United States Senate Committee on Finance, Subcommittee on Health Care

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

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Statement of David C. Grabowski, PhD
Professor, Department of Health Care Policy
Harvard Medical School, Boston, MA

Chairman Cardin, Ranking Member Daines, and distinguished members of the Subcommittee on Health: thank you for the opportunity to testify today on this important topic. I am a Professor of Health Care Policy at Harvard Medical School. I am here today speaking in my capacity as a researcher who has studied home health care for over two decades.

Care is shifting out of institutions and into the home. Several pre-pandemic policies[1,2] contributed to this change, but the pandemic further increased the delivery of care at home.[3] This shift to home-based care is consistent with the preferences of Medicare beneficiaries and their caregivers to "age in place."[4] From a policy perspective, a key objective is to provide individuals with the necessary services to not just age in place, but to age in place safely and successfully.

The Medicare home health benefit can potentially help beneficiaries to do this. As the Medicare Payment Advisory Commission (MedPAC) wrote in its March 2023 Report to the Congress, "home health care can be a high-value benefit when it is appropriately and efficiently delivered."[5] Three million fee-for-service Medicare beneficiaries used home health care from 11,474 agencies in 2021, accounting for 8.3 percent of all beneficiaries. The fee-for-service Medicare program spent $16.9 billion in 2021 on home health care services.

Overall, most Medicare beneficiaries live in an area served by home health care. According to the March 2023 MedPAC Report to the Congress, over 98 percent of fee-for-service Medicare beneficiaries live in a ZIP code served by at least one home health agency, while 87.6 percent live in a ZIP code with five or more agencies.[5] The MedPAC Report also found utilization of home health care was relatively comparable across rural and urban areas. However, a literature review of earlier peer-reviewed studies examining urban-rural home health access found that rural beneficiaries had significantly lower home health care utilization rates and physical therapy utilization rates.[6] Rural home health patients had 6% fewer home health rehabilitation visits after intensive-care unit stays, 11% lower physical therapy utilization after total knee arthroplasty, and 5.7% fewer visits from rehabilitation specialists.

Importantly, utilization of home health services does not necessarily equate directly to access. For example, just because a home health agency may see one patient in a ZIP code does not mean they regularly accept new patients or provide timely visits. Moreover, it is important to acknowledge a lag in the fee-for-service Medicare data, and the extenuating circumstances of the last several years with the pandemic and accompanying labor shortages.

My testimony focuses on how the Congress can address access to Medicare home health care services with the goal of increasing the number of beneficiaries who can age in place safely and successfully.

Medicare fee-for-service payments are adequate to ensure access: The 2023 MedPAC Report[5] to Congress found Medicare margins for freestanding HHAs reached an all-time high in 2021 of 24.9 percent.[i] From 2001 to 2019, Medicare margins for freestanding HHAs averaged 16.4 percent. In 2020, this increased to 20.2 percent. MedPAC has consistently recommended a reduction in the base payment rate for home health agencies, including a 7 percent reduction for calendar year 2024. In 2021, freestanding agencies serving rural areas had a higher Medicare margin (25.2 percent) relative to those serving urban areas (24.8 percent).

If the Congress is going to address rural access through payment, I would recommend they do so through a rural payment add-on[7] or some other targeted rural policy. They should not try to solve a potential rural access problem through an adjustment to the overall fee-for-service payment system, which is currently paying home health agencies well above costs.

Because the Medicare Patient Driven Groupings Model (PDGM) payment system was adopted at the start of the pandemic, it is not yet possible to determine whether and how the PDGM has impacted home health access*:* In January 2020, the method of Medicare fee-for-service payment for home health agencies shifted from one that paid agencies based on the delivery of therapy services to one that paid based on patient characteristics.[8] The new payment system, termed the Patient Driven Groupings Model (or PDGM), shifted the payment episode from 60-days to 30-days. Through 2021, home health agencies nationally are doing better financially during the pandemic and under the new PDGM payment system.[5] Once again, MedPAC reported higher Medicare margins in 2020 and 2021 relative to prior years.

One rationale for the new payment system was to limit the incentive to overprovide therapy. Because the PDGM model is based on patient characteristics, it should encourage greater home health care access for higher acuity patients. Under the prior system, the most lucrative patients were those who received the most therapy. Under the PDGM, the most lucrative patients are those with the greatest number of care needs. It will be important to examine whether the PDGM has changed the use of services and the mix of patients. Given the timing of the PDGM however, researchers have not yet been able to disentangle what changes are due to the PDGM and what is due to the pandemic.

Thus, I would caution the Congress about making major changes to the PDGM at this time. I believe it is too early to draw strong conclusions about how this policy has impacted access given it was introduced at the start of the pandemic.

Enrollees in Medicare Advantage plans use less home health care, often from lower-rated agencies. A growing share of home health patients are enrolled in Medicare Advantage plans. Beneficiaries in these plans use less home health, partly because of mechanisms like prior authorization and utilization management that are not allowed in fee-for-service Medicare.[9] The

[i] The Medicare home health margin is calculated by MedPAC using the following formula: (Medicare payments - Medicare allowable costs)/Medicare payments.

plans can also use networks to steer patients to certain home health agencies. Research has shown that enrollees in Medicare Advantage typically use lower star-rated agencies relative to their fee-for-service counterparts.[10] Medicare Advantage plans also pay home health agencies below the fee-for-service Medicare rate. When you factor in care from all payers (including Medicaid and other sources), the overall margin for HHAs was estimated at 11.9 percent in 2021, which is well below the Medicare margin of 24.9 percent.

An important question is the amount of unmet demand for home health services among Medicare Advantage enrollees in the context of prior authorization requirements and utilization management. Thus far, research has not found declines in claims-based outcomes like hospitalizations and mortality when the amount of home health is decreased.[11] However, these outcomes only tell a part of the story.

The Congress should request a comprehensive evaluation of home health care access for enrollees in Medicare Advantage plans.

Labor challenges are contributing to home health access issues: The pandemic has magnified home health labor challenges, especially in rural areas.[12,13] Using the 2021 Occupational Employment and Wage Statistics dataset, one study estimated that there are, on average, 32.9 home health aides per 1,000 older adults (age 65+) in rural areas and 50.4 home health aides per 1,000 older adults in urban areas.[14] In an analysis of the Medicaid home- and community-based services workforce through 2020, the number of workers per beneficiary has been declining over time.[15] We have seen similar shortages for workers in other post-acute and long-term care settings during the pandemic.[16,17]

The most direct policy to increase the size of the labor force is through wage increases. Once again, Medicare fee-for-service payment rates are well above costs such that most agencies should be able to pay home health care workers the prevailing wage rate.

If there are certain markets where this is not the case (e.g., rural markets with few available workers), Congress could consider targeted policies for home health agencies to use towards the higher cost of labor in these markets.

Another potential policy to ensure competitive home health wages and sufficient staffing involves increasing the accountability of home health agencies. Most home health agencies are for-profit owned, and multi-agency chains have expanded their ownership role in the home health sector over the past decade.[18] Moreover, we have seen increased common investor associations across hospitals and home health care in recent years too.[19] Similar to nursing homes and other post-acute providers, these agencies have become more complex in terms of their ownership. A key question is whether these complex entities are putting sufficient dollars back into direct patient care. In April 2023, CMS announced the release of public ownership information for home health care agencies.[20]

Continuing to publish financial and ownership data for home health agencies can help policymakers ensure that public payments are being used on staffing as intended.

Finally, it is important to note that many home health workers are immigrants.[21] In a recent study, we found increased immigration led to more nursing home workers and ultimately higher quality.[22] I would hypothesize similar relationships exist for home health care. Historically, federal policies on immigration visas have been used to grow the health care labor market.

The Congress could expand the home health care labor force by creating a new visa category for workers in home health care and other related jobs.

Data gaps prevent us from determining whether beneficiaries are accessing high-quality home health care: Unfortunately, we have a limited set of validated home health quality measures.[5] For this reason, MedPAC tends to rely on claims-based measures such as hospital readmissions in evaluating home health quality. Readmissions are an important measure, but they do not provide the full story. Home health agencies are mandated to collect detailed assessment data through the Outcome Assessment Information Set (or OASIS), but MedPAC and others have questioned the accuracy of the OASIS data because they are agency-reported and not subject to consistent audit or review. The OASIS could provide policymakers with important information on functional improvement and other key measures, but accuracy issues severely limit the usability of these data. It is troubling that agency-reported measures have been showing improvement over time, while claims-based measures have been stagnant or declining.[5]

The Congress should encourage the development of improved quality measures, including the increased auditing and oversight of the existing agency-reported OASIS data.

Medicare beneficiaries may not be able to access home health care due to additional caregiving needs: The home health care benefit typically consists of a mix of skilled nursing, therapy, and home health aide visits. Many individuals receiving care in the community also require extensive home care, which is assistance with their long-term care needs like bathing, dressing, and toileting. Because the Medicare home health care benefit does not include comprehensive home care, enrollees often must rely on family caregivers, paid help, or Medicaid for these needs. As such, there are disparities by race, ethnicity, and income as to who can age in place in a high-quality setting.[23] Not everyone has sufficient resources or familial support to access the Medicare home health care benefit.

Accessing home care can be challenging.[24] Family caregivers are often overburdened.[25,26] Medicaid has a waiting list for home care services in many states.[27] Private duty home care is expensive,[28] with many older adults caught in the "forgotten middle" of not being able to afford adequate care but also not qualifying for Medicaid based on the income and assets test.[29]

One important area that has been largely ignored is the issue of family caregiving in the context of home health care. On the one hand, home health care has been found to decrease family caregiving burden relative to the receipt of no home health care services.[30] However, home health care requires much greater family caregiving time compared to skilled nursing facility care.[31] In a study of individuals being discharged from a Boston-area hospital, we found living alone was a strong predictor of discharge to a skilled nursing facility, even after accounting for the health of the patient.[32] The Biden Administration recently announced a package of reforms to provide more support to family caregivers during the hospital discharge planning process.[33]

The Congress should continue to pursue policies to support family caregivers to ensure greater access to the home health care benefit.

For Medicare-Medicaid dually eligible beneficiaries, they can potentially qualify for home care services alongside Medicare home health care. Medicaid home- and community-based services (HCBS) have the potential to substitute for high-cost nursing home services and allow dually eligible beneficiaries to age in place.[34] Congress has enacted policies in the past including the increased federal match rate for Medicaid HCBS under the American Rescue Plan Act and the Affordable Care Act's Balancing Incentive Program.[35]

To encourage safe and successful aging in place, I would strongly recommend that the Congress continue to invest in policies to expand Medicaid HCBS.

Even in states that have invested in HCBS, Medicare and Medicaid services are often not well-integrated.[36] The 12.2 million dually eligible beneficiaries in the U.S. often face issues related to fragmented care and poor health outcomes associated with inadequate coordination of benefits and services across the two programs. There are currently three approaches in place to encourage care integration for dual beneficiaries: state Medicare–Medicaid plans (MMPs), the federal Program of All-Inclusive Care for the Elderly (PACE), and federal dual-eligible special-needs plans (D-SNPs). MMPs and PACE have strong models of care integration but relatively low enrollment. Capitated state MMPs cover slightly more than 400,000 dual eligibles, and PACE covers roughly 50,000 dual eligibles nationwide. In contrast, more than 4 million dual eligibles are enrolled in D-SNPs. However, these plans are highly variable in terms of their degree of integration across Medicare and Medicaid. Standard D-SNPs are poorly integrated while fully integrated dual-eligible plans (FIDE-SNPs) and highly integrated dual eligible plans (HIDE-SNPs) are better. Overall, only 10% of dually eligible beneficiaries are enrolled in strongly integrated care models (MMPs, PACE, or FIDE-SNPs), and integrated care is unavailable in many parts of the United States.

As I outlined in a recent piece in the New England Journal of Medicine,[36] I would strongly recommend the Congress undertake a series of activities to strengthen these Medicare-Medicaid integrated models including: 1) increased use of passive enrollment; 2) improved program alignment; 3) conversion of standard D-SNPs to FIDE-SNPs; 4) make investments in data and measures used to evaluate care of dual eligibles; and 5) begin to unify these disparate approaches to integrating care.

In summary, access to Medicare home health care is generally strong, but there are some steps the Congress can take to ensure this benefit is helping individuals to age in place safely and successfully. I look forward to working with the members of this Subcommittee on this effort. Thanks.

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