Statement

of

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"Aging in Place: The Vital Role of Home Health in Access to Care"

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Chair Cardin, Ranking Member Daines, members of the Subcommittee on Health Care, thank you for the opportunity to present my views on the vital role that home health services plays in our continuum of care and the challenges faced today in preserving access to these essential services.

I serve as President of the National Association for Home Care & Hospice, a trade association representing the home health agencies that serve patients in the setting of their choice, their own home. Our members consist of the full panoply of such providers across the country including non-profit, proprietary, and government-based entities of all sizes from small, family-owned agencies in rural areas to large companies operating nationwide. These home health agencies are both freestanding providers and divisions within multifaceted health systems.

In my 47 years representing Medicare beneficiaries and home care providers before Congress, state legislatures, federal and state administrative agencies, and in numerous courts across the country, I have had the great honor of witnessing the importance of health care services at homes across the country. My immediate family has been fortunate enough to have received this incredible care, including my mother, father, sister, and son.

I come to you today to present information on the state of the Medicare home health services benefit. While it continues to provide significant care support for millions of beneficiaries each year, the home health agencies providing care and the beneficiaries receiving care need your help if such is to continue in the years ahead. I hope my testimony will be helpful as you consider how Congress can restore and protect this benefit for existing and future Medicare enrollees. The American people far prefer their home as the setting of choice for their health care and home health services has proven its value to both Medicare beneficiaries and the Medicare program as a high quality, cost-effective service since 1965.

The Medicare home health benefit covers an increasingly essential health service. The original 1965 design of the benefit put it in a unique class within Medicare as it is the only benefit that is available under both Medicare Part A and Part B. Since the beginning of Medicare, Congress has enacted multiple improvements in the benefit design and standards of coverage and care. These improvements include:

- Elimination of beneficiary cost sharing on services.
- Extending the scope of coverage to an unlimited number of service visits.
- Elimination of the prior-hospitalization requirement.
- Defining the scope of "part-time or intermittent" services to include certain daily care.

- Refining the definition of “confined to home” to allow non-medically related absences from the home, such as attending religious services.
- Establishing patient rights, quality of care measures, and compliance standards that ensure care quality.

As implemented in federal regulations by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services, beneficiaries are entitled to coverage of medically necessary skilled nursing, physical therapy, speech-language pathology, occupational therapy, medical social services, and home health aide services when meeting the eligibility standards. These services are available to patients without regard to whether their condition is acute, chronic, or at end-of-life. Further, eligibility is based on whether the patient is homebound and in need of intermittent skilled nursing or therapy services.

While the benefit design and standards of coverage present a valuable Medicare benefit, in practice it falls short of intended purposes.

Over the last 25 years, the benefit has been subject to many changes in payment, payment models, and scope of coverage brought on by a combination of congressional action, regulatory changes, and operational shortcomings. Providers of care face multiple barriers to the provision of services that include wholesale misunderstanding of coverage standards by Medicare contractors along with reimbursement pressures that affect patient service and clinical practice. The environment surrounding the benefit operation has not been stable for many years with events such as the OIG Operation Restore Trust, the elimination of provider protections from retroactive claim denials, expanded claims audits and oversight, and a misperception by MedPAC and others that the benefit was becoming something akin to a “long term care” program because of extended services and patient length of stay. In addition, justifiable concerns have been raised at various points that the benefit wrongly has focused only on patients with a potential for functional restoration to the exclusion of patients whose needs are for care that maintains function or prevents accelerated deterioration in their condition.

Fortunately, the home health benefit continues to provide access to high quality, medically necessary services to millions of Medicare beneficiaries each year. However, the benefit trajectory is deteriorating and requires reforms if it is to ensure its significant value to Medicare beneficiaries and the Medicare program itself. CMS recognizes that value in that it expanded the Home Health Value-Based Program (HHVBP) nationwide this year after a 4-year demonstration that proved significant Medicare savings and improved patient outcome in using home health services. Over the next few years, CMS projects savings on nearly $3.5 billion through reduced inpatient hospital and skilled nursing facility costs.

Since 2011, Medicare beneficiaries have experienced reduction or loss in access to care and reduction in the level of care and scope of services provided. The data from CMS offers a stark picture of the future of the home health services benefit. Appendix, TABLE 1

- In 1997, with 33 million Original Medicare enrollees, there were 3.6 million unique users of home health services, receiving an average of 74 visits during the year.
- Following the onset of a payment model reform known as the Interim Payment System, 500,000 fewer beneficiaries received home health services, with the average visits per patient dropping to 51 in 1999.
- By 2011, after several years of stability under another payment system reform, 3.5 million users of home health services out of 36.5 million enrollees received an average of 36 visits per year.
- However, by 2021 after two more changes to the payment model , only 3.0 million users out of 36.4 million enrollees, a drop of 500,000 patients, received an average of 25.4 visits.
- Since 2011, the number of available home health agencies has dropped by over 1000 nationwide. Rural areas have been especially hit, as the testimony of Carrie Edwards suggests. Closures are occurring across the country, including providers that had been in operation for decades.

These losses in care are not the direct result of legislative or regulatory actions seeking to address "out of control spending" in home health services. In fact. home health spending in 2021 was $16.9 billion compared to $16.7 billion in 1997 without regard to 24 years of cost inflation. In comparison, inpatient hospital spending rose from $80.7 billion to $131.3 billion while Skilled Nursing Facility spending rose from $11.2 billion to $27.2 billion over that same time. In 2019, the year before the payment model changed, spending was $17.8 billion, and as stated previously, the expenditure in 2021 was nearly $1 billion less. Medicare continues to spend less money on home health.

While the past 25 years in home health services have been an extended roller coaster ride for beneficiaries and providers alike, the future presents an outlook that calls for significant action from Congress, HHS, CMS, and all other stakeholders. Certainly, not everything happening is the outcome of payment model and payment rate changes. However, the correlation of such changes is obvious and ominous as the 1998 Interim Payment System debacle showed. It took more than a decade to recover to an adequate level for care access from that point only to see history repeating itself over the decade that followed.

Once again, we are at a crossroad on the future of the home health services benefit. A new payment model, the Patient Driven Groupings Model or PDGM began in January 2020. Amazingly, despite the chaos that normally ensues with such a dramatic change in systems, home health agencies distinguished themselves from the very beginning of the COVID-19 pandemic in March 2020, filling a void in health care services left by closed nursing facilities

and unavailable hospitals. However, the pressures of PDGM have now taken over and providing access to care is challenging, at best.

The evidence is mounting that patients in need of home health services are dealing with major barriers to access to care today, some of which may reach a point where they are insurmountable. The deep labor shortages, particularly in nurses and home health aides are getting worse rather than improving. Home health agencies are spending greater time recruiting and retaining staff because of their precarious financial status that does not permt competitive compensation to clinicians in comparison to hospitals and other care settings.

Home health agencies are fully reliant on payments from Medicare, Medicaid, Medicare Advantage, and other government-based programs that have not raised reimbursements commensurate with labor cost changes. The proposed 2024 rate cut of 5.653% on top of the 3.925% cut in 2023 and combined with the 5.2% shortfall in the 2021-22 inflation updates will only make matters worse. These rate cuts are just the latest in an extended series of rate cuts over the years. Appendix, TABLE 2. It was fully foreseeable that these rate cuts would reduce care access.

There are several signs of the existing difficulties in care access. For example, hospital discharge data shows that hospitals are facing a growing level of patient referral rejections for prospective home health patients. This has led to delays in discharging patients to their homes, and extending costly inpatient stays as reported by the American Hospital Association. CarePort, a data analytics are of EMR vendor Wellsky, reports a nearly 50% increase in the rate of referral rejections by home health agencies. Homecare Homebase, another EMR vendor, shows a similar access problem with only 55% of patient referrals converted to patient admissions so far in 2023. Finally, data analytics company Care Journey explains that only 63% of inpatient discharges are securing and initiating home health services within 7 days with racial minorities least likely to find care access. Appendix, TABLE 3

A story just this last week in Modern Healthcare pointed out how the lack of available post-acute care, specifically home health care, has led to increased penalties for hospitals due to rising readmission rates.

The PDGM system is greatly contributing to this growing access problem. For example, under the proposed 2024 model there is shift of reimbursement away from patients with medically complex and multiple chronic conditions. Patients in the current 2023 payment model that are determined to have a “high” functional impairment level shift down to “medium” functional impairment level in the proposed 2024 model with a corresponding reimbursement reduction even though their clinical and functional condition is unchanged. The reimbursement change for some cases is as much as 18% from 2023 levels. This will affect home health agencies serving some of the sickest Medicare beneficiaries receiving home health care services.

To understand the true financial status of home health agencies facing the proposed rate cuts in 2024 requires a comprehensive review of the state of the industry. Using the cost reports filed with CMS and available directly from CMS, NAHC undertook such an analysis. Notably, NAHC examined both the data on Original Medicare home health services costs and revenue

along with the data on the overall financial status of home health agencies that includes all costs and all payers of care. The results are very concerning. It shows that 52.7% of freestanding home health agencies are projected to have financial margins below zero with the cuts proposed for 2024. Appendix, TABLE 3. The actual percentage is likely to be greater because the data does not include "hospital-based" home health agencies where the margins are typically lower.

NAHC strongly believes that overall margins are the most accurate measure of the financial stability of home health agencies in contrast to the MedPAC analysis that limits the focus to the "Medicare margin." No business, health care or otherwise, limits its assessment of financial stability to one revenue source or service line. MedPAC instead conveys "Medicare margins" that only offer an illusion of the true financial status of home health agencies. Not only does the MedPAC approach provide an uninformed picture of financial stability, that analysis is further compromised as it excludes certain usual and customary business costs such as marketing and current health care costs like telehealth services and remote patient monitoring. In addition, MedPAC's failure to include hospital-based home health agencies is particularly concerning given the significant presence of those providers in rural areas.

To the extent that there is a financial margin in traditional Medicare home health services, it primarily is used to subsidize longstanding payment shortfalls from Medicare Advantage plans and state Medicaid programs, a financial deficit facing most health care sectors. However, home health agencies, unlike most other sectors, do not have a material level of commercial insurance revenue that can offset financial losses from Medicare Advantage or Medicaid. As a result, Medicare margins primarily go towards patient care, not profit.

As with any business, an operating margin is essential just to supply the means to meet routine payroll costs on a timely basis. In health care, a margin is also needed to provide the opportunity to invest in innovative technologies for improvements in care quality and operational efficiencies. Additionally, investment capabilities are essential for health care providers to participate in potentially game-changing innovations such as Accountable Care Organizations.

To restore and preserve the Medicare home health services benefit, NAHC offers the following recommendations:

1. Congress should pass S.2137/H.R.5159, the Preserving Access to Home Health Act of 2023.
2. CMS should withdraw its proposal to reduce Medicare home health services payment rates by an additional 5.653% in 2024 and correct its 5.2% forecasting error on the rate of cost inflation.
3. Congress should mandate the development of a comprehensive analysis of the root causes of the ongoing deterioration of the home health services benefit and institute the corrective actions needed to restore and preserve the benefit consistent with the intentions of multiple Congresses since 1965.

Thank you for the opportunity to present this testimony. The National Association for Home Care & Hospice stands ready to work with the subcommittee to bring the full value of health care at home to the millions of Medicare beneficiaries that need this essential and cost-effective care.

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Respectfully submitted,

William A. Dombi

APPENDIX

TABLE 1

YEAR	Traditional Medicare Enrollees	USERS (1000s)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (1000s)	PAYMENTS PER PERSON	PAYMENTS PER EPISODE
1990	N/A	1967.1	36	N/A	$3,713,652	$1,892	N/A
1991	N/A	2242.9	45	N/A	5,369,051	2,397	N/A
1992	N/A	2506.2	53	N/A	7,396,822	2,955	N/A
1993	N/A	2874.1	57	N/A	9,726,444	3,389	N/A
1994	34,076	3179.2	66	N/A	12,660,526	3,987	N/A
1995	34,062	3469.4	72	N/A	15,391,094	4,441	N/A
1996	33,704	3599.7	74	N/A	16,756,767	4,660	N/A
1997	33,009	3557.5	73	N/A	16,718,263	4,704	N/A
1998	32,349	3061.6	51	31.6*	10,456,908	3,420	N/A
1999	32,179	2719.7	42	N/A	7,936,513	2,921	N/A
2000	32,740	2461.2	37	N/A	7,215,958	2.936	N/A
2001	33,860	2402.5	31	21.4*	8,513,702	3,545	N/A
2002	34,977	2544.4	31	20*	9,550,683	3,765	$2,329*
2003	35,815	2681.1	31	18.39**	10,069,628	3,770	N/A
2004	36,345	2835.6	31	18.0**	11,402,560	4,039	N/A
2005	36,685	2975.6	32	18.21**	12,779,158	4,314	$2,366*
2006	35,647	3026.2	34	18.45**	13,912,750	4,619	N/A
2007	35,490	3099.5	37	18.19**	15,565,441	5,046	$2,566*
2008	35,320	3171.6	38	19.1**	16,872,735	5,361	$2,705*
2009	35,360	3281.1	40	18.7**	18,733,108	5,747	N/A
2010	35,910	3434.4	37	18.0**	19,407,218	5,688	N/A
2011	36,458	3463.9	36	17.0**	18,362,264	5,357	$2,916*
2012	37,214	3459.6	34	17.0**	18,025,554	5,256	N/A
2013	37,613	3452.0	32	16.79	17,924,989	5,193	$2,687
2014	37,790	3417.2	32	16.66	17,736,862	5,190	2,703
2015	38,025	3454.4	32	16.60	18,203,863	5,280	2,762
2016	38,610	3451.5	31	16.63	18,117,018	5,249	2,780
2017	38,668	3392.9	31	16.60	17,830,844	5,255	2,823
2018	38,665	3365.9	31	16.67	17,934,054	5,328	2,876
2019	38,577	3281.4	31	16.57	17,850,864	5,440	2,952
2020***	37.776	3054.5	27.57	9.27	17,082,332	5,592	1881
2021***	36.356	3018.5	25.44	8.27	16.872,835	5.590	1.818

Sources: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cmsprogramstatistics ; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS

*Data from Medicare Payment Advisory Commission (MedPAC) various March Reports to Congress

** Data from CMS HHA cost reports

***The payment model shifted to a 30-day episode

TABLE 2

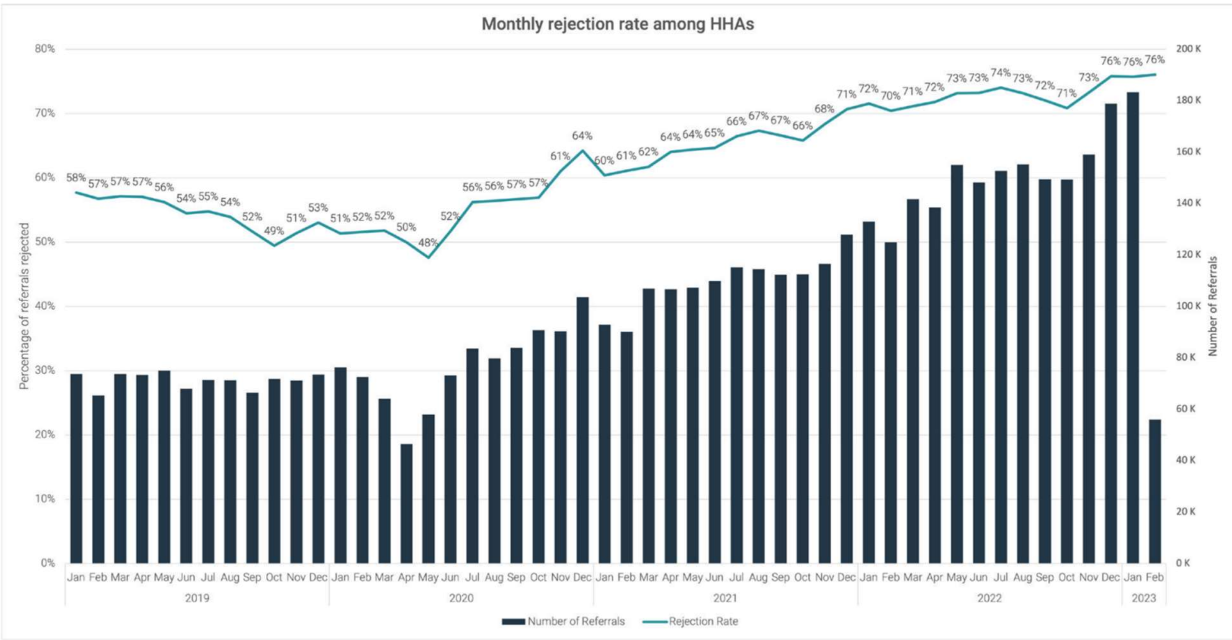
YEAR	MBI REDUCTION	PRODUCTIVITY ADJUSTMENT	BUDGET NEUTRALITY and CASE MIX WEIGHT ADJUSTMENT**	REBASING REDUCTION
FY2001			11.577%	
FY2002				
FY2003	1.1%		7%	
FY2004				
CY2005	0.8%			
CY2006	0.8%			
CY2007				
CY2008			2.75%	
CY2009			2.75%	
CY2010			2.75%	
CY2011	1.0%		3.79%	
CY2012	1.0%		3.79%	
CY2013	1.0%		1.32%	
CY2014				$80.65 (3.5%)
CY2015		0.5%		$80.65 (3.5%)
CY2016		0.4%	0.97%	$80.65 (3.5%)
CY2017		0.3%	0.97%	$80.65 (3.5%)
CY2018	2.0%		0.97%	
CY2019		0.8%	1.69%	
CY2020 PDGM begins			4.36%	
CY2021		0.3%		
CY2022		0.5%		
CY2023	5.2% forecast error	0.20%	3.925%	
CY2024 (Proposed)		0.30%	5.653%	
TOTAL REDUCTIONS*	12.9%	3.3%	54.265%	$322.60 (14.0%)

Sources: https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-prospective-payment-system-regulations-and-notices

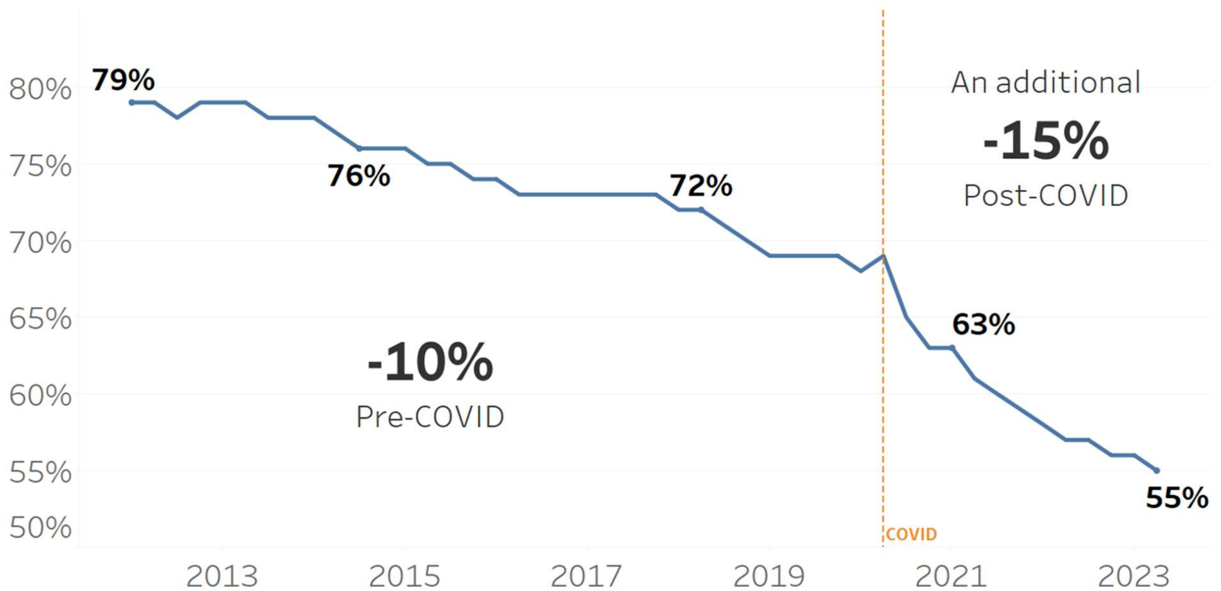
*This represents the sum of the cuts. However, the cumulative impact is much greater as each cut affects the base rate on a permanent basis.

** Reductions unrelated to adjustments made to achieve budget neutrality with case mix weight or wage index recalibrations

TABLE 3

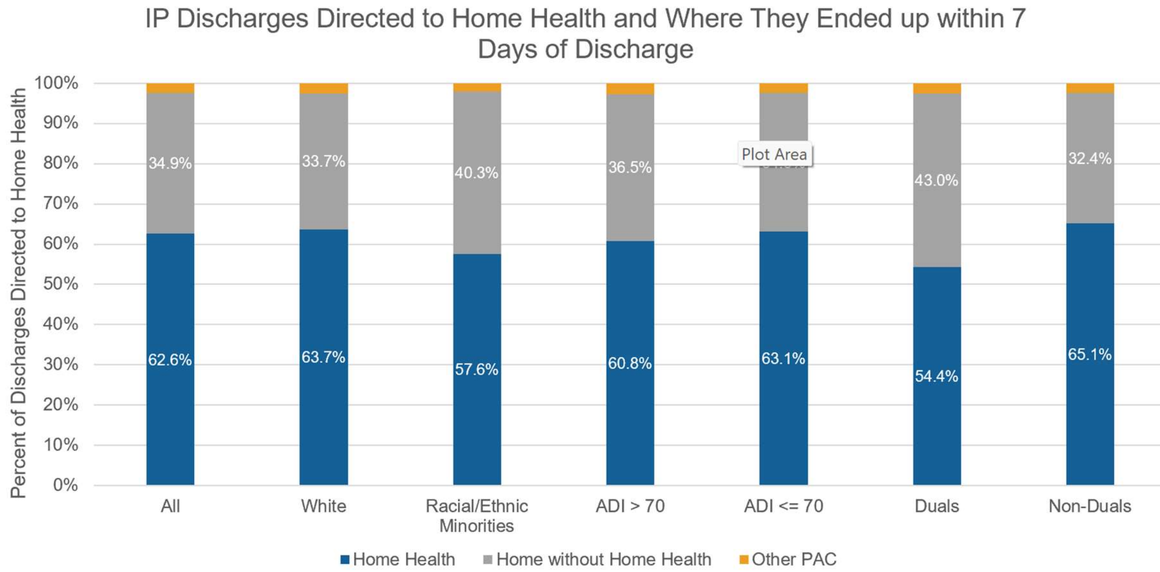


Source: July 25, 2023, WellSky Evolution of Care report, available at:
https://careporthealth.com/about/results/the-evolution-of-care-2023/



Source: HCHB data, as presented in HCHB comments on this Proposed Rule.

About 63% of beneficiaries directed to HHA are converted to HHA within 7 days of discharge. Racial/Ethnic minorities and Duals are less likely to convert



Source: CMS Virtual Research Data Center
Data: 2022 inpatient claim files filtered for STAC claims (see methodology slides for how each discharge location is coded and how conversions are calculated). Discharge data based on Q1-Q3 2022 data

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TABLE 4

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State	HHAs	Overall Financial Projected Status	Percentage
Alabama	84	Percent of margins below 0%	47.6%
Alaska	6	Percent of margins below 0%	50.0%
Arizona	91	Percent of margins below 0%	65.9%
Arkansas	53	Percent of margins below 0%	47.2%
California	774	Percent of margins below 0%	58.3%
Colorado	65	Percent of margins below 0%	61.5%
Connecticut	28	Percent of margins below 0%	53.6%
Delaware	7	Percent of margins below 0%	42.9%
District of Columbia	4	Percent of margins below 0%	0.0%
Florida	484	Percent of margins below 0%	57.0%
Georgia	58	Percent of margins below 0%	48.3%
Guam	2	Percent of margins below 0%	50.0%
Hawaii	6	Percent of margins below 0%	16.7%
Idaho	34	Percent of margins below 0%	55.9%
Illinois	265	Percent of margins below 0%	53.2%
Indiana	87	Percent of margins below 0%	54.0%
Iowa	28	Percent of margins below 0%	39.3%
Kansas	38	Percent of margins below 0%	50.0%
Kentucky	37	Percent of margins below 0%	32.4%
Louisiana	98	Percent of margins below 0%	49.0%
Maine	11	Percent of margins below 0%	63.6%
Maryland	19	Percent of margins below 0%	21.1%
Massachusetts	56	Percent of margins below 0%	42.9%
Michigan	178	Percent of margins below 0%	55.1%
Minnesota	25	Percent of margins below 0%	48.0%
Mississippi	24	Percent of margins below 0%	16.7%
Missouri	57	Percent of margins below 0%	70.2%
Montana	7	Percent of margins below 0%	42.9%
Nebraska	19	Percent of margins below 0%	52.6%
Nevada	84	Percent of margins below 0%	50.0%
New Hamphire	5	Percent of margins below 0%	60.0%
New Jersey	26	Percent of margins below 0%	38.5%
New Mexico	22	Percent of margins below 0%	63.6%
New York	54	Percent of margins below 0%	51.9%
North Carolina	63	Percent of margins below 0%	30.2%
North Dakota		Insufficient Data	
Ohio	156	Percent of margins below 0%	56.4%
Oklahoma	134	Percent of margins below 0%	41.8%
Oregon	22	Percent of margins below 0%	45.5%
Pennsylvania	115	Percent of margins below 0%	41.7%
Puerto Rico	18	Percent of margins below 0%	50.0%
Rhode Island	14	Percent of margins below 0%	64.3%
South Carolina	35	Percent of margins below 0%	60.0%
South Dakota	4	Percent of margins below 0%	50.0%
Tennessee	65	Percent of margins below 0%	49.2%
Texas	703	Percent of margins below 0%	51.9%
Utah	51	Percent of margins below 0%	51.0%
Vermont	3	Percent of margins below 0%	66.7%
Virgin Islands	2	Percent of margins below 0%	100.0%
Virginia	116	Percent of margins below 0%	54.3%
Washington	47	Percent of margins below 0%	46.8%
West Virginia	29	Percent of margins below 0%	62.1%
Wisconsin	32	Percent of margins below 0%	37.5%
Wyoming	11	Percent of margins below 0%	45.5%
National		**Percent of margins below 0%**	**52.70%**