Center for Medicare Advocacy
Advancing Access to Medicare and Health Care

HEARING

AGING IN PLACE: THE VITAL ROLE OF HOME HEALTH AND ACCESS TO CARE

United States Senate Finance Committee
Subcommittee on Health Care

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TESTIMONY

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Good morning, Chairman Cardin, Ranking Member Daines, and distinguished members of the Committee. Thank you for inviting me to testify today. I am Judith Stein, founder and executive director of the Center for Medicare Advocacy (the Center). The Center is a national private, non-profit, non-partisan law organization based in Connecticut and Washington, D.C. with additional attorneys in Massachusetts and California.

The Center works to advance access to comprehensive Medicare coverage, quality health care, and health equity. We provide education and legal assistance to assist Medicare beneficiaries throughout the United States. We respond to over 7,000 calls and emails annually, host a website, educational programs, webinars, and a national convening of Medicare beneficiary stakeholders and policymakers, publish a weekly electronic newsletter, and pursue thousands of Medicare appeals. Our policy work is based on the real-life experiences of the beneficiaries and families we hear from every day.

Our health care system is in dire need of reform, including Medicare. We have many ideas about how to do so, as I'm sure my fellow panelists and members of this committee do. But, when it comes to the Medicare home health benefit, my basic message is very simple: **enforce the law that already exists**. Payment policies, oversight measures, audits, and quality measures must be geared to ensuring public Medicare funds are used to provide necessary home health care for <u>all</u> who qualify under the law. If the law was properly enforced, and the benefit administered as intended, there would be transformational change for so many people who could obtain the care they need to live well and safely at home.

Our Experience Assisting Medicare Beneficiaries in Need of Home Health Care

The Center for Medicare Advocacy hears from people from all over the country who are trying to obtain Medicare coverage for sufficient home health care to remain safely at home. In particular, people living with longer-term and debilitating conditions find themselves facing significant access problems. For example, patients have been told (incorrectly) that Medicare will only cover one to five hours per week of home health aide services, or only one bath per

week, or that they aren't homebound (because they roam outside due to dementia), or that their condition 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.

Here is the experience of an individual who contacted the Center for help in August 2023:

Ms. S is quadriplegic having suffered a spinal cord injury. She clearly qualifies for Medicare's home health benefit. In fact, unlike so many people who cannot even gain access to Medicare home care, she had been successfully living at home with traditional Medicare coverage for many years. (Nursing from a home health agency for catheter changes 2 times week, each preceded by a suppository, necessary to prevent severe, chronic Urinary Tract Infections. She also received 20 hours a week of personal hands-on home health aide care.) However, this summer, her home health agency completely stopped this care (although the agency <u>is</u> accepting new patients for home health aide services who private pay.) She manages to sponge bathe herself, but her lower body doesn't get cleaned.

In June, Ms. S called her home health agency to confirm she could visit her family for a brief period and still be considered homebound and not lose services. They said yes, that was OK. However, the day she returned, the agency called to tell her she'd been discharged from care. She was not given any other notice. She appealed the discharge. The agency refused to provide medical records or cooperate with the appeal. Kepro, the Medicare Quality Improvement Organization responsible for the appeal, agreed that Ms. S qualified for care and that the discharge was not appropriate. Nonetheless, the home care agency told Ms. S it made no difference what Kepro said, they would not recommence care. Kepro's medical leadership said this case was "appalling," adding:

> "Despite our communication with the home health agency regarding our concerns that this beneficiary's care has been improperly terminated, they refuse to provide services. I am escalating these concerns to CMS. Please let me know if there is anything else you think we can do on our end. This case is very concerning."

While Ms. S pursued efforts with Kepro, she also sought care from the twelve other Medicare-certified home health agencies in her geographic area. <u>None</u> of them would even agree to assess her for care. Thus, she began going to the hospital emergency room for catheter changes, but the hospital told her she can't continue to use the ER. Although she seems incredibly calm and resourceful, she has no idea who can provide her the necessary catheter changes and related care.

An attorney from my office contacted the home health agency on Ms. S's behalf. The agency has committed numerous violations of the Medicare Conditions of Participation: It did not obtain clearance from Ms. S's doctor to discharge her, it did not provide Ms. S with any notice regarding the discharge, it made no attempt to recertify her for care, and it made no effort to transfer her care to another provider. Ms. S is currently out of options.

While this may seem like an extreme example, it is not. Older and disabled Medicare beneficiaries are constantly denied adequate or all necessary home health care. It has become more the norm than the exception.

Medicare Home Health Coverage: Reality Conflicts with the Law

Medicare home health coverage can be an important resource for Medicare beneficiaries who need health care at home. When properly implemented, 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, or maintain, or slow decline of the individual's condition. Further, coverage is available even if the services are expected to continue over a long period of time.[1]

Unfortunately, however, people – like Ms. S. – who legally qualify for Medicare coverage have great difficulty obtaining and affording necessary home care. There are legal standards that define who can obtain coverage, and what services are available. However, the criteria are often narrowly construed and misrepresented by providers and policy-makers, 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 vulnerable people often need to remain safely at home.

Here is an example from the daughter of a Medicare beneficiary that typifies what we hear:

- "My dad is in the end stages of Parkinson's disease. He has been informed that he qualifies for Medicare home health coverage and that means 2 hours per week of Medicare-covered home health aides. We were told he could receive the daily aide care he needs if we can pay for it. However, the financial burden for paying for home health care is too much for us - and the average family. We were shocked to hear from home health agencies that Medicare only covers a few hours per week. We would like to see changes to allow more coverage for individuals living with a long term, progressive, terminal disease."

The harm to people in need of home care is compounded by the incorrect information constantly promulgated about Medicare coverage, namely that it is a short term, acute care benefit. This is incorrect. In fact, Medicare does cover far more than a few hours of home health aides per week – 28 to 35 hours per week combined with nursing under the law. But Medicare providers and contractors constantly tell people otherwise, maintaining incorrectly that the Medicare home care benefit is short term, for acute care, and that aides are only available a few hours per week. The law is clearly otherwise. For example, here some of what my organization's staff were told when we interviewed staff from 200 home agencies from 17 states in 2021:

- "A home health aide is a maximum of an hour visit twice a week. That's what Medicare allows." (Maryland)
- "The agency can provide one hour of aide per week. This is all Medicare covers." (Utah)
- "As long as I have been with this agency, we have provided no more than 1 or 2 aide visits a week. It doesn't matter if it was before or during COVID." (Michigan)
- "They can't cover a chronic condition under Medicare." (Massachusetts)

News from providers about Medicare Advantage home health coverage was only more dispiriting. When asked if there were differences in services they could provide to traditional Medicare vs. Medicare Advantage patients, agencies commented that, in their experience, Medicare Advantage plans provide less to patients and require more of agencies. Common

themes included, MA plans deny more, allow fewer visits, delay onset of care, require more changes to care plans, and there are major challenges from their Prior Authorization process. Comments included:

- "Abso-freakin-lutely! Medicare Advantage plans in our area are rotten." (Kansas)
- "Very much so, there's a difference. Medicare Advantage plans don't approve as much services." (Louisiana)
- "Medicare Advantage plans often fight tooth and nail on the number of visits they will allow. […] is the worst. They use […], a company for prior authorization work and allow very few visits." (Connecticut)

When we called the 1-800-MEDICARE help line we often received inaccurate information. We were told,

- "[Home health care]is not long-term care. There must be recovery to be covered."
- "Medicare only covers aides for bathing, showering, or grooming."

As geriatrician Dr. Laurie Archbald-Pannone states, "While family caregivers truly do selflessly give of themselves in the care of others, they need more than our recognition of their work. They need the Medicare system to provide appropriate resources for the care of their family members."[2] (Emphasis added.)

Medicare coverage does provide significant resources under the law. In practice it does not. This must change. People who are eligible for Medicare home health coverage are living and aging at home, but they are doing so unsafely, without the care they need and should be receiving under the Medicare home health benefit.

The Law: What Home Care Is Covered Under the Medicare Act?[3]

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, as discussed here, these problems are increasing. 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 longer-term, chronic, and debilitating conditions.

1. Medicare Home Health Qualifying Criteria

Medicare covers home health services under both Parts A and B when the services are medically "reasonable and necessary," and when:[4]

- A physician or other authorized practitioner has established a plan of care for furnishing the services that is periodically reviewed as required;
- 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 an assistive device, such as a wheelchair or walker. (Occasional "walks around the block" are allowable. Attendance at an adult day

care center, religious services, or a special occasion is also not a bar to meeting the homebound requirement.);

- The individual needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology (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.[5]

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:[6]

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical therapy, speech-language pathology, and occupational therapy;
- Part-time or intermittent services of a home health aide;
- Medical social services; and
- 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.[7] A patient must initially require and receive one of these skilled services in order to receive Medicare for other covered home health services.[8] Home health aide, medical social worker, and occupational therapy services[9] are defined as "dependent services," (*dependent* upon a skilled service being in place) as are certain medical supplies.[10] While occupational therapy is not considered a skilled service to begin 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.[11]

The term "part-time or intermittent" means skilled nursing and home health aide services furnished any number of days per week as long as they are provided less than 8 combined hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).[12]

3. Medicare Home Health Coverage Can be Long Term

Importantly, and contrary to what is often stated, Medicare home health coverage is not just a short-term, acute care benefit.[13] Indeed, 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.[14] In addition, 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 beyond 100 visits if a beneficiary was not enrolled in Part B.[15]

There is No Duration of Time Limit for Medicare Home Health Coverage

So long as the law's qualifying criteria are met, coverage can continue for an unlimited number of visits. "to the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries … for an unlimited number of covered visits."

(42 CFR §§409.48(a)-(b); Medicare Benefit Policy Manual, Chapter 7, §70.1)

The Reality: Access to Medicare Coverage and Home Care 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. As similarly reported in *Health Affairs* in November 2019**:**

> When asked how much costs had burdened their family, 25 percent of the seriously ill said that costs were a major burden, and 30 percent said that they were a minor burden… When asked about getting help in recent years, 60 percent said that family members and friends helped a lot, 25 percent said that they helped a little, and 14 percent said that they provided no help. Family members and friends experienced considerable strain as a consequence of providing help, including financial problems, lowered income, and lost or changed jobs or reduced hours. Twenty-nine percent of respondents said that there was a time when they did not get outside help because of cost.[16]

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

Help with personal hands-on care is key to the well-being of patients, as well as their families and caregivers. Unfortunately, access to Medicare coverage for such care has declined. This is true even when individuals have an order and meet the law's homebound and skilled care requirements – and thus qualify for coverage. Unfortunately, Medicare beneficiaries are often misinformed. They are told they can only get home health aide services 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.

As noted above, 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.[17] 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.[18] In the past, this level of home health aide coverage was actually available. Indeed, the Center for Medicare Advocacy has helped many clients remain at home because these services were in place.

Currently, however, this level of coverage and care is almost never obtainable. Data demonstrate this dramatic change in coverage. Home health aide utilization has declined steadily over the past two decades by almost 94% - from a 30-day average of 6.7 visits in 1998[19] to less than half a visit a month in 2022.[20] As a percent of total visits from 1997 to 2021, home health aides declined from 48% of total services to 5%.[21]

The real, personal impact of this reduced access to home health aides was highlighted in a 2019 *Kaiser Health News* article.[22] The article includes stark findings about the unmet needs of vulnerable Americans struggling to live at home with little or no help. For example:

- "About 25 million Americans who are aging in place rely on help from other people and devices such as canes, raised toilets or shower seats to perform essential daily activities, according to a new study documenting how older adults adapt to their changing physical abilities."
- "Nearly 60 percent of seniors with seriously compromised mobility reported staying inside their homes or apartments instead of getting out of the house. Twenty-five percent said they often remained in bed. Of older adults who had significant difficulty putting on a shirt or pulling on undergarments or pants, 20 percent went without getting dressed. Of those who required assistance with toileting issues, 27.9 percent had an accident or soiled themselves."
- "60 percent of the seniors surveyed used at least one device, most commonly for bathing, toileting and moving around. (Twenty percent used two or more devices and 13 percent also received personal assistance.)" and
- "Five percent had difficulty with daily tasks but didn't have help and hadn't made other adjustments yet."

The Medicare home health benefit is misunderstood, inaccurately articulated, and narrowly 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 skilled 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.

As Dr. Archbald-Pannone notes,

> "As a geriatrician, every week I see patients who are fortunate enough to have family who are able to provide medical care and support. However, I also see more patients who do not have family available to provide full care, are in desperate need of more home care

> support, but cannot afford the price tag … Without in-home care, we're leaving our family members alone and at risk. ... We may not be available to stay home with them, but Medicare should support trained care aides who can be."[23]

When Medicare doesn't cover in-home care, patients and families often must go without. Those who can afford to, pay out-of-pocket, from savings or with credit cards. Others, who are, or become, poor (often due to health care costs) look to their state's low-income Medicaid program for help. Thus, costs are regularly shifted to people in need and, their families, and for those who are dually eligible for Medicaid as well as Medicare, to state Medicaid programs. The needs and costs of caring for people who are dually eligible are substantial:

> In 2019, there were 12.3 million individuals simultaneously enrolled in Medicare and Medicaid. These dually eligible individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors. Twenty-seven percent of dually eligible individuals enrolled in Medicare Fee-for-Service have six or more chronic conditions, compared to 15 percent of beneficiaries with Medicare only.[24]

In summary, as the authors in the November 2019 *Health Affairs* article concluded, "Medicare insurance is broadly popular, but seriously ill beneficiaries who most need financial protection report widespread problems affording care and financial instability."[25]

The harm to Medicare beneficiaries and their families would be greatly reduced if home health aide coverage was provided as intended by law. As it is, access to help with personal care and activities of daily living is minimal.[26]

B. Medicare's Home Health Payment System Influences Access to Care

On January 1, 2020, CMS implemented a new Medicare payment system for home health services called the "Patient Driven Groupings Model" (PDGM). PDGM changed home health agencies' financial incentives and disincentives to admit or continue care for Medicare beneficiaries.[27] Unfortunately, the financial motivations are often harmful to vulnerable beneficiaries, particularly those with chronic conditions and longer-term health care needs. Although CMS has stated that "PGDM relies more heavily on clinical characteristics,"[28] such as functional levels and co-morbidities, the most significant components of PDGM consider admission source and timing, not patient needs.

PDGM's financial incentives include higher rates for the first 30 days of home care. Payments are also 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 hospitalized patients in "Observation Status," as well as patients who start care from home, without a prior hospital or SNF stay.) The new payment model also reduced the billing period from 60 days to 30 days, encouraging shorter periods of care. Additionally, PDGM lowered the financial incentive to provide physical, occupational or speech language pathology therapy by removing therapy service utilization payment thresholds.

The current Medicare home health payment system and shift in financial incentives have reduced access to necessary care.[29] *Home Health Care News* reports 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..."[30] Reductions in skilled therapy not only harm the individual who needs that care; they can also end access to home health aides, because aide coverage is dependent on the individual's also receiving skilled therapy or nursing.

In response to misinformation and service changes in light of PDGM, CMS released a special edition *Medicare Learning Network (MLN) Matters* article on February 10, 2020.[31] The MLN made clear that, while the reimbursement system had changed, Medicare coverage law and rules had not:

- Home health services can continue as long as individuals meet the Medicare coverage criteria; and Medicare home health coverage and service rules have not changed;
- Beneficiaries can receive home health services to improve their condition, and to maintain their current condition, or to slow or prevent further decline.[27]

Since the PDGM bundled payment model, access to all home health care has diminished, particularly for longer-term patients. Access to home health aides and therapy have also decreased. The Medicare payment system must be revised to ensure it creates proper, fiscally sound incentives so that Medicare-certified home health agencies actually provide all legally authorized, necessary home care included in the benefit. Medicare Advantage plans must be required to do nothing less.

Conclusion

All too often, older adults and people with disabilities are unfairly denied access to necessary, Medicare-covered home health care. As a result, they and their families suffer. The Center for Medicare Advocacy urges Congress, CMS, and CMS contractors to ensure that Medicare beneficiaries obtain the Medicare home health coverage and necessary services they qualify for under the law. Payment policies, oversight measures, audits, and quality measures must be geared to ensuring public Medicare funds are used to provide necessary home health care for all who qualify under the law. **Congress must insist the law that already exists is properly implemented and fully enforced.**

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[1] 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.

[2] *The Hill*, "Family Caregivers Need Support, Medicare Should Cover In-Home Aides" by Laurie Archbald-Pannone, MD (November 15, 2019), available at: https://thehill.com/opinion/healthcare/470677-family-caregivers-need-support-medicare-should-cover-in-home-care-aides.

[3] For a fuller discussion of Medicare home health coverage, *see*, Chiplin Jr., Alfred, Stein, Judith, *Medicare Handbook*, Chapter 4, Home Health Coverage, (Wolters Kluwer, 2020; updated annually).

[4] 42 U.S.C. §1395f(a)(2)(C); 42 C.F.R. §§409.42 et seq.

[5] 42 U.S.C. §1395x(m).

[6] 42 U.S.C. §1395x(m)(1)–(4).

[7] 42 C.F.R. §409.42.

[8] 42 C.F.R. §409.44.

[9] 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.
[10] 42 C.F.R. §409.45.
[11] 42 C.F.R. §409.42(c)(4); Medicare Beneficiary Policy Manual, Ch. 7, §30.4.
[12] 42 U.S.C. § 1361(m)
[13] 42 C.F.R §§409.48(a)-(b); Medicare Beneficiary Policy Manual, Ch. 7, §§40,1.1 and 70.1.
[14] 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.
[15] Congressional Research Service Report, (2014) "Medicare Home Health Benefit Primer: Benefit Basics and Issues" Congressional Research Service, R42998.
[16] *Health Affairs*, "Financial Hardships of Medicare Beneficiaries With Serious Illness" by Kyle, Blendon, et al, Vol. 38, No. 11, pp. 1801-1806 (November 2019). Note: The authors define "serious illness" as individuals "reported having a serious illness or condition that, over the past three years, had required two or more hospital stays and visits to three or more physicians." p. 1802
[17] 42 U.S.C. §1395x(m)(1)-(4). Note, receipt of skilled therapy can also trigger coverage for home health aides.
[18] 42 CFR §409.45(b)(1)(i)-(v). See also, Medicare Benefits Policy Manual, Chapter 7, §§50.1 and 50.2.
[19] Medicare Payment Advisory Commission (MedPAC), "Report to Congress: Medicare Payment Policy" (March 2021), Ch. 8, page 236: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch8_sec.pdf.
[20] Centers for Medicare & Medicaid Services (CMS), Proposed Home Health Rule (CMS-1780-P), 88 Fed Reg 43654 (July 10, 2023), at pp. 43663, 43671.
[21] Medicare Payment Advisory Commission (MedPAC), "Report to Congress: Medicare Payment Policy" (March 2023), Ch. 8, p. 250, available at: https://www.medpac.gov/wp-content/uploads/2023/03/Ch8_Mar23_MedPAC_Report_To_Congress_SEC.pdf; Medicare Payment Advisory Commission (MedPAC), "Report to Congress: Medicare Payment Policy" (March 2019), Ch. 9, pp. 234-235, available at: http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec_rev.pdf?sfvrsn=0.
[22] *Kaiser Health News*, "Seniors Aging In Place Turn To Devices And Helpers, But Unmet Needs Are Common" by Judith Graham (February 14, 2019), available at: https://khn.org/news/seniors-aging-in-place-turn-to-devices-and-helpers-but-unmet-needs-are-common/. See also, *Kaiser Health News*, "Home Care Agencies Often Wrongly Deny Medicare to Chronically Ill," Susan Jaffe (1/18/2018), https://khn.org/news/home-care-agencies-often-wrongly-deny-medicare-help-to-the-chronically-ill/.
[23] *The Hill*, "Family Caregivers Need Support, Medicare Should Cover In-Home Aides" by Laurie Archbald-Pannone, MD (November 15, 2019), available at: https://thehill.com/opinion/healthcare/470677-family-caregivers-need-support-medicare-should-cover-in-home-care-aides.
[24] Centers for Medicare & Medicaid Services (CMS), Medicare-Medicaid Coordination Office, Fact Sheet: "People Dually Eligible for Medicare and Medicaid" (March 2023), available at: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/mmco_factsheet.pdf.
[25] *Health Affairs*, "Financial Hardships of Medicare Beneficiaries With Serious Illness" by Kyle, Blendon, et al, Vol. 38, No. 11, pp. 1801-1806 (November 2019).
[26] *See also*, Johns Hopkins University Bloomberg School of Public Health study that also finds people with limitations in activities of daily living (ADLs) experience significant harm when they cannot access adequate help with ADLs at home. "Medicare Spending and the Adequacy of Support with Daily Activities in Community-Living Older Adults with Disability" by Jennifer L. Wolff, Lauren H. Nicholas, Amber Willink, John Mulcahy, Karen Davis and Judith D. Kasper, Commonwealth Fund and National Institutes on Aging (May 2019), as reported by American Association for the Advancement of Science (AAAS) EurekAlert website at: https://www.eurekalert.org/pub_releases/2019-05/jhub-msh_1052819.php.
[27] *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/.
[28] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.

[29] https://www.cms.gov/medicare/quality/home-health; .
The Medicare payment structure creates incentives for home health agencies to provide care for beneficiaries with shorter-term, post-acute care conditions. Further, CMS policies and practices create barriers to Medicare-covered home care for people with longer-term and chronic conditions.
These barriers and incentives include:

- Inaccurate and/or incomplete training for entities that make Medicare coverage determinations;
- Home Health Quality Reporting Program (HHQRP);
- Home Health Value Based Purchasing (HHVBP) Models;
- Office of Inspector General, Medicare Contractor, and other audits of Home Health Agencies pointing to so-called "overutilization".

[30] *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/.

[31] CMS, MLN Matters article "The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)", Number: SE20005 (Feb. 10, 2020), available at: https://www.cms.gov/files/document/se20005.pdf. "… [E]ligibility criteria and coverage for Medicare home health services remain unchanged. … 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. … Citing to the *Jimmo v. Sebelius* Settlement Agreement, the MLN also states "there is no improvement standard under the Medicare home health benefit and therapy services can be provided for restorative or maintenance purposes." (Emphasis added.)"

APPENDIX

As the Center for Medicare Advocacy has long asserted, when properly implemented, the Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services. People with Medicare, however, have had growing difficulty obtaining and affording necessary home care, particularly home health aide services.

The following is a sample of some of the Center for Medicare Advocacy's writings on these issues over the last several years:

- CMA Comments to CMS' 2024 Notice of Proposed Rule Making (NPRM) for Home Health Care (August 2023): https://medicareadvocacy.org/wp-content/uploads/2023/08/Home-Health-Aides-2024-NPRM-RFI-Response.pdf
- CMA Comments to CMS CY 2023 Proposed Home Health Rule (August 2022): https://medicareadvocacy.org/home-health-comments-2023/
- ***Bipartisan Policy Center*** (BPC) Paper "Optimizing the Medicare Home Health Benefit to Improve Outcomes and Reduce Disparities" (including Appendix authored by CMA)(April 2022): https://bipartisanpolicy.org/wp-content/uploads/2022/04/Optimizing-the-Medicare-Home-Health_R0_Web-Ready.pdf
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- *Also, see, generally, CMA website at*: https://medicareadvocacy.org/medicare-info/home-health-care/