August 19, 2019. <https://www.businessinsider.com/aging-baby-boomers-raise-risk-long-term-crisis-not-ready-2019-8>

² Genworth, “Cost of Care Survey 2019,” August 26, 2019. <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>

³ Ibid.

“Private pay” opportunities for future long-term care needs are also dwindling as older adults’ savings are drained to pay for immediate health care needs. A 2019 poll from Gallup and West Health revealed that seniors have withdrawn an estimated \$22 billion from their long-term savings to pay for health care just in the past 12 months.⁴ Also indicating that future ability to privately pay may be in jeopardy: a 2019 Health Affairs article noted that in 10 years, more than half of middle-income Americans 75 and above will not be able to afford assisted living or medical expenses—the average annual financial resources of middle-income older adults are projected to be approximately \$60,000 (including home equity), and the annual cost of assisted living alone is projected to be \$62,000.⁵

How Can We Make Care Affordable?

How do we fix this? The passage of comprehensive long-term care/long-term services and supports legislation has been a challenge for the past 30 years. A report by the then-Chairman of the House Select Committee on Aging Claude Pepper outlined a series of proposals that would have constituted good legislation. It was largely ignored. Several different bills were episodically considered in both the House and Senate until the CLASS Act was adopted as part of the Affordable Care Act. However, it was later repealed after actuaries determined it was not sustainable.

Where are we today? Again, we have an array of ideas. I urge that all viable proposals deserve to be vetted, studied and moved forward. Action might come via other legislation such as the House prescription drug pricing bill or some future Medicare/Medicaid reform legislation. I believe we can all agree that something needs to be done.

In the meantime, individual states are beginning to take the lead. Washington state enacted the Long-Term Care Trust Act into law earlier this year. It creates a long-term care insurance plan that will distribute \$36,500 per person in lifetime benefits. They are in the middle of a five-year implementation process now and will start providing the first benefits to vested, eligible residents in 2025.

Recently, I had the pleasure to address the annual conference of the Washington Association of Area Agencies on Aging. During that conference, I learned about two realities that aided in getting this bill passed which might be relevant in other states and nationally. The first reality is the recognition that long-term care legislation is not just a public, private or individual responsibility; it combines all three elements. The second reality came through a poll that found that 83 percent of voters aged 18-34 supported the bill’s concept, which demonstrates that long-term care is an intergenerational issue.

⁴ Lance Stevens and Lawrence Mallory, “U.S. Seniors Pay Billions, yet Many Cannot Afford Healthcare,” *Gallup Blog*, April 15, 2019. <https://news.gallup.com/opinion/gallup/248741/seniors-pay-billions-yet-cannot-afford-healthcare.aspx>

⁵ Caroline F. Pearson et al, “The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources For Housing And Health Care,” *Health Affairs*, April 24, 2019. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05233>

Other states that are active in this space include Hawaii and Arizona. Hawaii legislators passed a measure in 2017 called the Kupuna Caregivers Program that uses state dollars to fund up to \$70 a day for respite care and other assistance for working family caregivers. In 2019, Arizona enacted a Family Caregiver Grant Program, a three-year pilot program that reimburses family caregivers for 50 percent of qualifying expenses incurred, up to \$1,000 for each qualifying member.

As the Pepper report said years ago, a real national solution involves several elements. We must maintain a strong Medicaid program and let it continue its positive trend of supporting home and community-based services over institutional care. We should examine the addition of a long-term care benefit in Medicare. We should also use the tax code positively to both provide a meaningful tax credit for family caregivers and a tax deduction for the purchase of sustainable private long-term care insurance that provides choices and consumer protections.

I hope this Committee will build on this hearing and replace denial with a detailed bipartisan legislative proposal on long-term care.

Achieving Quality Care in Nursing Facilities

In our nation, less than five percent of older adults are nursing home residents, but they are some of our most vulnerable. Achieving quality care in nursing facilities is critical to ensuring their safety. We see a disturbing pattern of abdication by certain federal agencies vested by law with the responsibility to ensure quality care in nursing homes, assisted living and long-term care facilities.

Recent reports by the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) provide some disturbing figures:

- 20 percent of high-risk emergency room admissions of patients from skilled nursing facilities were the results of potential abuse and neglect;⁶
- 85 percent of these potential abuse incidents were not reported to state survey agencies;⁷
- 67 of 69 substantiated cases of potential elder abuse were not reported by state survey agencies to local law enforcement;⁸
- Further, 80 percent of hospices had at least one deficiency related to quality of care over a four-year period.⁹

⁶ HHS Office of Inspector General, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509), June 2019.

⁷ Ibid.

⁸ Ibid.

⁹ HHS Office of Inspector General, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries* (OEI-02-17-00020), July 2019.

As I noted in Congressional testimony earlier this year, there are high-quality nursing homes in this nation staffed by dedicated people and owned by companies with integrity. I know this first-hand; my late mother spent her last years in one. They are not at fault here and we should not stigmatize all nursing homes and staff.

For the bad actors, we should revisit the conditions of participation for any nursing home or hospice receiving Medicare or Medicaid funds. These facilities must be cited for failing to report elder abuse and neglect and meaningful remedies must be enforced, including the potential risk of suspension of Medicare and Medicaid funding. State surveyor and survey agencies should also report elder abuse and neglect or risk consequences. Otherwise, federal funds could be enabling elder abuse.

I also note the important introduction of the bipartisan, bicameral Hospice Care Improvement Act in response to the HHS OIG hospice report and hope this bill will get serious consideration in the House and Senate.

Another way to ensure that elder abuse and neglect is prevented is to work to ensure that nursing homes have adequate numbers of competent staff. Studies have established the relationship between staffing levels and quality of care.¹⁰ When there is not enough well-trained and well-supervised staff, residents can suffer. Per the Elder Justice Roadmap report published by the Departments of Justice (DOJ) and HHS, residents of understaffed nursing homes are 22 percent more likely to be admitted to hospitals due to neglect.¹¹

One recent initiative announced by the Center for Medicare and Medicaid Services (CMS) is the inclusion of a consumer alert icon on Nursing Home Compare to denote facilities “cited on inspection reports for one or both of the following: 1) abuse that led to harm of a resident within the past year; and 2) abuse that could have potentially led to harm of a resident in each of the last two years.”¹²

That only gets to a part of the issue. In testimony before the Senate Finance Committee earlier this year, a daughter told of her mother’s death by dehydration through days of neglect in a nursing home that had been given a five-star rating for quality by CMS on Nursing Home Compare.¹³ Displaying an icon is a good first step, but regular audits of data submitted to CMS

¹⁰ Charlene Harrington et al. “The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes,” *Health Serv Insights*, April 12, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/>

¹¹ Centers for Medicare and Medicaid Services, “Appropriateness of Minimum Nurse Staff Ratios in Nursing Homes, Phase II Final Report.” 2001.

¹² Centers for Medicare and Medicaid Services, “Trump Administration Empowers Nursing Home Patients, Residents, Families, and Caregivers by Enhancing Transparency about Abuse and Neglect,” October 7, 2019. <https://www.cms.gov/newsroom/press-releases/trump-administration-empowers-nursing-home-patients-residents-families-and-caregivers-enhancing>

¹³ United States Senate Committee on Finance, “Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes,” March 6, 2019. <https://www.finance.senate.gov/hearings/not-forgotten-protecting-americans-from-abuse-and-neglect-in-nursing-homes>

to get a rating in the first place must also be conducted. Also, it is worth noting that the icon does not distinguish between facilities that fix a problem and those that do not.

There must be a better process of ensuring the prompt reporting of crimes that occur in nursing homes—it is part of the Elder Justice Act, but slow implementation by the previous Administration and a lack of interest or involvement by this Administration has made this a law with no teeth.

We should implement a sound recommendation made five years ago by the HHS OIG for the development and offering of training to state and federal surveyors on best practices for identifying and reducing adverse events in long-term care facilities.

Further, we cannot forget incidents like Hurricane Katrina in Louisiana, Hurricane Irma in Florida, and ongoing wildfires in California, where natural disasters severely impacted nursing home residents. We must mandate coordination between all levels of government in coordinating emergency response plans and training for nursing homes.

We should also ensure criminal background checks of employees at long term care facilities. Our Coalition has been very committed to this issue since it first appeared as a demonstration program in the Medicare Modernization Act of 2003. Back then, it was estimated that more than 7,000 individuals were turned away from employment because of what was found on their background check—in only seven states.¹⁴ The Affordable Care Act included a grant program to allow all states to conduct criminal background checks. However, less than half of all states conducted checks and some of those states provided inadequate data to CMS. We need to improve on this program and provide proper incentives for states to participate.

Though abuse deficiencies are relatively rare—they comprise less than one percent of the total deficiencies cited according to the Government Accountability Office—the Office did also find a doubling of cited abuse deficiencies in nursing homes between 2013-2017.¹⁵ Therefore, it is critical that this Committee and this Congress do all within its legislative and oversight powers to work to ensure adequate and strong protection of the rights of all nursing home residents.

We need to renew the bipartisan Elder Justice Act so we might achieve dedicated and adequate funding for adult protective services, which protects both older adults in facilities and the 95 percent of older adults who live in communities. In addition, we need stronger funding and additional training for long-term care ombudsmen so they can expand their important work into assisted living. And, we should continue the fine work of the Elder Justice Coordinating Council.

¹⁴ Abt. Associates, “Evaluation of the Background Check Pilot Program, Final Report,” October 2008. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/White8-2008.pdf>

¹⁵ Government Accountability Office, *Improved Oversight Needed to Better Protect Residents from Abuse* (GAO-19-433), July 2019.

Elder abuse, whether it occurs in a facility or in the home, is a scourge on our nation. In fact, it affects one in ten older Americans. We must recognize this fact and commit the necessary resources as we would to address any other health emergency.

Quality Care in Rural Areas

Quality care for aging Americans must include the older adults living in rural America, who face unique challenges. More than 25 percent of those 65 and over in our nation live in rural areas, and in some states the percentage is considerably higher such as in Maine, where 58 percent of older adults reside in rural areas.¹⁶ Further, rural counties tend to have much older populations than urban counties. Rural older adults tend to have more housing challenges; 24 percent of rural older adult homeowners face housing costs of more than 30 percent of their income, and more than half of rural older adult renters pay more than 30 percent of their income on rent.¹⁷

Transportation for rural older adults is an ongoing challenge. A poll taken by the National Aging and Disability Transportation Center found that less than half of rural elders felt they had access to good transportation alternatives to driving, meaning that those who cannot drive are unable to visit friends, access health care, or go grocery shopping.¹⁸ New incentives need to be provided to ensure that ride-sharing services come to rural America. We should also ensure that funding from the Department of Transportation responds to growth in rural public transit programs.

Research also shows that people living in rural areas have a higher prevalence of chronic disease, a higher disability rate, and a lower prevalence of healthy behavior.¹⁹ However, they lack health care facilities to address these issues. Fifty-nine percent of Primary Care Health Shortage areas are in rural areas, according to the Health Resources and Services Administration (HRSA).²⁰ Specialists are in even shorter supply in rural areas than primary care providers, and 64 rural hospitals (including critical access hospitals) closed between 2013 and 2017, more than twice as many as had closed in the previous 5 years.²¹

Some solutions to rural older adults' health challenges are developing but must be expanded. One prime example is expansion of telehealth services, with the important caveat that this must be accompanied by an absolute commitment to close the digital divide that still disproportionately affects rural America. We also need to ensure that adequate resources reach rural America from the new money being committed to combat the opioid crisis. We

¹⁶ Patrick Arbore, "Suicide Prevention Among Rural Older Adults," *Generations*, Summer 2019, p 62.

¹⁷ Suzanne Anarde, "Home Sweet Home: Aging in Place in Rural America," *Generations*, Summer 2019, pp 18-19.

¹⁸ Virginia Dize, "Getting Around in Rural America," *Generations*, Summer 2019, p 34.

¹⁹ Ibid.

²⁰ Health Resources and Services Administration, Bureau of Health Workforce, "Designated Health Professional Shortage Areas Statistics," July 12, 2017.

https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_HTML

²¹ Clinton MacKinney et al. "Aging Well in Rural America—The Role and Status of Healthcare," *Generations*, Summer 2019, p 50.

should also consider any potential rural hospital closure to be a public emergency and allow time to hopefully avert the closure and its corresponding devastating impact to the entire community.

Other steps to take include considering the social determinants of health in rural health care planning system development and payment, addressing health care workforce issues with an emphasis on rural healthcare access, and ensuring a commitment to quality care in rural nursing homes and long-term care facilities. We should also provide more funding for rural PACE (Program of All-Inclusive Care for the Elderly) providers to help them serve more older adults.

LGBTQ Older Adults

LGBTQ (lesbian, gay, bisexual, transgender and queer) older adults face unique challenges as well. Today, more than 1.1 million persons in America over 65 are LGBTQ according to Movement Advancement Project.²² One in five LGBTQ older adults are people of color and one-third of the population lives at 200 percent of the federal poverty level or below.²³

In recent times, our society has become more aware of the issues many of these older adults have endured most of their lives. This includes multiple forms of discrimination, from employment to housing to benefits. As we look at aging in America, we should give special consideration to proposals addressing the challenges LGBTQ older adults face.

For example, as we focus more attention on the growing problem of isolation and loneliness among older adults, we need to better understand the unique elements that contribute to this for LGBTQ older adults. Any workforce development programs for older adults must serve LGBTQ older adults without discrimination.

LGBTQ older adults are even more concerned about elder abuse in skilled nursing facilities than the average older adult. According to a recent AARP national survey, more than 60 percent of LGBTQ older adults were “concerned about how they would be treated in a long-term care setting, including fear that they might be refused or receive limited care; be in danger of neglect or abuse; or face verbal or physical harassment, and be forced to hide or deny their identity once again.”²⁴ To address these concerns, HHS should designate LGBTQ older adults as an underserved population for purposes of gathering accurate data on the extent to which elder abuse is an issue for this community.

We must ensure that staff in these facilities and communities are properly trained to understand and work with LGBTQ older adults. As a resource, the Human Rights Campaign

²² Movement Advancement Project, “Who Are LGBT Elders?” <http://www.lgbtmap.org/file/lgbt-older-adults-infographic-who-are-lgbt-elders.pdf>

²³ Ibid.

²⁴ Human Rights Campaign Foundation, “Why the Long-Term Care Quality Index?” https://assets2.hrc.org/thelei/documents/Why_the_LEI.pdf

Foundation and SAGE (Advocacy and Services for LGBT Elders) have developed the Long-Term Care Equality Index “to promote equitable and inclusive care for LGBT older people in residential long-term care communities.”²⁵

Food Insecurity and Malnutrition in Older Adults

According to the U.S. Department of Agriculture (USDA), food insecurity is measured by whether people can obtain enough food to lead a healthy life. Feeding America has found that 5.5 million older adults, or 7.7% of the older population, were food insecure in 2017, which is more than double the number in 2001.²⁶

There are many factors that can influence food insecurity, such as living in an area with more convenience stores than full-service grocery stores (“food deserts”). Combined with potentially limited transportation options and functional impairments, food insecurity can present a real threat to the health and well-being of an older adult. Food insecure older adults have higher rates of chronic conditions—which can also impact older adults’ ability to remain at home in their communities.

Closely connected to food insecurity are its consequences such as malnutrition—the lack of adequate protein, calories, and other nutrients needed for tissue maintenance or repair. Older adult malnutrition is a growing crisis in America today. Up to half of all older adults are at risk of malnutrition.²⁷ And, as individuals age, those with complex care needs are more likely to experience malnutrition concerns in an outpatient setting.

There are some achievable things this Congress can do this year to address the issues of food insecurity and malnutrition in older adults. One is to maintain the House-passed funding increases for Fiscal Year 2020 for the Older Americans Act nutrition programs, which by their daily existence help to prevent food insecurity and malnutrition. The Senate should also take up the House-passed Older Americans Act reauthorization bill which includes malnutrition screening for the first time.

We also need to continue to expand outreach efforts to get more needy older adults into the Supplemental Nutrition Assistance Program (SNAP), which has a two-fold mission: to help people facing difficult economic times access food and to reduce food insecurity. Currently, three in five older adults who are eligible for SNAP have not applied to participate.²⁸

²⁵ Human Rights Campaign Foundation, “Why the Long-Term Care Quality Index?”

https://assets2.hrc.org/thelei/documents/Why_the_LEI.pdf

²⁶ Feeding America, “Senior Food Insecurity Studies,” 2019. <https://www.feedingamerica.org/research/senior-hunger-research/senior>

²⁷ Defeat Malnutrition Today, “Malnutrition: An Older Adult Crisis,” September 2019.

https://www.defeatmalnutrition.today/sites/default/files/images/DMT_Malnutrition_Info_Graphic_OnePage_Update_2.pdf

²⁸ National Council on Aging, “Senior Hunger and SNAP Fact Sheet.” <https://www.ncoa.org/resources/senior-hunger-and-snap-fact-sheet/>

We should complete a national inventory of where food deserts currently exist and work to address the situation, potentially using financial incentives for the development of higher-quality food stores or markets.

We also stand on the threshold of Medicare Advantage programs' 2020 coverage of an array of non-medical supplemental services for chronically ill beneficiaries. This includes the provision of nutrition services in both home and congregate settings—an important way to combat food insecurity and older adult malnutrition. We need to ensure that Medicare Advantage plans are accessible to rural communities and that any contracted meals adhere to the standards on nutrition quality as contained in the Older Americans Act. I hope this Committee will closely monitor how this works for the key plan years of 2020 and 2021 and if it is successful allow fee-for-service Medicare to follow suit in providing these benefits.

Finally, to specifically help to combat malnutrition among older adults, we call on CMS to give final approval to pending malnutrition electronic clinical quality measures which would call on acute care providers to perform malnutrition screening, assessment, diagnosis and treatment.

This hearing is timely for so many reasons. In just 10 years, those 65 and over will comprise 20 percent of our population, up from 13 percent today. These demographics confirm the greater quantity of life that Americans are enjoying. Present and future public policy needs to also focus on improving Americans' quality of life as they age.