



TO: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services

FROM: Gretchen Jacobson, Vice President, Medicare, The Commonwealth Fund
Christina Ramsay, Program Officer, Federal and State Health Policy, The Commonwealth Fund

DATE: August 29, 2023

RE: Response to Request for Information for Access to Home Health Aide Services; CY 2024 Home Health Prospective Payment System Rate Update; File Code: CMS-1780-P; Docket ID: CMS-2023-0113

Thank you for the opportunity to respond to your request for information on the challenges facing Medicare beneficiaries in accessing home health aide services.

The Commonwealth Fund supports independent research on health care issues and makes grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable, including people of color, people with low income, and those who are uninsured.

Below we offer responses to some of your questions, informed by research on the Medicare home health benefit conducted by Fund-supported grantees and other peer organizations and researchers.

[Q1] Why is utilization of home health aides continuing to decline as shown in Table B2 and Figure B4 if the need for these services remains strong?

The following factors have contributed to the decline in home health aide utilization and beneficiaries' access to care under Medicare's home health benefit.

- **Actions to curb fraud and abuse have impacted home health aide use.** Despite beneficiaries' persistent needs for personal care assistance, home health aide visits precipitously dropped from 13.4 per episode in 1998 to 1.3 in 2019.¹ Following rapid growth in home health agencies (HHAs) and Medicare payments for home health

¹ Medicare Payment Advisory Commission. "Chapter 8: home health care services," *Report to the Congress: Medicare Payment Policy*. (MedPAC, March 2021). https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch8_sec.pdf

services in the 1990s, government regulators increased audits and oversight, which uncovered significant overutilization and fraudulent activity by HHAs.² Fraud and abuse concerns led to heightened scrutiny of medical necessity determinations, as well as the revocation of liability waivers that protected HHAs in good standing from having to pay back Medicare for disallowed claims. Heightened oversight and payment policy changes reduced inappropriate use of services but also disincentivized the use of home health aides and prompted HHAs to curtail beneficiaries' access to these services.³ Between 2001 and 2019, HHAs more than doubled therapy visits but reduced aide visits by 90 percent.⁴

- ***Medical necessity determinations are inconsistent and often more restrictive than what is allowed under statute.*** Providers and Medicare Administrative Contractors (MACs)—the private insurance companies with whom CMS contracts to review claims for home health services—must determine that skilled care and home health aide services are “medically necessary” to improve, maintain, or slow deterioration of a patient’s condition. However, MACs have the flexibility to apply their own “reasonable and necessary” standards in interpreting medical necessity.⁵ As a result, patients may face inconsistent or unwarranted denials of care, despite provider attestation to the need for services. While MACs refer to the Medicare Benefit Policy Manual to inform their decisions, CMS has not defined a minimum threshold of functional or cognitive impairment for services.

To streamline coverage and eligibility determinations, CMS could issue clarifying guidance to ensure consistent application of home health eligibility criteria and reduce unwarranted claims denials.⁶ Medicaid also offers lessons learned on how to take a more holistic and consistent approach to medical necessity determinations, based on the needs of beneficiaries and their families.⁷ In determining the appropriate care plan and mix of services, Medicaid programs usually conduct comprehensive needs assessments that include consideration of functional impairment, clinical conditions, mental/behavioral health issues, caregiver support, safety, and home situation.⁸

- ***Medicare payment policies disincentivize the use of home health aides for beneficiaries who need longer-term care.*** With the intent of rebalancing financial incentives to better meet patients' care needs, CMS implemented the Patient-Driven

² Marilyn W. Serafini et al., “Optimizing the Medicare Home Health Benefit to Improve Outcomes and Reduce Disparities,” Bipartisan Policy Center, April 2022. <https://bipartisanpolicy.org/report/optimizing-the-medicare-home-health-benefit-to-improve-outcomes-and-reduce-disparities/>

³ Judith Stein and David Lipschutz, “The Medicare Home Health Benefit: An Unkept Promise,” *To the Point* (blog), Commonwealth Fund, Apr. 28, 2022. <https://doi.org/10.26099/M366-WV45>

⁴ MedPAC, March 2021 report.

⁵ Marilyn W. Serafini et al.

⁶ Marilyn W. Serafini et al.

⁷ Barbara Lyons, Molly O’Malley Watts, and Diane Rowland, *Approaches to Improving Medicare’s Home Health Benefit: Lessons from Medicaid* (Commonwealth Fund, July 2022). <https://doi.org/10.26099/8a6d-4a98>

⁸ Barbara Lyons, Molly O’Malley Watts, and Diane Rowland.

Groups Model (PDGM) to better account for patients’ clinical characteristics in determining payment.⁹ However, the PDGM incentivizes providers to treat patients with more acute short-term needs.¹⁰ For example, the model pays HHAs more for beneficiaries admitted after an inpatient stay and less for those admitted from home. The model also offers higher payment rates for the first 30 days of home care, with declining payments after the first 60 days.¹¹ These incentives raise concerns over whether patients in need of longer-term care and support are put at a disadvantage.

Similarly, under the Home Health Value-Based Purchasing (HHVBP) Model that expanded nationwide this year, HHAs receive payment based on their performance on measures intended to promote higher-quality care. In practice, however, this payment model rewards health improvement and may deter providers from serving people with ongoing, debilitating, and chronic conditions who would benefit from services but may not improve or improve quickly.¹²

- ***Medicare beneficiaries are misinformed (or even unaware) about the home health benefit and often receive inconsistent or inaccurate information from providers.*** Interviews of a diverse range of Medicare beneficiaries found that most were unaware that Medicare even covered in-home assistance and had not received home health referrals, despite their hospitalizations.¹³ Some explored their eligibility but gave up after growing tired of “jumping through hoops” and facing “dead ends.”¹⁴ All participants agreed that in-home services would ease pressure off family caregivers but could not afford the financial or administrative burdens on top of their already daunting experiences in navigating the health care system.

In 2021, the Center for Medicare Advocacy surveyed 217 home health agencies (HHAs) across 20 states and found that HHAs regularly gave misleading and even incorrect information about the type and level of home health aide services covered by Medicare, the legality of providing care to maintain or slow declines in health, and even the appropriateness of seeking home health care at all.¹⁵ 85 percent of agencies surveyed offered three hours of services or less per week—a far cry from the 28 hours authorized under the law.¹⁶

⁹ Medicare Payment Advisory Commission. “Chapter 8: home health care services,” *Report to the Congress: Medicare Payment Policy*. (MedPAC, March 2022). https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch8_SEC.pdf

¹⁰ Judith Stein and David Lipschutz.

¹¹ Judith Stein and David Lipschutz.

¹² Judith Stein and David Lipschutz.

¹³ Barbara Lyons and Diane Rowland, “Improving Help at Home: Medicare Beneficiaries’ and Caregivers’ Experiences,” *To the Point* (blog), Commonwealth Fund, July 11, 2022. <https://doi.org/10.26099/CYTT-G524>

¹⁴ Barbara Lyons and Diane Rowland.

¹⁵ Center for Medicare Advocacy. “Center For Medicare Advocacy Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved,” December 2021. <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>

¹⁶ Center for Medicare Advocacy.

A possible approach for addressing these issues is for CMS to carry out an education campaign to explain the scope of services and qualifying criteria to providers, prescribers, contractors, adjudicators, and beneficiaries.¹⁷ Customized, culturally competent outreach to beneficiaries could also be included to illustrate how home health aides have supported beneficiaries of different backgrounds at home, as informed by lived experiences.^{18, 19}

[Q2] To what extent are higher acuity individuals eligible for Medicare (for example, individuals with multiple co-morbidities or impairments of multiple activities of daily living) having more difficulty accessing home health care services, specifically home health aide services?

Medicare beneficiaries with multiple comorbidities or complex care needs are less likely to have access to home health services.²⁰ Per our response to Q1, while CMS has implemented new payment models such as the PDGM and HHVBP, experts remain concerned that these models still disincentivize the delivery of home health care to beneficiaries with longer-term chronic care needs.

With home health aides often unavailable, beneficiaries may need to spend more out-of-pocket to secure the level of services that meet their needs—particularly beneficiaries of color. White Medicare beneficiaries have over six times the median per capita savings of Black or Hispanic beneficiaries; these socioeconomic disparities may contribute to the fact that Medicare beneficiaries of color are more likely to rely on unpaid informal caregivers than white beneficiaries.²¹ On top of these financial strains, beneficiaries of color experience diminished access to care in the face of racism in the health care system, along with cultural and linguistic barriers.²²

Reliance on unpaid caregiving has significant implications for the health outcomes and well-being of patients and families alike. An analysis of Medicare home health claims in 2019 and 2020 found that the need for caregiver training and supportive services was higher for Black, Latinx/Hispanic, and Asian American beneficiaries compared to white beneficiaries—particularly among beneficiaries of color admitted to home health from an acute or post-acute facility.²³ Prior research also suggests a higher risk of mortality among older adults relying on

¹⁷ Barbara Lyons, Molly O’Malley Watts, and Diane Rowland.

¹⁸ Barbara Lyons, Molly O’Malley Watts, and Diane Rowland.

¹⁹ Marilyn W. Serafini et al.

²⁰ Marilyn W. Serafini et al.

²¹ Loren Saulsberry, “Medicare Beneficiaries of Color More Likely to Rely on Unpaid Informal Caregivers for Home Health,” *To the Point* (blog), Commonwealth Fund, Jan. 18, 2023. <https://doi.org/10.26099/hbm9-t426>

²² Barbara Lyons and Diane Rowland.

²³ Melissa Morley et al., *Changes in Medicare Home Health Use During COVID-19 and the Implications for Health Equity and Caregiver Availability* (Commonwealth Fund, June 2022). <https://doi.org/10.26099/c5kb-cp46>

unpaid caregiving; this underscores the importance of ensuring high-quality sources of home health care, whether delivered by caregivers or home health agencies.²⁴

[Q3] What are notable barriers or obstacles that home health agencies experience relating to recruiting and retaining home health aides? What steps could home health agencies take to improve the recruitment and retention of home health aides?

Barriers to recruitment and retention include limited advancement opportunities, minimal training on managing chronic and complex health conditions, low compensation, and poor benefits.²⁵

Home care agencies are trying to recruit more direct care workers—including family members of beneficiaries—by providing a wide range of benefits, including same-day pay, cell phones, and referral bonuses.²⁶

Building a robust, valued, and fairly compensated direct care workforce will require action in both the public and private sectors—including significant wage increases, family-supporting benefits, and innovative recruitment, pipeline, and career advancement strategies.²⁷

[Q7] Are physicians' plans of care less reliant on home health aide services [than] in the past, or are HHAs less willing/able to provide these services? If so, what are the primary reasons for why such services are not provided?

Physicians and other practitioners who are authorized to order home health aide services are often unaware of the scope of services they can prescribe under the Medicare benefit, which hinders patient access to needed care. While hospital discharge is a key checkpoint for referral to home health services, beneficiary interviews suggest that patients often don't receive these referrals to help manage post-acute care needs.²⁸ Providers may not realize that beneficiaries are eligible for such care for longer episodes, and that Medicare can cover home health aides when skilled care is also required.²⁹

HHAs may be less willing to provide services to the extent promised under statute, out of fear of audits and oversight determining inappropriate use. Surveys of HHAs also suggest a concerning lack of understanding of the contours of the HHA benefit and what beneficiaries are

²⁴ Loren Saulsberry.

²⁵ Marilyn W. Serafini et al.

²⁶ Barbara Lyons, Molly O'Malley Watts, and Diane Rowland.

²⁷ Barbara Lyons, Molly O'Malley Watts, and Diane Rowland.

²⁸ Barbara Lyons and Diane Rowland.

²⁹ Marilyn W. Serafini et al.

entitled to under the law.³⁰ The direct care workforce shortage compounds these issues and limits staff availability.

[Q8] What are the consequences of beneficiary difficulty in accessing home health aide services?

For most beneficiaries, assistance from home health aides is often needed to make skilled care at home a real option. Without coverage of home health aides, beneficiaries must pay out-of-pocket for that care, rely on unpaid caregivers like spouses or children, or be forced to receive care at a nursing home instead.³¹

A higher proportion of Latinx/Hispanic, Asian American, and, to a lesser extent, Black beneficiaries had acute hospitalizations during home health episodes when caregivers were identified as needing training, compared to professional aides or trained caregivers.³²

These findings indicate that caregivers of high-acuity beneficiaries of color may benefit from additional training and support, especially during transitions from acute/post-acute care to home settings. Preventable hospitalizations among these beneficiaries increase Medicare spending, funds which could be spent instead on training and support for caregivers.

³⁰ Judith Stein and David Lipschutz.

³¹ Barbara Lyons and Diane Rowland.

³² Melissa Morley et al.