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Optimizing the Medicare Home Health Benefit to Improve Outcomes and Reduce Disparities

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

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Glossary of Acronyms

ADL	Activities of daily living
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
HCBS	Home and community-based services
HHS	U.S. Department of Health and Human Services
HHVBP	Home Health Value-Based Purchasing
LTSS	Long-term services and supports
MACs	Medicare Administrative Contractors
MedPAC	Medicare Payment Advisory Commission
OASIS	Outcome and Assessment Information Set
PDGM	Patient-Driven Groupings Model
PPS	Prospective Payment System
SNF	Skilled nursing facility

Executive Summary

For years, rising health care costs have led to a general movement of services out of facility settings and into the home, a trend that will continue as the population of aging Americans grows.¹ By 2030, more than one in five people in the United States are expected to be 65 or older and, by 2035, the number of individuals over 85 will nearly double.² The COVID-19 pandemic's toll on patients and health workers in congregate settings has increased the urgency of bringing care to patients where they live. To facilitate safe access to Medicare services for the duration of the public health emergency, Congress introduced temporary flexibilities allowing new types of care to be delivered in the home setting, such as [telehealth](#) and [hospital-level](#) services.^{3,4}

As broad discussions on “home-based care” continue, policymakers should give special attention to the traditional services that are delivered by home health agencies—including skilled nursing, rehabilitative therapies, home health aide services, and medical social services.^a These services constitute a narrowly defined benefit for individuals who need skilled care but are unable to leave the home without considerable and taxing effort.⁵

More than 3 million fee-for-service Medicare beneficiaries received home health services in 2019, at a cost of \$17.8 billion to the federal government.⁶ However, the benefit does not adequately address the needs of beneficiaries with multiple comorbidities or complex conditions.⁷ This shortcoming is largely the result of fraud and abuse guardrails and updates to payment policies that temper access to the home health benefit and limit the availability of some services.

BPC's Health Project conducted a literature review, interviewed more than 25 policy experts, and convened a roundtable with experts and stakeholders. Through those efforts, we identified the following key factors as having a deleterious effect on care delivery under the Medicare home health benefit:

- Inconsistent Medicare coverage determinations influence which beneficiaries home health agencies serve.
- Payment methodology and quality metrics disincentivize services for those with higher levels of need or without an expectation of functional improvement.

^a Rehabilitative therapies include physical therapy, occupational therapy, and speech-language pathology; home health aides may provide personal care assistance, such as help with bathing, dressing, and other activities of daily living; and medical social services are delivered by social workers “to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery.”

- Home health agencies overlook the importance of home health aides on recovery and health outcomes.
- Beneficiaries and family caregivers are not appropriately educated about home health services and do not receive adequate support.

A history of fraud and abuse in the home health sector has been a key driver of policymaking decisions. The [Medicare Payment Advisory Commission](#) (MedPAC), which advises Congress on Medicare payment policy, has regularly highlighted program integrity issues related to home health services.⁸ In response, Congress and the U.S. Department of Health and Human Services (HHS) have worked to curb overutilization of home health services, uncovering multimillion-dollar fraud schemes in the process.⁹ The increased oversight had the desired effect of reducing inappropriate Medicare payments.¹⁰ However, the increase in audits and medical necessity denials also reduced access to services for Medicare beneficiaries with complex needs.¹¹ The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies to review claims for home health services.¹² Although these Medicare Administrative Contractors (MACs) base coverage determinations on the guidance provided by CMS, they apply their own “reasonable and necessary” standards for interpreting medical necessity.¹³ This discretionary authority has led to inconsistent, and potentially unwarranted, claims denials, placing home health agencies at risk of having to return payments for services that they have already provided.

Updates to payment policies also led to significant changes in the number of visits and type of services delivered.¹⁴ MedPAC attributes the alteration in care patterns to home health agencies shifting services to maximize reimbursement.¹⁵ The most significant change to home health payments was the result of the Bipartisan Budget Act of 1997, which introduced payment limits and led to the implementation of the Home Health Prospective Payment System (PPS).¹⁶ The PPS established a fixed payment for each 60-day period, or episode of care, instead of reimbursing agencies for individual visits.¹⁷ Home health agencies responded by dramatically reducing home health aide and social worker services and increasing rehabilitative therapy visits.¹⁸ Between 2001 and 2019, agencies more than doubled therapy visits, while reducing aide visits by 90%.¹⁹

More recently, the Bipartisan Budget Act of 2018 required updates to the Home Health PPS to better reflect the costs of care.²⁰ In 2020, CMS implemented the [Patient-Driven Groupings Model \(PDGM\)](#), linking reimbursement to patient complexity rather than volume of services. In addition, the payment period was reduced by half, with the first 30-day episode receiving the highest payment rate. These changes have reduced the availability of services for individuals who may require more visits or longer treatments.²¹

Current policies lead home health agencies to alter delivery patterns to maximize profits or avoid providing services for fear of rejected claims. CMS

should institute operational improvements to the administering of the home health benefit to ensure services are covered when eligibility criteria are met. In addition, payment policies should incentivize agencies to deliver an appropriate mix of services to qualified beneficiaries.

BPC acknowledges the importance of maintaining the home health benefit's current structure and understands that Congress did not intend for Medicare to cover long-term custodial care. However, CMS must not overlook the needs of Medicare beneficiaries with chronic illness or the influence of current policy on racial and ethnic disparities among those receiving home health services. Given these realities, BPC developed policy recommendations for actions that can be adopted under the current regulatory framework using existing CMS authorities.

BPC recommends that CMS streamline coverage determination processes, alter payment policies that disadvantage higher cost beneficiaries, confirm beneficiary needs are met to the extent allowed under current law, and ensure the practical availability of home health aides and clinical social workers for those qualifying for Medicare home health services.

SUMMARY OF RECOMMENDATIONS

Streamline Coverage and Eligibility Determinations

To improve the administering of the Medicare home health benefit and prevent unwarranted coverage denials, CMS should:

- Implement uniform claims review processes, establish training requirements for MACs, monitor for outliers, and institute penalties for unwarranted denials.
- Require MACs to report coverage denials by condition, service type, race, age, functional status, cognitive deficit, and episode trigger to identify access disparities.
- Establish a baseline level of functional and cognitive impairment that should indicate medical necessity, similar to criteria used for chronic care management or Medicaid home and community-based services (HCBS).

Adjust Quality and Payment Incentives

To ensure that quality metrics and payment policies reward whole-person care, CMS should:

- Confirm that updates to the Home Health PPS adequately capture the costs of providing care to those with chronic illness and cognitive deficits.
- Develop measures reflecting the stabilization of a beneficiary's condition in order to reward outcomes when improvement is unlikely.
- Adopt measures with a focus on reducing racial and ethnic disparities and explicitly link payment to meeting performance benchmarks.

Optimize Service Availability

To ensure beneficiaries receive the services for which they qualify by appropriate members of the care team, CMS should:

- Create a toolkit to assist home health agencies in determining the appropriate mix of services for a beneficiary.
- Limit provider and beneficiary burden when implementing the proposed social drivers of health elements in the home care assessment.
- Update home health agency conditions of participation to include standards for home health aide staffing, such as staffing ratios, and institute penalties for withholding services.

Improve Beneficiary Experience

To improve beneficiary and caregiver experience, CMS should:

- Conduct educational outreach to certifying providers, beneficiaries, and family caregivers regarding coverage parameters and the full panel of home health services.
- Establish a robust monitoring program to ensure beneficiary needs are met.
- Enforce the family caregiver preparedness requirements that are included in current home health agency conditions of participation.

Introduction

The Bipartisan Policy Center has released several reports with the aim of improving care for individuals with chronic, complex care needs. [*Next Steps in Chronic Care: Expanding Innovative Medicare Benefits*](#) (2019) offered recommendations for expanding access to non medical supports through Medicare Advantage Special Supplemental Benefits for the Chronically Ill. To improve access to and the delivery of home and community-based services (HCBS), BPC released [*Bipartisan Solutions to Improve the Availability of Long-term Care*](#) (2021) and [*Streamlining and Simplifying Medicaid HCBS Authorities*](#) (2021). [*An Updated Policy Roadmap: Caring for Those with Complex Needs*](#) (2022) incorporates recommendations from 12 previous reports with policy solutions to improve equity in access to care and enhance quality for individuals with complex needs.

This project focuses specifically on Medicare home health services, which were delivered to more than 3 million fee-for-service beneficiaries in 2019, at a cost of \$17.8 billion to the federal government.²² Because it did not intend for Medicare to cover long-term custodial care, Congress narrowly defined the home health benefit to address periodic interventions, with eligibility tied to an individual being homebound and requiring skilled care.²³ Nevertheless, the benefit does fall short of ensuring appropriate services are delivered to qualified beneficiaries.

Medicaid covers home health services differently, with more expansive coverage provided under long-term services and supports (LTSS). Federal law requires state Medicaid plans to cover home health services, including nursing services and home health aide services, as well as medical supplies, equipment, and appliances for individuals requiring institutional-level care.²⁴ States may also cover physical therapy, occupational therapy, or speech pathology and audiology services under the benefit.²⁵ However, states that opt to provide LTSS are more likely to deliver these services as a component of HCBS, which is less restrictive than the home health benefit and offers a broader range of medical and social services.²⁶ HCBS generally include “case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.”²⁷

BPC’s Health Project conducted a literature review, interviewed more than 25 policy experts, and convened a roundtable with experts and stakeholders to identify barriers that beneficiaries face when trying to access Medicare home health services. In addition, the Center for Medicare Advocacy provided an

issue brief summarizing the legislative and regulatory history of the benefit (see Appendix). Through those efforts, we identified the following key factors as having a deleterious effect on care delivery under the Medicare home health benefit:

- Inconsistent Medicare coverage determinations influence which beneficiaries home health agencies serve.
- Payment methodology and quality metrics disincentivize services for those with higher levels of need or without an expectation of functional improvement.
- Home health agencies overlook the importance of home health aides on recovery and health outcomes.
- Beneficiaries and family caregivers are not appropriately educated about home health services and do not receive adequate support.

Based on these findings, BPC developed policy recommendations to better meet the needs of Medicare fee-for-service beneficiaries with chronic illness and reduce racial and ethnic disparities among those receiving home health services. The recommendations are set in the current episodic payment structure, so changes to the volume or mix of services would not alter payment rates. Understanding the importance of maintaining the home health benefit's current structure, BPC only considered actions which fall under the existing authorities of the Centers for Medicare & Medicaid Services (CMS).

Notably, we did not examine whether Medicare Advantage enrollees face similar barriers to the home health benefit, and the recommendations in the report would address only the coverage, quality, and availability of Medicare home health services for beneficiaries in traditional Medicare.

Background

For years, rising health care costs have led to a general movement of services out of facility settings and into the home, a trend that will continue as the population of aging Americans grows.²⁸ Certainly, the toll of the COVID-19 pandemic on beneficiaries and health workers in congregate settings created greater urgency for shifting care to the home setting. Although payers may have led the charge, providers have become receptive to the change as well. In a recent [McKinsey & Company](#) survey, Medicare providers responded that a significant portion of their services could be delivered in the home.²⁹

Broad discussions around home-based care will continue, but traditional Medicare home health services delivered by home health agencies require special attention. These services constitute a narrowly defined benefit for individuals who need skilled care but are unable to leave the home without considerable and taxing effort. Medicare home health services include skilled services, such as nursing and rehabilitative therapies (i.e., physical therapy, occupational therapy, and speech-language pathology), as well as home health aide and medical social services, which are covered only as optional adjuncts to skilled care.³⁰ Home health aides provide personal care assistance, such as help with bathing, dressing, or other activities of daily living (ADL); clinical social workers, meanwhile, deliver medical social services “to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient’s medical condition or rate of recovery.”³¹

Evidence supports the use of home health services for improving outcomes and reducing costs. A 2019 University of Pennsylvania [study](#) demonstrated that functional outcomes are similar whether care is delivered at home or in a skilled nursing facility (SNF).³² In addition, an [analysis](#) of Medicare claims revealed fewer hospital admissions/readmissions and lower costs among patients who were discharged to home health after an emergency department visit, compared with those with similar conditions who were admitted to the hospital.³³ The Cleveland Clinic also found 18% fewer readmissions and a 20% lower mortality rate among patients who received post-hospitalization home health care, compared with those discharged from the hospital to “self-care.”³⁴ Associated savings of nearly \$6,500 per patient were also seen in the home care group.³⁵

Despite the benefits of home health care, fraud and abuse guardrails and the home health payment system have tempered the availability of appropriate services. Medicare beneficiaries with multiple comorbidities or complex care needs are less likely to have access to services.³⁶ When these individuals do qualify for home health services, they are not guaranteed to receive the level of care needed.³⁷

The [Medicare Payment Advisory Commission](#) has regularly highlighted program integrity issues related to home health services.³⁸ Following a proliferation of for-profit home health agencies in the early 1990s, Medicare payments for home health services increased by more than 300% over a six-year period.³⁹ In response, the U.S. Department of Health and Human Services (HHS) took several actions to reduce the fraud, waste, and abuse associated with home health services. Operation Restore Trust, run by the HHS Office of the Inspector General (OIG), employed audits and other activities to uncover significant overutilization of home health services and multiple fraud schemes.⁴⁰ The Health Insurance Portability and Accountability Act of 1996 instituted monetary penalties for providers engaged in fraudulent activities.⁴¹ These and other actions resulted in a \$1.7 billion home health agency settlement in 2003, which the U.S. Department of Justice called the “largest health care fraud case in U.S. history.”⁴² Opportunities for home health fraud have continued, with several multimillion-dollar cases making headlines in 2020 and 2021.^{43,44}

In addition to increasing audits and applying greater scrutiny to medical necessity determinations, the HHS secretary revoked waivers of liability based on favorable presumption.⁴⁵ These waivers protected agencies deemed to be in good standing from having to repay Medicare for retroactively disallowed claims, so long as they delivered services based on an expectation of satisfying the “homebound” and “intermittent skilled nursing care” criteria.⁴⁶ Although MedPAC supported the move, the National Association of Home Care and Hospice cites the 1995 expiration of this protection as a contributing factor leading agencies to adopt a more conservative approach to admitting patients.⁴⁷

Increased oversight had the desired effect of reducing inappropriate payments.⁴⁸ However, the frequency of audits and medical necessity denials also made home health agencies reluctant to serve patients with complex needs. Certainly, the use of audits has had a bigger impact on in-the-field operations than guidelines or regulations.

Agencies responded to the heightened oversight by changing which services they delivered. Home health aide services, which had accounted for the majority of growth over the previous decade, were dramatically reduced after the implementation of the new payment systems in 1998 and 2000.⁴⁹ At the same time, physical therapy, occupational therapy, and speech-language pathology visits became more frequent.⁵⁰ Between 2001 and 2019, agencies more than doubled therapy visits, while reducing aide visits by 90% (see table).⁵¹ MedPAC attributes the alteration in care patterns to home health agencies shifting services to maximize reimbursement.⁵²

Table 1: Medicare beneficiaries received more than 13 aide visits per episode before the implementation of the home health payment systems, but only 1.3 visits per episode in 2019.

	Visits per episode				Percent change in visits per episode		
	1998	2001	2018	2019	1998–2001	2001–2018	2018–2019
Skilled nursing	14.1	10.5	8.2	8.1	-25.5%	-21.9%	-1.25
Therapy (physical, occupational, and speech-language pathology)	3.8	5.2	8.0	8.1	38.6	53.8	1.3
Home health aide	13.4	5.5	1.4	1.3	-59.0	-74.5	-7.1
Medical social services	0.3	0.2	0.1	0.1	-35.8	-50.0	>0.01
Total	31.6	21.4	17.8	17.7	-32.3	-17.3	>-0.01

Notes: Data exclude low-utilization episodes. Components may not total 100 due to rounding.

Source: MedPAC analysis of home health standard analytic file from CMS.

Whether by selecting patients likely to require fewer visits or altering the type of services delivered, home health agencies tend to serve beneficiaries who will get better quickly and respond to the rehabilitative therapies that are likely to offer the most expedient improvement in functional status.⁵³ However, the exclusion of aide services from care plans further disadvantages beneficiaries with chronic illness or cognitive deficits, particularly for those without a caregiver at home, and may exacerbate long-standing racial and ethnic health disparities within the home health care sector.

Beneficiaries belonging to racial and ethnic minority groups experience more adverse events, a greater decline in functional status, and worse experiences when receiving home health care than white beneficiaries.^{54,55,56} Black patients receiving home care services are more likely to require hospitalization than whites, despite comparable access to care.⁵⁷ The reasons for this are uncertain; contributing factors may include fewer visits per episode, longer wait times until the first home health visit, and a lower likelihood of receiving care from a home health aide or high-quality agency when compared to white beneficiaries.^{58,59,60} Additional research is necessary to fully understand these issues, but reversing poorly designed payment policies and gathering additional data are reasonable starting points.

To meet the needs of chronically ill beneficiaries, CMS must adjust the current slate of incentives under which home health agencies avoid providing services for fear of rejected claims and then alter delivery patterns to maximize profits. CMS must not only cover home care services when a beneficiary meets eligibility criteria, but also ensure that they receive an appropriate mix of services. CMS can accomplish this by streamlining coverage determination processes, altering payment policies that disadvantage higher cost beneficiaries, confirming beneficiary needs have been met to the extent allowed under current law, and ensuring the practical availability of home health aides and clinical social workers for those qualifying for Medicare home health services.

Recommendations

STREAMLINE COVERAGE AND ELIGIBILITY DETERMINATIONS

- Implement uniform claims review processes, establish training requirements for Medicare Administrative Contractors (MACs), monitor for outliers, and institute penalties for unwarranted denials.
- Require MACs to report coverage denials by condition, service type, race, age, functional status, cognitive deficit, and episode trigger to identify access disparities.
- Establish a baseline level of functional and cognitive impairment that should indicate medical necessity, similar to criteria used for chronic care management or Medicaid home and community-based services.

Medicare has covered home health services since the program's inception in 1965. Under the original statute, Medicare Part A, which covers inpatient services, provided up to 100 days of home care following a three-day hospital stay; Medicare Part B, which covers outpatient services, covered an additional 100 days without requiring a previous hospitalization.⁶¹ Services may begin after a hospitalization or an acute health episode, but Part B has no time limit on home health services, provided qualifying services are necessary to improve, maintain, or prevent deterioration of health.⁶²

Since 1965, lawmakers have expanded access to home health care for fee-for-service beneficiaries. Unlike Part A, Part B services were subject to both a deductible and standard cost-sharing. Congress has since eliminated visit limits, hospitalization requirements, and beneficiary cost-sharing. As of 2018, Part B covered two-thirds of home health services.⁶³

The Social Security Act requires certain criteria for Medicare to cover home health services.⁶⁴ A physician or advanced practice provider must establish and oversee a care plan and certify that the beneficiary is confined to the home and in need of intermittent skilled nursing. Congress did not further define the “homebound” and “intermittent” criteria and authorized CMS to specify what would satisfy homebound status.

CMS considers beneficiaries homebound if they have a general inability to leave the home without considerable effort. Beneficiaries must also be unable to travel independently, require an assistive device (e.g., walker or cane), or have a medical contraindication to leaving the home.⁶⁵ In later guidance, CMS clarified

that leaving the home for religious services, health care, or other infrequent and short periods does not affect homebound status.⁶⁶ It defined “intermittent” as skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less with extensions in exceptional circumstances.⁶⁷

CMS relies on four MACs to process claims for home health services.⁶⁸ These private insurance companies base coverage determinations on the guidance provided in the [Medicare Benefit Policy Manual](#).⁶⁹ However, CMS does not explicitly define a minimum threshold of functional or cognitive impairment that might justify the need for home health services.

To improve the administering of the Medicare home health benefit and prevent unwarranted coverage denials, CMS should:

Implement uniform claims review processes, establish training requirements for MACs, monitor for outliers, and institute penalties for unwarranted denials.

To reduce the impact of unpredictable coverage denials and ensure agencies are not held to unreasonable standards, CMS should increase the reliability of the claims review process. Current guidance provides MACs with the flexibility to apply their own “reasonable and necessary” standard for interpreting medical necessity.⁷⁰ This discretionary authority can lead to inconsistent or potentially unwarranted claims denials. For instance, the Center for Medicare Advocacy finds that Medicare supports an overly restrictive understanding of the law and is overzealous in its denials of appropriate care.⁷¹ In essence, when Medicare denies a claim, it overrides the certifying provider who has attested to the need for home care and places agencies at risk of having to return payments for services that they have already provided. Without any safeguards, agencies will continue to adjust service availability to preempt retroactive claims denials.

Although the creation of additional rules and regulations may not be necessary, CMS should provide clarifying guidance to ensure consistent application of home health eligibility criteria and reduce unwarranted claims denials. It should also introduce performance benchmarks and penalties for withholding coverage of appropriate services. Medicare monitors MAC compliance and performance through Quality Assurance Surveillance Plans but does not assess for inappropriate denials.

Require MACs to report coverage denials by condition, service type, race, age, functional status, cognitive deficit, and episode trigger to identify access disparities.

Data regarding denied claims should be examined to establish a better understanding of who is being denied access to the benefit and examine potential trends. If certain groups or populations have higher denial rates, potential opportunities to address disparities could emerge. Based on this information, CMS could also consider reinstating the presumption of eligibility, in a manner that addresses specific barriers to access. Any waiver of liability

would be subject to appropriate guardrails, such as limiting the waiver to agencies with a low rate of claims denials or those agreeing to greater oversight.

Establish a baseline level of functional and cognitive impairment that should indicate medical necessity, similar to criteria used for chronic care management or Medicaid home and community-based services.

To ensure consistency, CMS should create coverage recommendations for common clinical indications for shared use by MACs and home health agencies. These recommendations should include illustrative scenarios that might automatically trigger medical necessity, such as specific combinations of chronic conditions or degenerative neurologic diseases that follow a relapsing-remitting course. However, there is an element of subjectivity in deciding on the appropriateness of home care. Patients with similar conditions can experience different levels of impairment. For example, a patient with a knee injury who is otherwise healthy might be able to leave the home with a walker, without much effort. On the other hand, a beneficiary who has diabetic neuropathy and heart failure may be more debilitated by the same knee diagnosis. In this instance, a MAC denial based solely on the injury would overlook important clinical information. Flexibility should be preserved, but additional guidance would be beneficial.

ADJUST QUALITY AND PAYMENT INCENTIVES

- Confirm that updates to the Home Health Prospective Payment System (PPS) adequately capture the costs of providing care to those with chronic illness and cognitive deficits.
- Develop measures reflecting the stabilization of a beneficiary's condition in order to reward outcomes when improvement is unlikely.
- Adopt measures with a focus on reducing racial and ethnic disparities and explicitly link payment to meeting performance benchmarks.

MedPAC has consistently urged Congress to reduce payments for Medicare home health services to more closely reflect the costs incurred by home health agencies.⁷² Over the years, Congress and HHS have, in fact, adopted a number of policies designed to slow the rate of growth in home health spending and improve program integrity. Nevertheless, in 2019, Medicare margins still averaged nearly 16% for all freestanding home health agencies; all-payer

margins averaged 6%.^{73,b} In comparison, the average Medicare margin for inpatient hospitals was negative 9% that same year.⁷⁴

The most significant changes to home health payments were the result of the Bipartisan Budget Act of 1997, which Congress passed in an effort to contain double-digit program growth from what it perceived to be inappropriate overutilization of services.⁷⁵ First, the Interim Payment System was implemented in 1998, capping reimbursement.⁷⁶ Two years later, its replacement, the Home Health PPS, established a sort of bundled payment by paying agencies for each 60-day episode of care, rather than for individual visits or services.⁷⁷

More recently, policymakers have made several changes to the Home Health PPS. First, the Bipartisan Budget Act of 2018 required CMS to reduce the length of a home health payment episode from 60 to 30 days, prompting more frequent reassessment of patient status. Second, CMS implemented the Patient-Driven Groupings Model (PDGM) to more appropriately match payment rates to patient complexity and expected intensity of care needs, rather than the volume of services provided in a 30-day episode.⁷⁸ The PDGM, which was implemented in 2020, places beneficiaries in one of 432 distinct payment categories, based on source of admission, timing of episode, diagnoses, and functional limitations.⁷⁹ Finally, in 2023, the CMS Innovation Center will expand the [Home Health Value-Based Purchasing \(HHVBP\)](#) system nationally from its original nine demonstration states. The objective of the HHVBP is to improve performance on quality metrics by adjusting episode payment rates up or down, based on the Total Performance Score for a specific set of quality measures.⁸⁰

To ensure that quality metrics and payment policies reward whole-person care, CMS should:

Confirm that updates to the Home Health PPS adequately capture the costs of providing care to those with chronic illness and cognitive deficits.

Under the PDGM, CMS provides higher payments for services delivered post-hospitalization and during the first 30 days of care. Although these are reasonable measures for estimating the intensity of services an individual needs, they could also incentivize home health agencies to reduce admissions for beneficiaries without a prior hospitalization or with comorbidities that might slow their recovery. [Kaiser Health News](#) has reported that, despite the granularity of the new payment categories, the PDGM encourages acute, short-term treatment because of lower rates for “late” periods. Agencies, as a result, are turning away beneficiaries with long-term needs.⁸¹

To reduce the potential for agencies to avoid caring for high-cost beneficiaries, CMS should correct for any unintended consequences caused by payment and quality incentives that discourage serving beneficiaries who require

b According to [CMS](#), 11,724 home health agencies served Medicare beneficiaries in 2019. The majority were freestanding, with only 6% hospital-based. For-profit agencies accounted for 82% of all agencies. [MedPAC](#) found that 2019 Medicare margins for nonprofit agencies averaged 11% and for-profit averaged 17%.

multiple episodes of care, are admitted from community settings, or have a limited potential to improve. This includes ensuring that risk stratification methodologies adequately capture the costs of providing care, particularly for those with chronic illness or cognitive deficits, and reflect services provided by home health aides and clinical social workers. CMS should monitor agencies for potential reductions in therapy visits in order to maximize reimbursement, as the PDGM does not take the number of therapy visits into account. The OIG is already primed to increase audits to detect whether a drop in therapy under the PDGM signifies that unnecessary services were historically provided to trigger higher payments.⁸²

Develop measures reflecting the stabilization of a beneficiary's condition in order to reward outcomes when improvement is unlikely.

CMS should develop stabilization measures to assess and reward outcomes other than functional improvement for beneficiaries with a limited potential to improve. Both the HHVBP and the Medicare Home Health Quality of Patient Care Star Ratings utilize measures of improvement in patient status.⁸³ However, the potential for improvement is not an eligibility criterion for the Medicare home health benefit, a point that has been successfully challenged in court.⁸⁴ Generally, rewarding improvement is a beneficial incentive, but when improvement is not possible, agencies can still serve patients for whom stabilization or slowed decline could be achieved.

CMS should also leverage quality reporting to facilitate the evaluation of home health aide services on health outcomes, such as hospitalization or avoidance of facility-based nursing care. Recent data from the HHVBP demonstration showed that the use of home health aides declined in both the treatment and comparison states after its implementation.⁸⁵ Because the model did not appreciably change pre-existing trends of low and declining provision of aide visits, the metrics used to adjust payments do not sufficiently incentivize agencies to increase the number of medically-appropriate and necessary home aide visits. If increasing aide visits was perceived as an effective way to accomplish this, we would have expected to see increased utilization of aides in the demonstration group. If there is a presumption that providing home health aide services improves outcomes, CMS must create additional incentives for their use.

Adopt measures with a focus on reducing racial and ethnic disparities and explicitly link payment to meeting performance benchmarks.

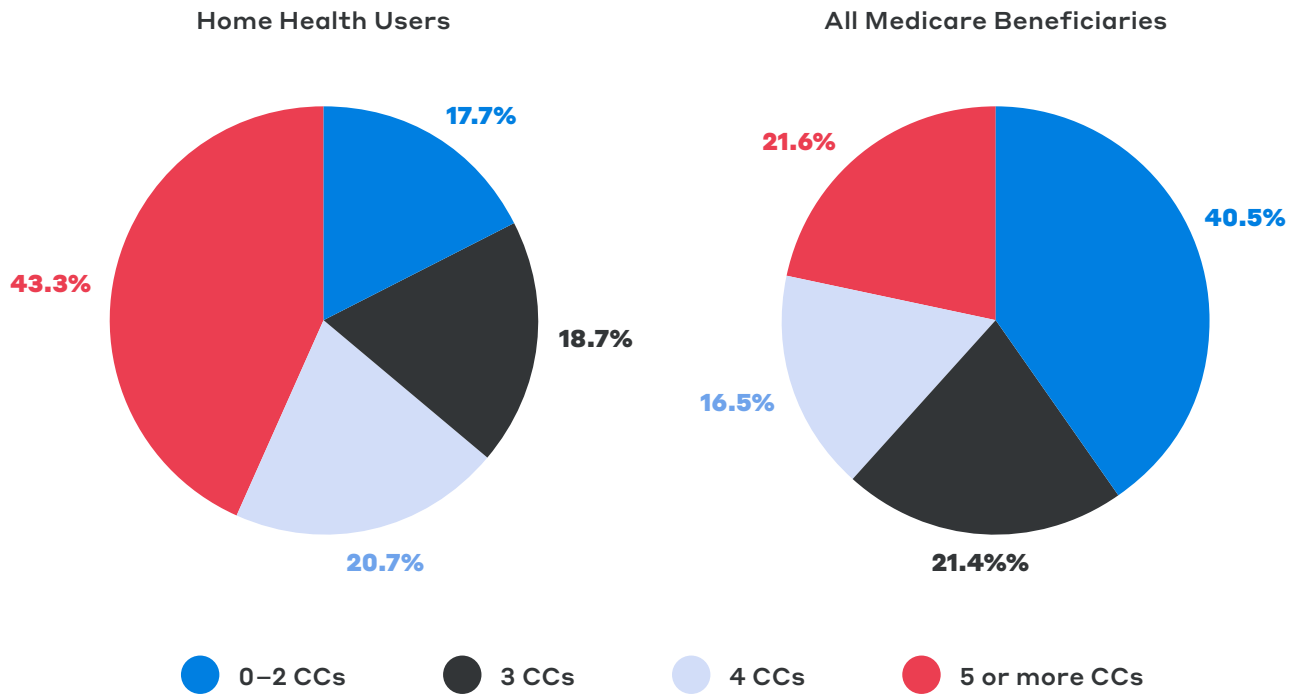
To better understand the major factors influencing lower quality care among certain populations, CMS should develop and implement quality measures specific to racial, ethnic, and socioeconomic disparities. Non-white and ethnic minority beneficiaries are less likely than white beneficiaries to receive home health services within two weeks of discharge or from an agency with a high Quality Star Rating, even when living in the same neighborhood.^{86, 87} To target these inequities, potential measures could include time to first visit and type and number of visits per episode. Performance metrics should also be instituted to actively engage providers in disparities reduction.

OPTIMIZE SERVICE AVAILABILITY

- Create a toolkit to assist home health agencies in determining the appropriate mix of services for a beneficiary.
- Limit provider and beneficiary burden when implementing the proposed social drivers of health elements in the home care assessment.
- Update home health agency conditions of participation to include standards for home health aide staffing, such as staffing ratios, and institute penalties for withholding services.

Forty percent of Medicare home health recipients have five or more chronic conditions, and 85% have three or more (see Figure 1).⁸⁸ The presence of multiple chronic conditions adversely affects recovery and outcomes.⁸⁹ Because beneficiaries with complex conditions have increased needs, a more robust panel of services and a greater intensity of visits might be warranted. In fact, CMS requires agencies to administer a comprehensive health assessment to assess beneficiary needs for the purpose of developing a care plan. However, the [Home Health Outcome and Assessment Information Set \(OASIS\)](#) primarily assesses functional deficits, rather than chronic illness, and may overlook the level of personal care assistance needed. The OASIS, which is also used in determining payment rates, is not designed to reward agencies for addressing non functional deficits.⁹⁰

Figure 1: The percentage of home health users with five or more chronic conditions is double that of all Medicare beneficiaries.



Source: Avalere analysis of the Medicare Current Beneficiary Survey. Access to Care file, 2018. Totals may not equal 100% due to rounding.

In addition to multiple comorbidities, cognitive deficits and social drivers of health can affect the rate of recovery. In January 2023, after a two-year delay, CMS is expected to implement an updated Home Health OASIS to create a more comprehensive picture for optimizing care plans. This is part of an agency-wide effort across HHS to better understand the role of social drivers of health in health outcomes. The OASIS-E will include new elements to capture cognitive function, ethnicity, health literacy, and other social drivers of health. Assessing for cognitive deficits is important for all Medicare beneficiaries, but it also has racial and ethnic implications: Asian, Black, and Hispanic beneficiaries with dementia experience lower degrees of improvement with ADLs compared with white beneficiaries.⁹¹

The updated assessment will provide home health agencies with greater insight in order to deliver an optimal mix of services. Agencies are already able to deliver whichever services they choose under the home health payment system. They receive a fixed payment for each 30-day episode, independent of the type of services or number of visits provided over a minimum threshold. Without any guidelines for selecting services, many home health agencies provide services in the most cost-effective manner. Notably, Medicare Advantage beneficiaries receive fewer visits, have shorter episodes, and experience lower quality care.⁹²

Not only do rehabilitative therapies make up the majority of services provided, agencies are less likely to have home health aides and clinical social workers on staff. In a 2021 survey, home health agencies were asked whether they had the capacity to provide the eight hours per day or 28 hours per week of aide services that Medicare covers.^{93,94} Only 2% of agencies reported they would be able to provide 20 hours or more of home health aide services per week.⁹⁵ Home health agencies often attribute the lack of aide availability to their inability to recruit and retain adequate staff.

The home health aide workforce shortage has been worsening for some time and became critical during the pandemic.⁹⁶ Despite significant need, home care workers continue to be undervalued and underpaid.⁹⁷ Home health and personal care aides receive a median hourly wage of \$12.98, 16% live in poverty, and 43% are on Medicaid.⁹⁸ Because part-time employment is common among home care workers, many do not receive employer-sponsored health insurance or other benefits.⁹⁹ In addition to the financial barriers, they have few advancement opportunities.

However, initiatives to improve job satisfaction and validate the importance of this segment of the workforce have shown promise at the local level. Job satisfaction increases when home care workers receive additional training to recognize clinical signs and function as a member of an integrated care team.^{100,101} A 2014-2015 [pilot program](#) implemented by Partners in Care, an affiliate of the Visiting Nurse Service of New York, improved patient-reported outcomes by training home health aides to provide health coaching for chronically ill home care recipients.¹⁰² In addition, bridge programs registered with the U.S. Department of Labor present a model for creating career advancement opportunities. For example, the [California Center for Caregiver Advancement](#) operates a Certified Nursing Assistant Apprenticeship for nursing aides, as well as multiple caregiver training programs. While largely outside the scope of this report, bolstering the home health aide workforce will require federal investment and interagency coordination.

To ensure beneficiaries receive the services for which they qualify by appropriate members of the care team, CMS should:

Create a toolkit to assist home health agencies in determining the appropriate mix of services for a beneficiary.

CMS should work with stakeholders, including providers, beneficiaries, and caregivers, to develop a toolkit that can be used to assist agencies with selecting the optimal mix of services improve a beneficiary's recovery. A standardized needs profile, which reflects common conditions and captures social drivers of health, should indicate when a particular service, such as personal care assistance or medical social services, is appropriate. Some stakeholders suggest the need for an independent third-party to administer the home care assessment. However, this would add greater complexity to an already burdensome process and could further exacerbate delays initiating home care services.

Limit provider and beneficiary burden when implementing the proposed social drivers of health elements in the home care assessment.

A better understanding of the impact of health aide services on health outcomes is necessary, as is an understanding of the degree to which a reduction in aide services disproportionately affects racial and ethnic minorities, the chronically ill, and those with cognitive deficits.

To create a more comprehensive picture for optimizing care plans, CMS should finalize the implementation of the updated OASIS-E measure set to capture ethnicity, as well as race, health literacy, cognitive function, and other social drivers of health. However, the burden of the additional questions on both providers and beneficiaries must not be overlooked. Wherever possible, the new elements should replace others that offer information which can instead be drawn from claims data. Alignment of data collection across models and settings should be maximized and cross-walked with the current Z-codes used for social drivers of health across Medicare fee-for-service payment systems. CMS should also monitor the effects of preemptive auditing under the Review Choice Demonstration on access to care and care disparities.

Update home health agency conditions of participation to include standards for home health aide staffing, such as staffing ratios, and institute penalties for withholding services.

CMS should clarify and enforce expectations for the availability of home health aides by updating conditions of participation and establishing standards for home health aide staffing.

CMS should also evaluate whether episodes which include home health aide visits reduce mortality, hospital admissions, or emergency service utilization. Little data are available on the effect of home health aides on outcomes and racial and ethnic disparities for Medicare fee-for-service beneficiaries. CMS should look to local programs that have improved outcomes and reduced costs after providing disease-specific training to home health aides.¹⁰³ Until broad evidence suggests that providing aide services within a covered episode is cost-effective, aides' increased availability is unlikely. However, if aide services demonstrate improved outcomes and lower overall costs, CMS should offer greater incentives for agencies to include home health aides in care plans and increase supply of the workforce.

IMPROVE BENEFICIARY EXPERIENCE

- Conduct educational outreach to certifying providers, beneficiaries, and family caregivers regarding coverage parameters and the full panel of home health services.
- Establish a robust monitoring program to ensure beneficiary needs are met.
- Enforce the family caregiver preparedness requirements that are included in current home health agency conditions of participation.

Traditional Medicare, or Medicare fee-for-service, generally covers services ordered by a provider, without being subject to prior authorization or other utilization management tools. The expectation is that care decisions are made within the confines of the patient-provider relationship, by those with the greatest appreciation of patient needs. Medicare home health services, however, fall outside what is “normal” for fee-for-service beneficiaries and are subject to approval by MACs.¹⁰⁴ In essence, the certifying provider is not the final arbiter of what services, if any, a beneficiary ultimately receives.

For this reason, beneficiaries may not be fully aware of the limited nature of the Medicare home health benefit or the specific eligibility criteria that they must meet to qualify for services. Indeed, at the time of referral, beneficiaries often rely on home health agency staff to decode service limitations, such as the maximum number of hours a nurse or home health aide can be in the home. This reverse education creates unnecessary frustration for both providers and patients.

Two-thirds of older Medicare beneficiaries need some sort of assistance with ADLs.¹⁰⁵ However, a recent study published by [JAMA](#) found that fewer than half of the beneficiaries who had assistance with ADLs after hospital discharge received services from a home health agency.¹⁰⁶ Although ADL deficits are not an independent criteria for home health services, the benefit does include personal care assistance by a home health aide when skilled services are also indicated. When an agency excludes home health aides from a care plan, beneficiaries often rely on family, friends, or other members of the community to provide the additional support. Medicare requires agencies to include patient and caregiver education and training as part of care plans, but this condition of participation is not enforced.¹⁰⁷

Beneficiaries who receive assistance from untrained caregivers experience worse health outcomes, including more falls and emergency department visits, and higher Medicare spending, according to various studies.^{108, 109, 110} Avalere also found higher rates of hospitalization during home care episodes when

beneficiaries received help from individuals without proper caregiver training.^c This not only highlights the need to train unpaid caregivers, but also suggests that well-trained home health aides could reduce hospitalizations.

In addition, policymakers and stakeholders need to better understand racial and ethnic disparities among beneficiaries receiving home health care. Multiple factors contribute to disparities, and parsing out the impact of individual issues is difficult. Both the timeliness of care initiation and the quality of home care are reduced for those in disadvantaged demographic groups or residing in underserved or rural communities.^{111, 112, 113}

In fact, biases in home care precede admission to an agency. They begin when the decision is made whether to discharge a patient home to self-care or make a referral to an agency, SNF, or long-term care setting. Hispanic and Native American beneficiaries are less likely to be referred for home health care.¹¹⁴ Of course, the effects of unequal care are rooted even further upstream, as Blacks, Hispanics, Asian Americans, and Native Americans are more likely to forego health care because of fears of discrimination.¹¹⁵ It is important to note that no assessment or beneficiary survey can capture data on patients who are not referred for home care, are lost to follow-up, or refuse services.

To improve beneficiary and caregiver experience, CMS should:

Conduct educational outreach to certifying providers, beneficiaries, and family caregivers regarding coverage parameters and the full panel of home health services.

CMS should develop additional guidance to ensure that beneficiaries, caregivers, and certifying providers fully understand the Medicare home health benefit. Although CMS has produced educational materials on qualifying criteria and coverage limitations, confusion persists.¹¹⁶ This educational outreach should be performed prior to a potential referral for services, and independent of home health agency communications. The information provided should clarify when non medical services, such as personal care assistance, are indicated. It should also reduce misinformation regarding limits on services, as beneficiaries often receive inaccurate details from agency staff regarding the criteria for receiving aide services and which services the aides may perform.¹¹⁷ The added clarity would help manage expectations and ensure beneficiaries are equipped to advocate for supports or services that may be inappropriately denied. Beneficiaries and family caregivers should also be instructed on how to advocate for services or appeal unwarranted denials.

Establish a robust monitoring program to ensure beneficiary needs are met.

CMS should build upon the data collected in the [Home Health Consumer Assessment of Healthcare Providers and Systems](#) (CAHPS[®]) to ensure beneficiaries receive appropriate services. The Home Health CAHPS is

^c Publication forthcoming.

administered as a component of quality reporting activities. But, it does not adequately distinguish between medical services and services provided by home health aides and clinical social workers; nor does it assess whether personal care assistance was provided by another member of the care team or if the services were deemed valuable by the patient.¹¹⁸ CMS should perform a more holistic assessment of referral patterns and service utilization across racial and ethnic groups. The [Medicare Current Beneficiary Survey](#) should include additional questions regarding referrals; responses should then be compared to hospital/SNF discharge rates, utilization, and CAHPS reporting.

Enforce the family caregiver preparedness requirements that are included in current home health agency conditions of participation.

CMS should enforce caregiver preparedness training and encourage agencies to engage beneficiaries and caregivers in shared decision-making, based on a full disclosure of service options at the time of an assessment. Agencies that lack the resources to provide caregiver training should be required to connect beneficiaries with external resources, such as community-based organizations that have established training programs.

Conclusion and Next Steps

The Centers for Medicare & Medicaid Services continues to search for the right balance between preventing fraud, waste, and abuse and encouraging the availability of home health services for Medicare fee-for-service beneficiaries. Some stakeholders maintain that the variability inherent in home care delivery is incompatible with a prospective payment system and an alternative solution should be developed. However, BPC has identified several ways to improve the current payment structure while protecting program integrity.

Guardrails will remain important as both the Medicare population and health care spending continue to increase. However, the adverse effects of Medicare policies should be minimized to the extent possible. CMS should ensure that MACs and home health agencies do not limit access to appropriate care under the existing benefit.

Preliminary data suggest that agencies altered coding patterns and increased the use of secondary diagnoses to increase payment rates under the PDGM. Because the inaugural years of the updated payment methodology and PDGM coincided with the COVID-19 pandemic, the ultimate effects on utilization patterns remain to be seen. An expected increase in audits could also impact access to services, further reduce visits, and exacerbate racial and ethnic disparities.¹¹⁹ The BPC Health Project will continue to monitor the response to the PDGM for signs of negative effects on the availability of home health services.

Our recommendations focus on beneficiaries in traditional Medicare and do not address Medicare Advantage enrollees who may face similar barriers in obtaining home health services. As we continue our work on chronic care and better integration of health care services, we will promote patient-centered policy across federal programs. We look forward to additional opportunities to drive policy that ensures Medicare beneficiaries are able to receive the services they need in the most cost-effective way possible.

Appendix: Legislative and Regulatory History of the Home Health Benefit

The Center for Medicare Advocacy provided this issue brief summarizing the legislative and regulatory history of the benefit. It does not necessarily represent the views or opinions of BPC staff.



December 2021

THE MEDICARE HOME HEALTH BENEFIT: AN UNKEPT PROMISE

I. Introduction

The Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services, all of which add to the health, safety, and quality of life of beneficiaries and their families. Under the law, Medicare coverage is available for people with acute and/or chronic conditions, and for services to improve, maintain, or slow decline of an individual's condition. Further, coverage is available even if the services are expected to continue over a long period of time. Although this expansive vision of coverage has not been limited by legislation or legislative intent, changes in payment systems and other policies and practices have greatly restricted access to Medicare-covered home health care. In other words, access to the full scope of benefits available under the law has been greatly diminished.

Unfortunately, people who legally qualify for Medicare coverage frequently have great difficulty obtaining, keeping, and affording necessary home care.^a The legal standards that define who can obtain coverage, and what services are available, are often narrowly construed and misunderstood by providers and Medicare adjudicators, resulting in inappropriate barriers to Medicare coverage for necessary care. This is increasingly true for home health aide services – the very kind of personal care services and help with activities of daily living that older and disabled people often need to remain healthy and safely at home.

After a brief review of the evolution of Medicare home health law, in Part II below, this paper details the scope of the benefit authorized by law, including eligibility criteria, in Part III, and then, in Part IV, explains how access to the benefit is greatly restricted in practice.

^a See, e.g., Center for Medicare Advocacy issue briefs: “Medicare Home Health Coverage: Reality Conflicts with the Law” (April 2021), available at: <https://medicareadvocacy.org/issue-brief-medicare-home-health-coverage-reality-conflicts-with-the-law/>, and “Medicare and Family Caregivers” (June 2020), available at: <https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf>.

II. Evolution of Medicare Home Health Law

The type of coverable services and eligibility criteria for the Medicare home health benefit has changed little since the program's inception and has even been expanded over the years. However, as noted by researchers Davitt and Choi, "interpretation of those criteria has varied historically, at times enhancing benefit access and at other times restricting access."^b

The Medicare Act of 1965 (P.L. 89-97), amending the Social Security Act, created the home health benefit under Part A for individuals who are homebound, in need of intermittent skilled care (including medically necessary skilled nursing, physical, occupational, or speech therapy) provided by a Medicare-certified home health agency under an authorized provider's plan of care. Individuals meeting these criteria are also eligible for medical social services, and part-time or intermittent services of a home health aide. The Act originally limited home health services to 100 days per benefit period for patients who had spent at least three days as a hospital inpatient immediately prior to receiving home care. Part B covered up to 100 days per year for patients with or without a hospital stay with both a deductible (\$60 in the beginning) and a 20% coinsurance.^c In 1972, when Medicare eligibility was expanded to include certain individuals with disabilities under age 65, amendments to the Social Security Act eliminated the Part B coinsurance for the home health benefit, (P.L. 92-603).^d

With an intent to expand home health services, Congress passed the Omnibus Budget Reconciliation Act of 1980 (OBRA 80, P.L. 96-499) which removed the annual 100 home health visit limitation for both Parts A and B, the 3-day prior hospital stay requirement and the Part B deductible.^e As noted by Davitt and Choi, "[n]ow the benefit could be available to eligible enrollees without a prior hospital stay and on an unlimited basis not subject to out-of-pocket expenditures [... but] [t]he law, however, did not provide additional clarity on the intermittent care or homebound criteria nor did it require" the Medicare agency (then called the Health Care Financing Administration/HCFCA, now the Centers for Medicare & Medicaid Service/CMS) "to establish consistent standards for intermediaries" that processed Medicare claims.^f

During the 1980s, as noted by Fishman, Penrod and Vladeck, "[t]he Reagan Administration, attempting to rein in the effects of the legislative loosening of requirements for Medicare home care, initiated the first clampdown on the benefit, largely successfully".^g For example, prior to 1989, HCFCA/CMS had interpreted "intermittent" to mean skilled nursing care provided four days or fewer per week.

b Davitt, Joan K. and Choi, Sunha (2008) "Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use," *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

c Davitt, Joan K. and Choi, Sunha (2008) "Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use," *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

d Davitt, Joan K. and Choi, Sunha (2008) "Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use," *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

e Davitt, Joan K. and Choi, Sunha (2008) "Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use," *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

f Davitt, Joan K. and Choi, Sunha (2008) "Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use," *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

g Fishman, Eliot Z., Penrod, Joan D. and Vladeck, Bruce C. (2003) "Commentary: Medicare Home Health Utilization in Context" *Health Services Research* 38:1, Part I.

Pursuant to an agreement reached in a class action lawsuit, *Duggan v. Bowen*, in 1989 HCFA refined its definition of “intermittent” to mean fewer than seven days a week.^h

Effective in 2000, the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) implemented a prospective payment system (PPS) for home health (and in certain other care settings), and gradually transferred some home health expenditures from Part A to Part B (episodes not preceded by a hospitalization or skilled nursing facility stay or exceeded the 100-visit Part A cap). Part A also provided payment if a beneficiary was not enrolled in Part B.ⁱ The BBA also eliminated venipuncture as a qualifying benefit and redefined, and broadened, the term “intermittent” to include “skilled nursing care that is either provided or needed on fewer than seven days each week or less than eight hours of each day for periods of 21 days or less” with extensions in exceptional circumstances.^j

Pursuant to BBA 97, the home health prospective payment system (PPS) was implemented in October 2000, changing payment to home health agencies from a per visit basis of “reasonable costs” to a predetermined payment formula adjusted based on beneficiary expected care needs, among other factors.^k

The Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) also clarified that beneficiaries who leave their home for an adult day care center to receive therapeutic, medical or psychosocial services, or to attend religious services, are not disqualified from being considered “homebound,” a prerequisite for Medicare home health coverage.^l Other legislation, including the Medicare Prescription Drug, Improvement, and Modernization Act (MMA, P.L. 108-173), the Deficit Reduction Act of 2015 (DRA, P.L. 109-171) and the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) made revisions to home health payment, but did not scale back eligibility or the scope of coverage.^m

More recently, the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) required CMS to implement a new payment system for home health, called the Patient Driven Groupings Model (PDGM), effective 2020. The BBA also reduced 60-day episodes of care and payment to 30-day episodes.ⁿ

The history of Medicare’s home health coverage is largely characterized by legislative expansion of the eligibility for and scope of the benefit; however, payment system changes and administrative restrictions – as discussed below – have combined to reduce access to the benefit. Medicare home health coverage law, and the intent of Congress to support and enhance coverage, have thus been thwarted. This dynamic was brought to providers’ attention by CMS in 2020, when the new Patient Driven Grouping Model (PDGM) payment system came into effect, and patients faced increasing barriers to covered care. According to a CMS Medicare Learning Network (MLN) article from February 2020:^o

h Congressional Research Service Report, (2014) “Medicare Home Health Benefit Primer: Benefit Basics and Issues” *Congressional Research Service*, R42998.

i Congressional Research Service Report, (2014) “Medicare Home Health Benefit Primer: Benefit Basics and Issues” *Congressional Research Service*, R42998.

j Davitt, Joan K. and Choi, Sunha (2008) “Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use,” *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

k Congressional Research Service Report, (2014) “Medicare Home Health Benefit Primer: Benefit Basics and Issues” *Congressional Research Service*, R42998.

l Congressional Research Service Report, (2014) “Medicare Home Health Benefit Primer: Benefit Basics and Issues” *Congressional Research Service*, R42998.

m See, generally, Appendix, Congressional Research Service Report, (2014) “Medicare Home Health Benefit Primer: Benefit Basics and Issues” *Congressional Research Service*, R42998.

n Congressional Research Service Report (2020) “Medicare Primer” *Congressional Research Service* R40425.

o CMS Medicare Learning Network (MLN) article, “The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)” (SE20005), (Feb. 10, 2020, updated Aug. 20, 2021), available at: <https://www.cms.gov/files/document/se20005.pdf>.

While there has been a change to the case-mix adjustment methodology and the unit of payment beginning in CY 2020, eligibility criteria and coverage for Medicare home health services remain unchanged. That is, as long as the individual meets the criteria for home health services as described in the regulations at 42 CFR 409.42, the individual can receive Medicare home health services, including therapy services. (Emphasis added.)

III. Current Benefit - In Law and Regulation

When properly implemented, the Medicare home health benefit provides coverage for an array of skilled and nonskilled services. Coverage is available for people with acute and chronic conditions, and for skilled care to improve, or maintain, or slow decline. Further, coverage can be available even if the services are expected to extend over a long period of time, so long as coverage criteria are met.^p However, in practice, Medicare beneficiaries have difficulty obtaining and retaining necessary home care. While there are legal standards that define who can obtain coverage, and for what services, the criteria are often narrowly construed and misrepresented, resulting in inappropriate barriers to Medicare and necessary care.

A. The Law: Coverage Under the Medicare Act?^q

Home health access problems have ebbed and flowed over the years, depending on the reigning payment model, systemic pressures, and misinformation about Medicare home health coverage. Regrettably, these problems are increasing^r and, if current and proposed policies and practices continue, they will only get worse. Accordingly, it is important to know what Medicare home health coverage should be under the law, especially for people with long term, chronic, and debilitating conditions.

1. Medicare Home Health Qualifying Criteria

Medicare provides coverage for home health services under Parts A and B when the services are medically “reasonable and necessary,” and when:^s

- A physician or other authorized practitioner^t has established a plan of care for furnishing the services, that is periodically reviewed as required;

p 42 C.F.R. §408.48(a)-(b); MBP Manual, Ch. 7, §§401.1 and 70.1. See, *Jimmo v. Sebelius*, No. 11-cv-17 (D.Vt.), filed January 18, 2011; Settlement 2013; Corrective Action Plan 2017. See, <https://medicareadvocacy.org/medicare-info/improvement-standard/>. See, <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>.

q For a fuller discussion of Medicare home health coverage, see, Chiplin Jr., Alfred, Stein, Judith, Kertesz, Kata, *Medicare Handbook*, Chapter 4, Home Health Coverage, (Wolters Kluwer, 2021; updated annually).

r See, e.g., “Center for Medicare Advocacy Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved” (Dec. 2021), available at <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>. A survey of 217 home health agencies across 20 states, conducted in 2021, found, among other things, that home health agencies reported that they cannot provide 20 hours of home health aide services. Indeed, 94% said they could only provide 6 hours or less of home health aide services, although the law authorizes 28 or more hours/week for beneficiaries that meet Medicare criteria, along with widespread misunderstanding of Medicare coverage law. Also see, e.g., Medicare Payment Advisory Commission (MedPAC): March 2021 Report to Congress (available here: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf), Table 8-1 (p. 236) illustrates how payments influence services (looking at post-PPS 2001-2019, nursing down 23%, therapy up 55%, home health aide down 82%) for an overall decline of almost 20% of services within an episode; also see July 2021 Data Book (available here: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/data-book/july2021_medpac_databook_sec.pdf), Chart 8-8 (p. 108) showing that between 2011 and 2019, a cumulative decline in episodes per patient of 7%, visits per episode of 4.7%, visits per patient of 11%, while average payment per episode increased 8.6%.

s 42 U.S.C. §1395f(a)(2)(C); 42 C.F.R. §§409.42 et seq.

t Note that the CARES Act of 2020 (P.L. 116-136) permanently authorizes physician assistants, nurse practitioners and clinical nurse specialists, in a manner consistent with state law, to order home health services for Medicare patients, establish a plan of care and certify and re-certify services.

- The individual is confined to home (commonly referred to as “homebound”). This criterion is generally met if non-medical absences from home are infrequent and leaving home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance, or the help of a wheelchair or walker, etc. Occasional “walks around the block” are allowable. Attendance at an adult day care center or religious services is not a bar to meeting the homebound requirement;
- The individual needs skilled care – which includes nursing care on an intermittent basis, or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need, but no longer requires skilled nursing care or physical or speech therapy, the individual continues to need occupational therapy; and
- Such services are furnished by, or under arrangement with, a Medicare-certified home health agency.^u

2. Medicare Covered Home Health Services

If the qualifying conditions described above are satisfied, Medicare coverage is available for an array of home health services. Home health services that can be covered by Medicare include:^v

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
2. Physical therapy, speech language pathology (speech therapy), and occupational therapy;
3. Part-time or intermittent services of a home health aide;
4. Medical social services; and
5. Medical supplies.

As described above, skilled nursing, physical therapy, and speech language pathology services are defined as “qualifying skilled services” for the purpose of establishing eligibility for Medicare home health coverage.^w A patient must initially require and receive one of these skilled services in order to qualify for Medicare coverage of home health services.^x Home health aide, medical social worker, and occupational therapy services^y are defined as “dependent services,” along with certain durable medical equipment and medical supplies.^z While occupational therapy is not considered a skilled service to qualify for Medicare home health coverage, if the individual was receiving skilled nursing, physical or speech therapy, but those services end, coverage can continue if occupational therapy continues.^{aa}

Medicare’s threshold coverage requirements are key. The patient must be confined to home (“homebound”) and require a qualifying skilled service provided under an appropriately authorized plan of care. If these preconditions are met, the beneficiary often qualifies for Medicare home health coverage for necessary skilled services and “dependent” services, including home health aides.^{ab} Even for those who meet these requirements, however, there are important gaps in the Medicare

u 42 U.S.C. §1395x(m).

v 42 U.S.C. §1395x(m)(1)–(4).

w 42 C.F.R. §409.42.

x 42 C.F.R. §409.44.

y Occupational therapy services can be either a qualifying service or a dependent service. Occupational therapy services that are not qualifying services under 42 C.F.R. §409.44(c) can be covered as dependent services if the requirements of reasonableness and necessity are met. 42 C.F.R. §409.45.

z 42 C.F.R. §409.45.

aa 42 C.F.R. §409.42(c)(4); Medicare Beneficiary Policy Manual, Ch. 7, §30.4.

ab 42 C.F.R. §§409.45(a)-(b).

home health aide benefit. Home health aides, like other home health services, must be provided by, or under arrangements with, a Medicare-certified agency.^{ac} Homemaker services are not covered unless those services are “incidental” to the personal care provided by home health aides.^{ad}

Importantly, and contrary to what is often expressed, Medicare home health coverage is not just a short-term, acute care benefit.^{ae} In 2013, a federal court approved a settlement agreement in the national class action case, *Jimmo v. Sebelius* confirming this and that improvement is not required to obtain or continue Medicare-covered home health care (or skilled nursing facility or outpatient therapy services). *Jimmo* was brought by the Center for Medicare Advocacy and Vermont Legal Aid on behalf of Medicare beneficiaries and six organizations to challenge the erroneous use of an “improvement standard,” resulting in claims for home health and other coverage being denied if full recovery or medical improvement was not possible.^{af} The Settlement confirmed that Medicare coverage should be determined by a beneficiary’s need for skilled care, not the individual’s potential for improvement. Further, coverage of skilled nursing or therapy, including that provided at home, is available to beneficiaries who need those services to maintain or slow deterioration – regardless of the underlying illness, disability, or injury.

Over the years, the Center for Medicare Advocacy has represented numerous individuals to enable them to obtain, and maintain, home health coverage to stay home with necessary care. With the receipt of Medicare-covered skilled nursing and/or therapy and home health aides, some of our clients have been able to remain home for years.^{ag} Unfortunately, to continue necessary Medicare coverage, these beneficiaries, and individuals like them, require zealous advocacy from attorneys with Medicare expertise. This kind of effort should not be necessary – and is not widely available. While ongoing Medicare-covered home care is available under the law, in practice, its receipt is the exception rather than the rule.

IV. Current Benefit – In Practice – Access is Limited

The Center for Medicare Advocacy hears regularly from people who meet Medicare coverage criteria, but are unable to access Medicare-covered home health care, or the appropriate amount of care. In particular, people living with long-term and debilitating conditions find themselves facing significant access problems. For example, patients have been told Medicare will only cover one to five hours per week of home health aide services, or only for a bath, or that they aren’t homebound because they occasionally leave the walls of their home, or that they must first decline before therapy can commence (or recommence). Consequently, these individuals and their families struggle with too little care, or no care at all.

A. Access to Medicare-Covered Home Health Aides is Shrinking

As noted by CMS in a recent proposed rule regarding home health payment, “home health aides deliver a significant portion of direct home health care. Ensuring that aide services are meeting the patient’s needs is a

ac 42 C.F.R §409.41(a).

ad 42 C.F.R §409.45(b)(4). “The home health aide also may perform services incidental to a visit that was for the provision of care as described in [...] this section. For example, these incidental services may include changing bed linens, personal laundry, or preparing a light meal.”

ae 42 C.F.R §§409.48(a)-(b); Medicare Beneficiary Policy Manual, Ch. 7, §§40,1.1 and 70.1.

af *Jimmo v. Sebelius*, No. 11-cv-17 (D.Vt.), filed January 18, 2011; Settlement 2013; Corrective Action Plan 2017. See, <https://medicareadvocacy.org/medicare-info/improvement-standard/>. See, <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>.

ag For examples of some of the clients that the Center for Medicare Advocacy has assisted, see, e.g., pp. 13-14 of Center’s Issue Brief: “Medicare and Family Caregivers” (June 2020), available at: <https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf>.

critical part in maintaining safe, quality care”.^{ah} Unfortunately, access to Medicare coverage for such care has declined precipitously. This is true even when individuals have an order and meet the law’s homebound and skilled care requirements – and thus qualify for coverage. In the experience of the Center for Medicare Advocacy, Medicare beneficiaries are often misinformed by home health agencies.^{ai} They are told, for example, that they can only get home health aides a few times a week, for a short time, and/or only for a bath. Sometimes they are told Medicare simply does not cover home health aides. The Center for Medicare Advocacy has even heard of an individual being told he could not receive home health aide coverage because he was “over income” – although Medicare has no income limit.

Under the law, Medicare authorizes up to 28 to 35 hours a week of home health aide (personal hands-on care) and nursing services combined.^{aj} While personal hands-on care does include bathing, it **also** includes dressing, grooming, feeding, toileting, and other key services to help an individual remain healthy and safe at home.^{ak}

In the past, this level of home health aide coverage was actually available. The Center for Medicare Advocacy has helped many clients remain safely at home because these services were in place; currently such coverage and care is almost never obtainable. Data demonstrate this point. In 2021 the Medicare Payment Advisory Commission (MedPAC) reported that home health aide visits per 60-day episode of home care declined by 90% from 1998 to 2019, from an average of 13.4 visits per episode to 1.3 visits. As a percent of total visits from 1997 to 2019, home health aides declined from 48% of total services to 9%.^{al} This decline has been so dramatic, that CMS recently solicited feedback in a proposed rule as to why this is occurring.^{am}

As the Center noted in comments to a recent CMS proposed home health rule,^{an} in our experience, home health agencies are increasingly not staffing for home health aides (current COVID-related circumstances aside),^{ao} and are instead referring patients to their non-Medicare, private pay “affiliates” for related services, or cost-shifting home health aides for dually-eligible Medicare/Medicaid patients to Medicaid, or, in the case of some Medicare Advantage plans, not providing home health aides.

For example, the Center recently worked with one hospital-affiliated home health agency that had one home health aide for 600 cases. This inadequate staffing and availability of home health aides for services as critical as bathing, toileting, grooming, skin care, walking, transferring, assistance with self-administered medications, and other activities of daily living, puts beneficiaries at risk. The risk includes entering an institutional setting, either via hospitalization to address falls, infections, and other preventable conditions, or by entering nursing homes in order to receive the services they cannot obtain at home.

ah 86 Fed Reg 35874 (July 7, 2021) at 35956, 35958.

ai See, e.g., “Center for Medicare Advocacy Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved” (Dec. 2021), available at <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>.

aj 42 U.S.C. §1395x(m)(1)-(4). Note, receipt of skilled therapy can also trigger coverage for home health aides.

ak 42 CFR §409.45(b)(1)(i)-(v). See also, Medicare Benefits Policy Manual, Chapter 7, §§50.1 and 50.2.

al Medicare Payment Advisory Commission (MedPAC), “Report to Congress: Medicare Payment Policy (March 2021) Ch. 8, p. 245, available at <https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/> and March 2019 MedPAC, “Report to the Congress: Medicare Payment Policy”, Ch. 9, pp. 234-235, available at: <https://www.medpac.gov/document/march-2019-report-to-the-congress-medicare-payment-policy/>.

am 86 Fed Reg 35874 (July 7, 2021).

an CMA Comments on CY 2022 HH Prospective Payment System & More (August 5, 2021), available at: <https://medicareadvocacy.org/cma-comments-on-cy-2022-hh-prospective-payment-system-more/>.

ao Note that there is a well-documented shortage of home health aides, which existed prior to the pandemic; see, e.g., “For Older Adults, Home Care Has Become Harder to Find” by Paula Span, *New York Times* (July 24, 2021, updated Nov. 1, 2024), available at: <https://www.nytimes.com/2021/07/24/health/coronavirus-elderly-home-care.html>; also see “There’s A Shortage Of Home Health Aides For The Elderly, And It’s Getting Worse” by Kavitha Cardoza, National Public Radio (NPR), (Sept. 28, 2021), available at: <https://www.npr.org/2021/09/28/1031651663/shortage-home-health-aides-elderly>.

The Medicare home health aide benefit is misunderstood, inaccurately articulated, and restrictively implemented. Medicare-certified home health agencies have all but stopped providing necessary, legally authorized home health aide services, even when patients are homebound and are receiving the requisite nursing or therapy to trigger coverage. The Centers for Medicare & Medicaid Services (CMS) does not monitor or rebuke agencies for failure to provide this mandated and necessary care.

B. Medicare’s Home Health Payment System Influences and Limits Access to Care

Throughout the history of the home health benefit, researchers Davitt and Choi note, “use of the benefit [...] was driven less by patient need or health status than by arbitrary interpretations of the validating device [determining eligibility for the benefit] and perverse incentives which encouraged agencies to adjust the amount of service, based not on patient need but on specific reimbursement procedures.”^{ap}

Diminishing access to coverage of home health aides, described above, is primarily related to home health agency payment incentives, while other CMS quality measures and audits also play a role. Based on short-comings in the prospective payment system (PPS), home health agencies apparently find little-to-no payment incentives to provide aide services. As annual payment “re-basing” occurs, service delivery data shows increasingly less home health aide services have been provided. This reduction in services is then reflected in payment rates, creating a cycle of reduced payment and reduced care. In other words, the less aide services that are provided, the less such services are incorporated into and accounted for in payment rates.

However, PPS was designed to be an aggregate bundled payment system. It is intended to provide adequate payment to meet the needs of all qualified patients, providing higher payment for some patients and less for others so that cumulatively agencies are fairly reimbursed. After decades of PPS data-collection, however, it has become clear that the data represents services that agencies decide to provide, based strongly on profit incentives, not on the services that patients need. The result is a huge chasm between the services Medicare home health law covers and the services home health agencies deliver. This is particularly true for patients with longer-term, chronic conditions who most need the services of a home health aide to remain at home.

The most recent iteration of PPS, the Patient Driven Groupings Model (PDGM), continues the bundled payment model, theoretically meant to cover all home health services. The Home Health Value Based Purchasing (HHVBP) Model, which will be expanded nationwide in 2023, focuses on payment adjustments to home health agencies (both positive and negative) based on quality measures intended to promote better quality of care. Unfortunately, in practice, these models include various provisions that may lead providers to avoid individuals with chronic and on-going conditions.

1. Patient Driven Groupings Model (PDGM)

Payment incentives affect not only what care is provided, but to whom. On January 1, 2020, CMS implemented the latest version of the prospective payment system (PPS) for home health services called the “Patient Driven Groupings Model” (PDGM). PDGM changed home health agencies’ financial incentives and disincentives to

ap Davitt, Joan K. and Choi, Sunha (2008) “Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use,” *The Journal of Sociology & Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.wmich.edu/jssw/vol35/iss1/12>.

admit or continue care for Medicare beneficiaries.^{aq} Unfortunately, the financial motivations are often harmful to vulnerable beneficiaries, particularly those with chronic conditions and longer-term health care needs.

Under PDGM, payments are higher for beneficiaries who are admitted after an inpatient institutional stay (hospitals and skilled nursing facilities), and lower for those admitted from the community. (The “community” category includes hospital outpatients, including hospital patients in “Observation Status,” as well as patients who start care from home, without a prior hospital or skilled nursing facility (SNF) stay.) Assessing the potential implications of this payment change, Burgdorf, Mroz, and Wolff noted that “Medicare beneficiaries receiving home health care without a preceding hospitalization have significant social vulnerability and clinical severity. Reducing reimbursement for home health care provided without a preceding hospitalization may threaten vulnerable beneficiaries’ ability to meet their care needs.”^{ar} They urged CMS to carefully monitor whether these payment changes “disproportionately reduce access to care for select groups of high-need beneficiaries.”

Pursuant to the BBA of 2018, the new payment model also reduced the billing period from 60 days to 30 days and lowered the financial incentive to provide therapy by removing therapy service utilization payment thresholds.

Further, PDGM’s financial incentives include higher rates for the first 30 days of home care. Analysis of the first full year of PDGM illustrates a sharp payment decline to agencies after 30 days of home health care.^{as} Payments for the first 30 days of care are, on average, more than 34% higher than for subsequent 30-day periods of care – regardless of the amount of home health services a patient needs, or for how long. After the first 60 days of home health care, payments decline even further. PDGM is thus a significant factor in reducing, and often eliminating, access to ongoing home health care for beneficiaries with longer-term and chronic conditions.

The 2020 PDGM payment system and shift in financial incentives have reduced access to necessary care. For instance, shortly after PDGM began in 2020, a [Home Health Care News](#) article reported that “[s]tories of widespread layoffs of PTs, OTs and SLPs persist – and now new reports of agencies incorrectly telling their patients that Medicare no longer covers therapy under the home health benefit...”^{at} Reductions in skilled therapy does not only harm the individual who needs that care, it can also end access to home health aides since aide services are dependent on the individual receiving skilled therapy or nursing.

2. Home Health Value Based Purchasing Model (HHVBP)

Section 3006(b) of the Affordable Care Act required the Secretary of Health and Human Services (HHS) to develop a plan to implement a value-based purchasing program for home health agencies.^{au} Effective January 2016, the Centers for Medicare & Medicaid Innovation (CMMI), a branch of the Centers for Medicare & Medicaid

aq See, e.g., Center for Medicare Advocacy Weekly Alert, “Medicare Home Health Is Not a Short-Term Benefit – Despite Payment Policies to The Contrary” (March 4, 2021), available at: <https://medicareadvocacy.org/medicare-home-health-is-not-a-short-term-benefit/>. Also see Center for Medicare Advocacy “Home Health Practice Guide: Medicare Home Health Coverage and Care Is Jeopardized By the New Payment Model – The Center for Medicare Advocacy May Be Able to Help” (Jan. 7, 2020) available at: <https://medicareadvocacy.org/home-health-practice-guide/>; also see, e.g., Center for Medicare Advocacy Weekly Alert “Medicare Coverage of Home Health Care Has Not Changed Under the New Payment System (PDGM)” (Feb. 20, 2020), available at: <https://medicareadvocacy.org/medicare-coverage-of-home-health-care-has-not-changed-under-the-new-payment-system-pdgm/>.

ar Burgdorf, Julia G., Mroz, Tracy M., Wolff, Jennifer L. “Social Vulnerability and Medical Complexity Among Medicare Beneficiaries Receiving Home Health Without Prior Hospitalization” *Gerontological Society of America, Innovation in Aging*, Vol. 4, No. 6 (2020), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7672253/pdf/igaa049.pdf>

as See chart in Center for Medicare Advocacy Weekly Alert, “Medicare Home Health Is Not a Short-Term Benefit – Despite Payment Policies to The Contrary” (March 4, 2021), available at: <https://medicareadvocacy.org/medicare-home-health-is-not-a-short-term-benefit/>.

at *Home Health Care News*, “CMS Watching Home Health Providers Closely Amid Shifting Therapy Strategies” by Robert Holly, (Feb. 12, 2020), available at: <https://homehealthcarenews.com/2020/02/cms-watching-home-health-providers-closely-amid-shifting-therapy-strategies/>.

au Congressional Research Service Report, (2014) “Medicare Home Health Benefit Primer: Benefit Basics and Issues” *Congressional Research Service*, R42998.

Services (CMS), implemented the Home Health Value-Based Purchasing (HHVBP) Model. CMMI states that the “overall purpose” of the model “is to improve the quality and delivery of home health care services to Medicare beneficiaries with specific goals to: 1. Provide incentives for better quality care with greater efficiency; 2. study new potential quality and efficiency measures for appropriateness in the home health setting; and, 3. enhance the current public reporting process.”^{av}

As noted in a recent CMS press release announcing a final home health rule, “[t]he HHVBP Model’s current participants provide services in nine randomly selected states and comprise all Medicare-certified Home Health Agencies (HHAs) providing services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington.”^{aw}

Pursuant to the final rule issued in November 2021, CMS is using its authority to expand the HHVBP model nationwide, effective 2023.^{ax}

As discussed further below, the current “Quality of Patient Care Star Rating” system for home health agencies focuses largely on measuring “improvement,” omitting measurements for care of people who, by definition, may never improve due to their particular condition but require covered care to maintain or slow decline of their condition. Similarly, as noted in the Center for Medicare Advocacy’s comments to the proposed rule,^{ay} since HHVBP was first proposed in 2015, the criteria used to measure HHVBP discriminate against Medicare beneficiaries with longer-term, chronic conditions who require skilled care but are not expected to improve – patients covered by the *Jimmo* class action settlement. The model does not provide any meaningful measurement criteria for people who qualify for home health care under the law, but who have an illness or injury that will not improve, or will not improve relatively quickly. As a result, the HHVBP design may be perceived by providers as penalizing agencies that serve people with longer term and chronic conditions, by taking payments back from agencies serving people who do not meet the improvement criteria.

CMS has failed to secure meaningful measures in HHVBP for individuals who cannot improve, but who need Medicare-covered services to maintain their conditions or slow decline. CMS continues to reject the use of stabilization measures, that could apply to such individuals. Instead, HHVBP measures penalize home health agencies when patient improvement is not achieved. As stated in our comments, expanding HHVBP will continue and exacerbate the loss of access to necessary home health care that such beneficiaries are already experiencing. Medicare beneficiaries living with longer-term and chronic conditions are disfavored patients under HHVBP due to penalties agencies may accrue, and the potential rewards they will sacrifice, by serving them.

av See CMMI website: <https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model>.

aw CMS Press Release “CMS Finalizes Calendar Year 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Expansion” (November 2, 2021), available at: <https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-calendar-year-2022-home-health-prospective-payment-system-rate-update-home-health>.

ax “CY 2022 Home Health Prospective Payment System Rate Update” 86 Fed Reg 62240 (Nov. 9, 2021) <https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf>.

ay CMA Comments on CY 2022 HH Prospective Payment System & More (August 5, 2021), available at: <https://medicareadvocacy.org/cma-comments-on-cy-2022-hh-prospective-payment-system-more/>. Note that these comments include a detailed discussion outlining the Center for Medicare Advocacy’s concerns with the HHVBP model.

C. Other Factors Limiting Home Health Coverage

1. Home Health Agencies, Providers, Medicare Contractors and Auditors Misconstrue the Benefit

The Center for Medicare Advocacy regularly encounters home health agencies that do not know or follow the law with respect to the home health benefit, including the duration of coverage, application of the homebound criteria, and inappropriate use of “improvement standard” criteria.

CASE EXAMPLES

These are individuals whom the Center for Medicare Advocacy has recently helped and/or spoken to.

Mrs. J is age 56 and has advanced multiple sclerosis. Among other services, she needs in-home biweekly catheter changes by a registered nurse, skilled therapy to prevent painful contractures, and aide services to help her transfer, bathe, dress, receive nail care, eat, take medications, and perform other activities of daily living that are covered by the Medicare aide benefit. Recently, at a hearing regarding termination of home health services, a Medicare Administrative Law Judge fully affirmed that Mrs. J’s necessary home health services are covered by Medicare, including skilled and unskilled services. Mrs. J has received services from three different home health agencies in just the first six months of this year. Each agency has discharged her after a few months, citing lack of Medicare coverage. She has new home health staff cycling through her home constantly.

Mrs. J will quickly exhaust access to the dozen or so Medicare-certified home health agencies that provide services in her zip code. As it is, home health agencies will currently offer only minimal services – nothing close to what she qualifies for or what is ordered by her doctors. Appeals are useless; even with a fully favorable hearing decision from an Administrative Law Judge, confirming her discharge from home health services was inappropriate. The judge was powerless to order the home health agency to reinstate her services. And while having a fully favorable decision should reassure other agencies that Medicare will cover Mrs. J, instead, her multiple sclerosis renders her a disfavored type of patient to home health agencies.

Mr. M., age 81, has primary lateral sclerosis (PLS), a progressive, neuromuscular disease. He is homebound under Medicare standards, and needs therapy services in the home in order to maintain sufficient function to help with transfers and daily care. Several home health agencies have cited different reasons why they cannot retain him as a patient, including erroneous improvement requirements, term limitations, and assertions that “home health is meant for acute short-term care and not for chronic long term care needs.” After therapy services were cut back by one agency, he developed pressure ulcers covering his behind and continuous cellulitis outbreaks on his feet and legs. According to his wife, he has become depressed because of difficulty controlling his urinal cup and other things he previously did without help. His wife has been told that she should be able to do what the therapist do, but she had to explain that she is unable to do so – she had already debilitated her back, both knees, and both hips trying to assist her husband. She also asserts that trying to get him in his shower chair and into the shower by herself is no longer safe, even with his hooyer lift. She was told by an agency, though, that if he gets aid with the shower, it will reduce any available therapy. She has also been told by an agency that she should consider taking him to an outpatient facility for therapy every day, even though it is physically impossible for her to load him into her car and the facilities do not provide transportation. Even if Mr. M could get to outpatient therapy, Medicare payment is precluded because all therapy must be provided or arranged through the home health agency due to consolidated billing requirements.

The combination of financial incentives, misunderstandings about the benefit, and lack of effective oversight, leads home health agencies to accept and discharge patients in a manner that denies meaningful access to people with chronic and/or disabling conditions. We hear from many such beneficiaries who are eligible for services but can either find no agency that will accept them, or can only find agencies willing to serve them for very short periods of time, often for far fewer services than they need and are covered by Medicare.

Further, physicians and other practitioners who are authorized to order home care, frequently do not realize they can order care for longer than short episodes, and that home health aides are Medicare-coverable when skilled care is also required. In other words, physicians are often unaware of the scope of services they can prescribe as Medicare-covered home health and therefore do not order them. Conversely, when a physician prescribes broader services, the Center has found that it is often difficult to enforce such orders with the home agency providing care.

This misunderstanding by physicians and other providers is reinforced by erroneous Medicare Administrative Contractor (MAC) coverage decisions and audits, as well as audits performed by the Department of Health and Human Services' Office of Inspector General (OIG). Care that is coverable under the law is sometimes erroneously treated as "fraud" singled out by auditors, deterring providers from offering such coverage. Auditing methodologies seem to disproportionately select home health claims that exceed the average home health length of care. More stringent scrutiny of claims for beneficiaries who require a longer duration of home health services provides yet another disincentive to serve these beneficiaries. In other words, OIG and Medicare contractors do not audit to protect either the program or beneficiaries by investigating agencies that underserve patients, even when practices such as refusing to accept or prematurely discharging beneficiaries with chronic conditions may constitute discrimination on the basis of disability. Instead, applying incorrect standards, they only focus on agencies "overserving" patients.

As noted above, CMS did take steps to respond to misinformation about and changes in the way providers are offering services in light of PDGM by, e.g., issuing a special MLN article in February 2020.^{az} The MLN reminded providers that eligibility criteria for home health services "remain unchanged" and reiterated that there is no applicable improvement standard. Individuals who are homebound and receiving skilled care pursuant to an authorized practitioner's order should be able to receive the full array of care authorized by law so long as they meet the qualifying criteria. While welcome, the MLN has not reversed the growing trend limiting access to home care.

2. Quality Ratings Inappropriately Focus on "Improvement"

The current "Quality of Patient Care Star Rating" system for home health agencies focuses largely on measuring "improvement," omitting measurements for care of people who, by definition, may never improve because they have a condition such as MS, Parkinson's disease, or another condition that is generally expected to continue or worsen over time. Because CMS does not reward quality care to maintain patients' conditions, or slow decline, home care agencies have yet another disincentive to admit such patients or to continue their needed care. Quality measurements should consider, and encourage the provision of necessary care to, all Medicare beneficiaries. As noted in our comments to the proposed home health rule, the Home Health Quality Reporting Program suffers the same flaws as the HHVBP model, discussed above.^{ba}

az CMS Medicare Learning Network (MLN) article, "The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)" (SE20005), (Feb. 10, 2020, updated Aug. 20, 2021), available at: <https://www.cms.gov/files/document/se20005.pdf>.

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V. Conclusion

In practice, Medicare home health coverage has morphed from a Congressionally authorized, robust benefit, to a narrowly construed, post-acute, short-term, skilled service benefit. Access to home care in general, and home health aides in particular, is denied far too often for beneficiaries who qualify for Medicare-covered home care. Further, when services are not provided, a beneficiary often cannot appeal because the system generally requires receipt of services in order to pursue Medicare coverage. Because of an array of incentives and penalties that impact Medicare home health providers, this is especially true for people with longer-term conditions. Most home health agencies seem to pick and choose more profitable patients – people with fewer and shorter-term needs – without apparent penalty for practices that discriminate against and harm Medicare-eligible beneficiaries.

The limited availability of Medicare home care conflicts with the law, Congressional intent, and the needs of a population that is living longer with more chronic conditions. In short, the Medicare home health benefit is an unkept promise.

Endnotes

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