

Home Health Issue Brief

Since 2017 the Center for Medicare Advocacy has been writing and disseminating a ten-part *Home Health Issue Brief Series* examining the growing crisis in access to Medicare-covered home health care, and outlining the Center's work to address the issue. This *Home Health Issue Brief* includes all ten prior *Briefs* in one document. We hope this complete *Brief* will help advocates and policy-makers access the relevant, often unknown, Medicare law, and related resource material, and assist them in efforts to resist inappropriate barriers to covered care.

We invite you to send comments about the [issues raised here](#) and submit Medicare home health stories to the Center at <http://www.medicareadvocacy.org/submit-your-home-health-access-story/>.

CMA Issue Brief Series: Medicare Home Health Care Crisis

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1. An Overview: The Crisis In Medicare Home Health Coverage and Access to Care

Medicare beneficiaries with long-term and debilitating conditions are often unable to access Medicare-covered home health services for which they are eligible under the law. For too many people this means not being able to remain at home, doing so at the risk of their health and well-being, or being forced to move to an institution.

How Do Home Health Agencies Factor into the Crisis?

Home health agencies are discouraged by the Medicare payment system, quality reporting measures, and overzealous fraud investigations from providing care to people who need more services for longer periods of time and whose underlying conditions will not improve. As a result, most Medicare-certified home health agencies will not provide care, or will provide only minimal care, to these particularly vulnerable individuals. For example:

A Medicare beneficiary with Multiple Sclerosis has an order from her doctor for Medicare-covered home health care. She contacts all Medicare certified home health agencies that serve her home region. She is told by each agency that they do not have the resources to serve her. Some agencies say they have the ability to offer her a drastically reduced amount of services, before they even assess her needs. She is left to accept what little services are offered to her by a limited number of agencies.

What is Causing the Crisis?

Home health agencies are extremely reluctant to serve people who have long term and debilitating conditions due to various disincentives, including Medicare payment and quality measures and fear of triggering fraud investigations. In fact, recent Medicare payment and quality regulations and policies discourage home health agencies from serving individuals with long-term and debilitating conditions – contrary to Medicare *coverage* law. For example:

1. CMS refers to the Medicare home health benefit as an acute, short-term benefit. Although there is no legal duration of time limit for those who meet coverage criteria.
2. Medicare's Conditions of Participation do not require, or even encourage, home health agencies to actually care for Medicare beneficiaries.
3. Medicare's Conditions of Participation do not protect Medicare beneficiaries from arbitrary discharge by a home health agency.
4. The Prospective Payment System (PPS), which pays home health agencies to provide services to Medicare patients, was intended to pay for all types of beneficiaries' home health care needs. But, agencies find it more lucrative to only serve those with short-term, acute care needs.
5. Relatively recent Home Health Value Based Purchasing (HHVBP) regulations provide payment incentives based on quality measures that require beneficiaries' conditions to improve. Improvement means greater pay. Lack of improvement means a reduction in payment.
6. The CMS Star rating system, developed to promote "quality" home health agencies, is predicated upon improvement in a beneficiary's condition. If a beneficiary does not improve, and many patients with long-term and debilitating conditions will not, the quality rating of the agency will decline.

What Should Be Done to Alleviate the Crisis?

1. All CMS and Social Security Administration home health materials should be reviewed and updated to accurately reflect Medicare coverage law. (See attached re concerns about the March 2017 Medicare Home Health Booklet.)
2. Medicare's home health Conditions of Participation must be changed to protect access to home health coverage for all Medicare's beneficiaries.

3. The Conditions of Participation must require Medicare-certified agencies to serve all Medicare patients and to discharge Medicare patients only for specified reasons.
4. Medicare-certified agencies must be required to have adequate staffing to provide all Medicare covered services
5. Medicare's payment systems and quality incentive programs must not discriminate against patients who will not improve, but who require Medicare-covered home care to maintain their conditions or slow decline.
6. Medicare's fraud investigations must not be based on the duration of home health coverage when services are reasonable and necessary. Further, CMS ought to investigate home health agencies that under serve Medicare patients.

Change is Needed

People who advocate and care for Medicare beneficiaries can join with the Center for Medicare Advocacy to help correct this crisis. Go to MedicareAdvocacy.org for more information. Tell your story at <http://www.medicareadvocacy.org/submit-your-home-health-access-story/>

2. Brief Description of Medicare Home Health Coverage Under the Medicare Act

Medicare coverage for home health care is available to people who have a normal inability to leave home (aka “homebound”) and require skilled nursing and/or therapies. Six disciplines are coverable (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Language Pathology, Home Health Aide and Medical Social Services). Legally, there are no limitations to the duration or amount of covered services, except that skilled nursing and home health aide services are generally limited to a combined 35 hours per week. The beneficiary must meet certain qualifying criteria to obtain these benefits. Qualifying criteria will be discussed in Part Three of this *CMA Issue Brief Series*.

Medicare home health coverage is often misunderstood and misstated. Thus, we are providing key provisions of the relevant law, regulations and policies to inform home health advocacy and decision-making.

Medicare Home Health Care – Law and Citations

- **Necessary and reasonable care can be covered so long as coverage criteria are met:** Benefits can continue with no duration of time limit so long as Medicare coverage criteria are met.
42 USC §1861(m); 42 CFR §409.48(a) and (b)
Medicare Benefit Policy Manual (MBPM), Chapter 7, §70.1
- **Plan of care requirements must be followed:** The home health agency must be acting upon a plan of care, and a physician certification or recertification, for home health services to be covered. The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services. If a range of visits is ordered, the upper limit of the range is considered the specific frequency. Any changes in the plan of care must be signed and dated by a physician.
42 CFR §409.43(b)
MBPM, Chapter 7, §30.2.1, §30.2.2, §30.2.4(B)
- **Intermittent Skilled Nursing:** Nursing that is provided less than daily (seven days per week) or daily, for up to eight hours per day, for periods of 21 days or less (with extensions possible in exceptional circumstances, when the continued need for daily care will end in a predictable period of time.) Nursing and Home Health Aide services combined can be covered up to 28-35 hours per week.
42 USC §1395x(m), 42 USC §1395f(a)(2), 42 USC §1395n(a)(2)(A)
42 CFR §409.42(c)(1)
MBPM, Chapter 7, §40 to §40.1.3
Skilled nursing **includes care to maintain an individual’s condition or slow decline.** MBPM, Chapter 7, §20.1.2, §40.1, §40.1.1
- **Part-Time Skilled Nursing:** Nursing that is provided less than daily (seven days per week) and less than 8 hours per day. (Nursing can be covered up to 28-35 hours per week combined with Home Health Aide services.)
42 USC §1395x(m), 42 USC §1395f(a)(2), 42 USC §1395n(a)(2)(A)
42 CFR §409.42(c)(1)
MBPM, Chapter 7, §40 to §40.3, §50.1, §50.7

This includes skilled nursing to maintain an individual’s condition or slow decline. MBPM, Chapter 7, §20.1.2, §40.1, §40.1.1
- **Home Health Aides: Personal care services for less than eight hours each day and less than seven days per week (up to 28-35 hours combined with Skilled Nursing services)**

42 USC §1395x(m); 42 CFR §409.45(b)
MBPM, Chapter 7, §50.1, §50.2

- **Physical Therapy (PT):** Skilled therapy by or under supervision of a skilled physical therapist
42 USC §1395x(m); 42 CFR §409.42(c)(2)
MBPM, Chapter 7, §40.2 to §40.2.2, §50.1
This includes therapy to maintain an individual's function or slow decline.
MBPM, Chapter 7, §40.2 to §40.2.2E

- **Speech Language Pathology (SLP)** (Also referred to as Speech Therapy (ST)): Skilled SLP by or under supervision of a skilled speech language pathologist.
42 USC §1395x(m); 42 CFR §409.42 (c)(4)
MBPM, Chapter 7, §40.2, §40.2.1, §40.2.3, §50.1

This includes services to maintain an individual's condition or slow decline.
MBPM, Chapter 7, §40.2, §40.2.1, §40.2.1(d)(2) and (3)

- **Occupational Therapy (OT):** Skilled OT by or under supervision of a skilled occupational therapist.
42 USC §1395x(m); 42 CFR §409.42(c)(4) and §409.45(d)
MBPM, Chapter 7, §40.2, §40.2.1, §40.2.4 to 40.2.4.2, §50.1

This includes therapy to maintain an individual's condition or slow decline
MBPM, Chapter 7, §40.2, §40.2.1, §40.2.1(d)(2) and (3)

- **Medical Social Services:** To resolve possible social/emotional impediments to effective treatment or rate of recovery.
42 USC §1395x(m); 42 CFR §409.45(c) MBPM, Chapter 7, §50.3
- **Medical Supplies:** Items that are essential to enable home health agency personnel to effectively carry out ordered care.
42 USC §1395x(m); 42 CFR §409.45(f)
MBPM, Chapter 7, §50.4.1, §50.4.1.1, §50.4.1.2, §50.4.1.3
- **Durable Medical Equipment (DME):** As in other situations, DME furnished by a home health agency is subject to a 20% coinsurance.
42 USC §1395x(m); 42 CFR §409.45(e)
MBPM, Chapter 7, §50.4.2
- **Services Included in the Physician's Plan of Care But Not Available from the Home Health Agency:** Home health agencies that are not able to provide all the Medicare-coverable care included in the patient's Plan of Care, are required to make arrangements with other providers to provide the care.
MBPM, Chapter 7, §10.11, §40

- **Improvement is Not Required to Qualify for Coverage**

“Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain the patient's condition, or to prevent or slow deterioration of the patient's condition.
MBPM, Chapter 7, §20.1.2

“Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided...”

MBPM, Chapter 7, §40.1.1

See, *Jimmo v. Sebelius*, No. 11-cv-17 (D. VT., 2013, 2016).

- **Comply with the Medicare Conditions of Participation or be subject to sanctions or termination from Medicare:** The Centers for Medicare & Medicaid Services (CMS) may sanction or terminate a HHA when a survey reveals that the HHA has been noncompliant with one or more Conditions of Participation.

42 USC §1395bbb(e); 42 CFR §488.810(b)

(Note: Surveys are to be conducted periodically, following changes in HHA information, or when a significant number of complaints against an HHA are reported to CMS, the State, or any other appropriate federal, state, or local agency.

42 USC §1395bbb(c)(2)(A) and (B); 42 CFR §488.730)

- **Administer drugs and treatments only as the physician has ordered.**
42 CFR §484.18(c)
- **Not discriminate against an individual due to his/her Medicare status.**
42 CFR §489.53(a)(2)

Individuals who meet Medicare Home Health Criteria Have a Right To:

- **Be fully informed of care and treatment:** Individuals have the right to be fully informed in advance of care and treatment, changes to care and treatment, and to participate in planning or changes of care and treatment.
42 USC §1395bbb(a)(1)(A); 42 CFR §484.10(c)
- **Be fully informed of Medicare coverage and payment:** Individuals have the right to be fully informed of items and services furnished under Medicare and of the coverage for such items and services.
42 USC §1395bbb(a)(1)(E); 42 CFR §484.10(e)
- **Voice grievances against the home health agency (HHA) regarding treatment or care:** Individuals may voice grievances for treatment or care that is (or fails to be) furnished. 42 USC §1395bbb(a)(1)(B); 42 CFR §484.10(b)(4)

Conclusion

The Medicare home health benefit is often misunderstood and misrepresented, including by the Centers for Medicare & Medicaid Services (CMS) and home health care providers. This misinformation exacerbates the crisis in access to coverage. Beneficiaries and their advocates should know what is actually available under the Medicare law in order to fully advocate for themselves and others.

Future topics in this *CMA Issue Brief Series* will examine how misinformation is one of the key reasons beneficiaries are losing access to their lawful benefits, and to necessary care.

3. Medicare Home Health Coverage Should Be Based on the Need for Skilled Care – Improvement Is Not Required

Medicare recognizes the need for skilled care and related services for chronic and long-term conditions to maintain an individual's condition. For home care to be covered, the beneficiary must meet the basic qualifying criteria and require skilled services, which may be designed to:

- Maintain the status of an individual's condition; *or*
- Slow or prevent the deterioration of a condition; *or*
- Improve the individual's condition

Skilled care is care which must be provided by, or under the supervision of, a qualified professional to be safe and effective. (Qualified professional includes nurses, physical or occupational therapists or speech language pathologists.)

The Law

By law, Medicare decisions should be based on whether the patient needs skilled care, whether to maintain or improve the individual's condition, and meets the other qualifying criteria for home health coverage. For example, the beneficiary must be confined to home – often known as “homebound” – and have a doctor's Plan of Care for home care, to be provided by a Medicare-certified home health agency.

- **Note:** “Homebound” does **not** mean bedbound, or that one can never leave home. Rather, it means the individual has a normal inability to leave home, or cannot leave without a taxing effort or assistance, or leaving alone is contra-indicated (for example, the individual has dementia). Individuals can leave home for medical appointments, religious services, adult day care, and occasional outings and still meet the homebound definition.

Medicare should be equally available whether the skilled care is to maintain or to improve the patient's underlying condition. Long-standing federal regulation included this coverage rule, but it was undercut by unfair denials and policies for decades. Only recently, as result of the Center for Medicare Advocacy's [Jimmo v. Sebelius](#) lawsuit, has CMS acknowledged, and started to educate Medicare stakeholders, that “improvement” is not necessary for Medicare coverage.

“Restoration potential is not the deciding factor in determining whether skilled care is required. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.”

- 42 C.F.R. § 409.32(c)

The settlement reached in *Jimmo v. Sebelius* resulted in CMS revising its Medicare policy manuals to properly reflect the law. New language was added to the Medicare home health manual to clarify that skilled maintenance nursing and therapies are covered, including the following:

“... Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presences or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.”

- Medicare Benefit Policy Manual (MBPM), Chapter 7, 20.1.2 (Home Health)

“... Skilled Nursing services are covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. ...”

- Medicare Beneficiary Policy Manual (MBPM), Ch. 7, 40.1.1

“Maintenance Therapy - Where services that are required to maintain the patient’s current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedure safely and effectively, the services would be covered physical therapy services. ...”

- Medicare Beneficiary Policy Manual (MBPM,) Ch. 7, 40.2.2.E

Emphasis added

Conclusion

In summary, Medicare should never use “rules of thumb” such as an illegal Improvement Standard to deny coverage. Rather, “[a] determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.” 42 CFR §409.44(b)(3)(iii)

Medicare, including Medicare Advantage plans, should look at the individual's total, overall condition as set forth in the medical record to determine if skilled care is needed and coverage standards are met. Medicare coverage should not be denied simply because an individual's condition is chronic or expected to last a long time. "Restoration potential" is not necessary – skilled care to maintain an individual's condition **can** be ordered.

Regrettably, we know people with long-term conditions still face unfair barriers to Medicare and necessary home care. If coverage appears to be denied because an individual’s condition is long-standing and skilled care is needed to maintain function or slow decline, contact the Center for Medicare Advocacy at improvement@MedicareAdvocacy.org.

4. Misleading and Inaccurate CMS Medicare Home Health Publications

Summary: Medicare home health coverage law is clear.¹ While the application of individual case facts to law is always open to interpretation, Medicare home health coverage law is not overly complicated. But the Centers for Medicare & Medicaid Services (CMS), the agency responsible for administering Medicare, continues to publish and communicate misleading and inaccurate statements about Medicare home health coverage. In turn, these actions by CMS perpetuate misinformation and confusion about home health coverage laws with the following:

- Medicare contractors who are responsible for payment of Medicare claims;
- Medicare certified home health agencies that deliver home health care services; and
- Beneficiaries who need accurate information about the benefits they may qualify for under law.

In Part 4 of our Medicare home health *Issue Brief Series*, CMA discusses the definition of home health aide services, and statements made by CMS that miscommunicate coverage.

I. Home Health Aide Coverage Defined (Includes, But is More Than Bathing!)

A. 42 CFR §409.45(b) defines Home Health Aide Services as follows:

Home health aide services. To be covered, home health aide services must meet each of the following requirements:

(1) The reason for the visits by the home health aide must be to provide **hands-on personal care** to the beneficiary or services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury. The physician's order must indicate the frequency of the home health aide services required by the beneficiary. These services may include but are not limited to:

(i) Personal care services such as bathing, dressing, grooming, caring for hair, nail and oral hygiene that are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition, routine catheter care, and routine colostomy care), assistance with ambulation, changing position in bed, and assistance with transfers.

(ii) Simple dressing changes that do not require the skills of a licensed nurse.

(iii) Assistance with medications that are ordinarily self-administered and that do not require the skills of a licensed nurse to be provided safely and effectively.

(iv) Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services.

(v) Routine care of prosthetic and orthotic devices.

(2) The services to be provided by the home health aide must be -

(i) Ordered by a physician in the plan of care; and

(ii) Provided by the home health aide on a part-time or intermittent basis.

(3) The services provided by the home health aide must be reasonable and necessary. To be considered reasonable and necessary, the services must -

(i) Meet the requirement for home health aide services in paragraph (b)(1) of this section;

(ii) Be of a type the beneficiary cannot perform for himself or herself; and

(iii) Be of a type that there is no able or willing caregiver to provide, or, if there is a potential caregiver, the beneficiary is unwilling to use the services of that individual.

(4) The home health aide also may perform services incidental to a visit that was for the provision of care as described in paragraphs (b)(3)(i) through (iii) of this section. For example, these incidental services may include changing bed linens, personal laundry, or preparing a light meal.

B. Medicare Benefit Policy Manual, Chapter 7, Section 40 - Covered Services Under a Qualifying Home Health Plan of Care (Rev. 1, 10-01-03) A3-3118, HHA-205, Allows Medicare Coverage of Home Health Aide as Follows:

Section 1861(m) of the Act governs the Medicare home health services that may be provided to eligible beneficiaries by or under arrangements made by a participating home health agency (HHA). Section 1861(m) describes home health services as.....

.....The term "part-time or intermittent" for purposes of coverage under §1861(m) of the Act means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 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). See §50.7.

For any home health services to be covered by Medicare, the patient must meet the qualifying criteria as specified in §30, including having a need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in this section.

III. Myths & Facts: CMS Provides Incorrect and Misleading Coverage Myths on Medicare.gov, the Social Security Program Operating Manual System (POMS) (“owned” by Medicare, per Social Security); and the newly published 2017 Medicare & Home Health Care Handbook.

Medicare coverage law specifically includes hands-on personal care by a home health aide. Why then does CMS perpetuate the following myths of non-coverage?

A. Myths on Medicare.gov:

1. MYTH: Home health aides typically provide help with basic tasks such as bathing, using the bathroom, and dressing and are not usually covered by Medicare.

From: Ask Medicare, Questions and Answers About Medicare for Caregivers <https://www.medicare.gov/files/ask-medicare-questions-and-answers.pdf>

FACT: These are the very tasks that usually ARE covered by Medicare. **42 CFR §409.45(b).**

2. MYTH: Medicare doesn't pay for personal care.

From: Your Medicare Coverage <https://www.medicare.gov/coverage/home-health-services.html#2778> Personal care is defined in subtext as “care given by home health aides, like bathing, dressing and using the bathroom, when this is the only care you need.” (Note – true but misleading and difficult to find)

FACT: Medicare DOES pay for personal hands-on care. **42 CFR §409.45(b).**

- 3. MYTH: Home health agencies are required to give you an ABN (Advanced Beneficiary Notice) before you get any items or services that Medicare may not pay for because of any of these reasons...custodial care (Note: subtext goes on to define custodial care as personal care).**

What if the home health agency is reducing or stopping my services? <https://www.medicare.gov/claims-and-appeals/medicare-rights/hhccn/home-health-change-of-care-notice.html> Custodial care is defined in subtext as “non-skilled personal care like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases Medicare doesn’t pay for custodial care.”

FACT: Medicare DOES pay for these types of personal hands-on care as dependent services when a beneficiary is also receiving skilled services. **42 CFR §409.45(a) and (b).**

- 4. MYTH: The goal of home health care is to treat an illness or injury. Home health care helps you get better, regain your independence, and become as self-sufficient as possible.**

What’s Home Health Care? <https://www.medicare.gov/what-medicare-covers/home-health-care/home-health-care-what-is-it-what-to-expect.html>

FACT: This is an incomplete and misleading statement. Sometimes a person has an illness or an injury and they will NOT get better, but they need skilled and unskilled services to help them maintain as much function as possible and prevent or slow deterioration. **MBPM, Chapter 7, §20.1.2, §40.1, §40.1.1 (Nursing); MBPM, Chapter 7, §40.2 to §40.2.2E (Physical Therapy); MBPM, Chapter 7, §40.2, §40.2.1, §40.2.1(d)(2) and (3) (Speech Language Pathology); MBPM, Chapter 7, §40.2, §40.2.1, §40.2.1(d)(2) and (3) (Occupational Therapy).**

B. Myths on the Social Security Program Operating Manual System

- 5. MYTH (highlighted in yellow) from the Social Security Program Operating Manual System (POMS) HI 00601.400 Services of a Home Health Aide (MYTH is highlighted in yellow)**

...Personal care duties which may be performed by a home health aide include assistance in the activities of daily living, e.g., helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the patient in necessary self-help skills. **Covered home health aide services usually last 1-3 hours per visit and generally are provided 2 or 3 times a week.**

While the primary need of the patient for home health aide services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may

also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization.

These services may include keeping a safe environment in areas of the home used by the patient, e.g., changing the bed, light cleaning, rearrangements to assure that the beneficiary can safely reach necessary supplies of medication, laundering essential to the comfort and cleanliness of the patient, etc., seeing to it that the nutritional needs (which may include the purchase of food and assistance in the preparation of meals) of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable.

FACT: Medicare home health aides may be covered for personal care services for less than eight hours each day and less than seven days per week (up to 28-35 hours combined with Skilled Nursing services). **42 USC §1395x(m); 42 CFR §409.45(b); MBPM, Chapter 7, §50.1, §50.2**

6. MYTH (highlighted in yellow) from the Social Security Program Operating Manual System (POMS) HI 00601.440 Part Time or Intermittent Services

Part-time or intermittent services of professional personnel and home health aides is usually service for a few hours a day several times a week. Occasionally, more service; i.e., eight hours, may be provided for a limited period when the physician recommends and, when because of unusual circumstances, neither the alternative of part-time care nor institutionalization is feasible. Services of professional staff usually are provided less frequently and for shorter periods of time than are the services of home health aides. For physical, speech, and occupational therapists and medical social workers, visit ordinarily should not exceed one hour.

Home health aide visits usually last 1-3 hours a day and generally are provided 2 or 3 times a week.

For the very few ill patients who need extensive personal care services in addition to skilled services, Medicare will pay for part-time medically reasonable and necessary aide services 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving *unusual circumstances* where a patient's personal care needs extend beyond 3 weeks. For example, the patient's condition is terminal; he or she has suffered a relapse which, while requiring more intensive care, either does not necessitate institutionalization or institutionalization cannot immediately be arranged.

FACT: This Myth incorrectly confuses the law of daily care for 21 days with the law of ongoing intermittent personal hands on care as a service that is dependent upon a beneficiary receiving skilled services with no time limit duration. **42 USC §1395x(m), 42 USC §1395f(a)(2), 42 USC §1395n(a)(2)(A); 42 CFR §409.42(c)(1); MBPM, Chapter 7, §40 to §40.1.3**

C. Myths in the 2017 CMS Medicare & Home Health Care Handbook

Unfortunately, the 2017 revised handbook on Medicare Home Health Care perpetuates the myths as described above on Medicare.gov and in the POMS

FACT: CMA has proposed corrections to CMS to clarify home health care benefits in the new handbook. Those corrections may be seen at <http://www.medicareadvocacy.org/wp-content/uploads/2017/06/CMA-Corrections-to-CMS-HH-Info.pdf>.

Conclusion

The Medicare Home Health coverage law is clear. Medicare beneficiaries have a right to know what benefits the law allows and how to qualify for those benefits. CMS should correct its misleading and inaccurate publicized statements to assist Medicare payment contractors, home health agencies, and beneficiaries understand the legally authorized Medicare home health coverage.

¹ 42 U.S.C. 1861(m)

5. The Home Care Crisis: An Elder Justice Issue¹

CMS rules and policies are resulting in neglected care and endangered safety for some Medicare beneficiaries. While Medicare home health coverage laws apply equally to all individuals, equitable application of coverage laws has been impeded by administrative payment rules and quality measure incentives that favor beneficiaries who have short-term care needs and disfavor those with long-term, chronic care needs.

The National Academies of Sciences includes in the definition of elder abuse, “intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder...this includes failure...to satisfy the elder’s basic needs or to protect the elder from harm.”²

Elder abuse involves “deprivation of services deemed necessary for maintenance of physical and mental health. Elder neglect is sometimes the result of an inability on the part of an elder to care for him or herself without external assistance or support. It also occurs when the [party] responsible to provide such support fails to fulfill...obligations.”³

Some Medicare beneficiaries are being harmed by a Medicare program that promises to cover their home health care, but actually provides little access to Medicare-certified home health agencies.

A Study of Two Medicare Beneficiaries: The Case for Elder Justice

Mr. B and Ms. K both meet the Medicare home health coverage criteria.

1. Mr. B has Parkinson’s Disease and needs long term home care. His plan of care, ordered by his doctor, includes: Nursing for 1 hour/week; Physical Therapy for 3 hours/week; Occupational Therapy for 2 hours/month; and a Home Health Aide for 28 hours/week.
2. Ms. K had a knee replacement and needs 6 weeks of home care to recover complete independent functioning. Her plan of care, ordered by her doctor, includes: Physical Therapy for 3 hours/week for 6 weeks; and a Home Health Aide to assist with bathing for 5 hours/week.

Mr. B made an exhaustive search of Medicare certified home health agencies that serve his home area. Most would not even evaluate him for care. One agency was willing to work with him, but even that agency said they could only provide him with limited services. Thus, instead of the hour of skilled nursing *a week* he needs, he receives an hour a month. Instead of 3 hours of physical therapy a week, he receives an hour a week. Instead of 2 hours of occupational therapy a month, he receives 1 hour a month. Instead of 28 hours of home health aide a week, he receives 3 baths a week. The doctor’s order and plan of care had to be adjusted to reflect the limited services Mr. B was actually able to obtain.

Ms. K easily secured a home health agency to provide her full plan of care.

Home health agencies can choose whom to serve, and when to discharge them, under the Medicare Conditions of Participation. CMS payment models and quality measure ratings incentivize home health agencies to serve beneficiaries who only need short term care to get better. Beneficiaries who need long term care are not even accounted for in CMS’ measurements. Individuals whose care is not “measured” by a home health agency will likely not receive care. CMS administrative rules and policies result in the following for Mr. B and Ms. K:

- Home health agencies want to provide care to Ms. K, not Mr. B.
- Home health agencies will likely receive a higher profit margin for Ms. K and may lose money caring for Mr. B.
- Home health agencies will receive a positive quality rating for Ms. K and a negative quality rating for Mr. B.

- Home health agencies will be rewarded with value-based incentive payments for Ms. K and be penalized for serving Mr. B.
- Long term care for Mr. B is more likely to trigger an agency fraud audit than short term care for Ms. K.

Mr. B, and other Medicare beneficiaries with long term and chronic care needs, are unable to obtain the Medicare coverage for which they qualify under the law. If they are fortunate enough to find any home health agency to serve them, they are often offered significantly diminished services - likely a fraction of the covered care for which they qualify. Mr. B's inability to obtain the care he needs, and the Medicare coverage for which he qualifies, jeopardizes his health and well-being. This amounts to an elder justice issue perpetrated by CMS payment and quality rules and policies.

For Mr. B to obtain justice, CMS should conduct Medicare contractor and home health agency trainings about legal home health coverage. CMS should also equalize all payment and quality measures to ensure every beneficiary has fair and equal access to care. If CMS fails to achieve these corrections, Congress should insist CMS properly effectuate coverage laws. Ultimately, if necessary, the courts must compel CMS to ensure that its rules and policies enforce the law to guarantee that Medicare-certified agencies provide appropriate care for *all* who qualify.

Conclusion

Medicare home health coverage laws are adequate to keep many people in their homes with the care they need. Regrettably, however, CMS home health payment rules and policies create a bias toward serving individuals with short-term needs and neglecting care for people with long term, chronic care needs.

The newly proposed home health rules, published in the Federal Register on July 28, 2017 (<https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf>) will greatly exacerbate the current inequities, further jeopardizing access to care for individuals like Mr. B. The Center for Medicare Advocacy is currently drafting comments regarding these proposed rules and invite all who are interested to contact us to sign on or to use our analysis to write your own response.

Too many of the most vulnerable Medicare beneficiaries are at risk of neglect and abuse due to CMS rules and policies that keep them from obtaining appropriate home health care. Medicare coverage laws are intended to allow people who legally qualify for the home health benefit to remain in their homes - this promise must be fulfilled.

¹ "Elder Justice", for purposes of this discussion, applies equally to Medicare beneficiaries under age 65 who are living with a disability.

² Elder Abuse: Abuse, Neglect, and Exploitation in an Aging America. (R. J. Bonnie and R. B. Wallace, eds., 2002).

³ T. Fulmer, T. & T. O'Malley, Inadequate Care of the Elder: A Health Care Perspective on Abuse and Neglect (1987).

6. Beneficiary Protections Expanded in Revised Home Health Conditions of Participation

2018 ushers in [newly revised Conditions of Participation \(COP\)](#) that must be met in order for home health agencies to participate in Medicare.¹ Effective January 13, 2018², beneficiary protections will be expanded under the COP which provide a more patient-centered focus of care. The revised regulations include: A new patient bill of rights that must be clear and accessible to patients and staff; additional patient assessment requirements to include psychosocial, functional and cognitive components; more significant consideration of patient preferences; greater patient involvement in care planning; coordination and integration with all of a patient's physicians; inclusion of patients, their representatives, and home health aides on the interdisciplinary care team; and, very significantly, **greater protections for patients from arbitrary transfer or discharge from home health care.**

Highlights from the [revised Conditions of Participation](#) that add protections for home health patients include the following revisions to 42 Code of Federal Regulation (CFR) Section (§) 484:

Section 484.2 – Definitions

§484.2 A Patient-Selected Representative is newly defined as someone chosen by the patient to participate in making decisions related to the patient's care or well-being, including family members or advocates, despite the fact that they may not have any legal standing. Legal Representatives continue to be someone who is acting on the legal authority to make health care decisions.

Section 484.50 – Condition of Participation: Patient Rights

§§484.50 - 484.50(a)(1)(iii) The patient and patient's legal representative (if any) have the right to be informed of the patient rights in a language and manner the individual understands. This must include the home health agency's policies regarding transfers and discharge from care.

§484.50(a)(3) The home health agency must provide at least verbal notice of patient rights no later than the completion of the second visit from a skilled professional.

§484.50(a)(4) This section requires: (1) written notice of patient rights and discharge or transfer policies be given to a patient-selected representative within 4 business days after an initial evaluation visit; (2) the home health agency to inquire about patient preferences and demonstrate progress toward goals; and (3) the home health agency to identify family caregivers and their willingness and availability to assist with care.

§484.50(c)(4)(i) Patients have a right to participate in and be informed about all assessments (the previous Conditions of Participation only extended the patient right to be involved in the initial comprehensive assessment).

§484.50(c)(4) Patients have the right to participate in, be informed about, and consent or refuse care in advance of and during treatment.

§484.50(c)(5) Patients have the right to receive all the services outlined in the plan of care.

§484.50(d)(1) Importantly, this section creates a new standard addressing transfer and discharge of patients by a home health agency. In this section, home health agencies are responsible for making arrangements for any safe and appropriate transfer of a patient to another agency.

§484.50(d)(3) Discharge is noted to be appropriate only when a physician and home health agency both agree that the patient has achieved measurable outcomes and goals established in the individual plan of care.

Remember that goals may include slowing deterioration of a condition, maintaining a condition, or improving a condition.

§484.50(e)(1)(i) The subject matter upon which patients may make complaints about a home health agency is not limited just to subjects specified in the regulations.

§484.50(e)(1)(iii) Home health agencies must take action to prevent retaliation against a patient while a patient complaint is investigated.

Section 484.55 – Condition of Participation: Comprehensive Assessment of Patients

§484.55(c)(1) The comprehensive assessment must assess or identify current health status. A new requirement has been added to include assessment of psychosocial, functional, and cognitive status.

§484.55(c)(2) The comprehensive assessment must include patient's strengths, goals and care preferences, including, but not limited to, patient's progress toward achievement of goals identified by the patient and measureable goal outcomes identified by the home health agency.

§484.55(c)(6) The comprehensive assessment must identify the patient's primary caregivers (if any) and any other actually available support.

§484.55(c)(6)(i) The comprehensive assessment must include information about caregivers' willingness and ability to provide care, their availability, and schedules.

Section 484.60 – Condition of Participation: Care Planning, Coordination of Services and Quality of Care

This section requires patients and caregivers to receive education and training including written instructions outlining medication schedules and instructions, home health personnel visit schedules, and other pertinent instructions related to patient care and treatment that the home health agency will provide specific to patient care needs.

§484.60(b)(1) Expands services, treatments and medications that can be ordered by any of the patient's physicians, not only the physician or physicians responsible for the plan of care.

§484.60(b)(4) Permits any nurse acting in accord with state licensure requirements to verbally receive physician orders.

§484.60(d)(1) and (2) Home health agencies must assure communication with all physicians involved in the plan of care, not just the physician that signed the plan of care, and the home health agency must integrate orders from all physicians to ensure appropriate coordination of services and interventions.

Section 484.65 – Condition of participation: Quality Assessment and Performance Improvement (QAPI)

This section sets out standards and required quality and improvement measures for home health agencies that are detailed, monitored and documented.

§484.75 – Condition of Participation: Skilled Professional Services

§484.75(b)(7) A home health agency must communicate with all physicians involved in the plan of care and accept orders directly from multiple physicians involved in the plan of care, even if they are not in the same practice group.

484.80 Condition of Participation: Home health Aide Services

§484.80(g)(1) Removes a previous requirement that the skilled professional who is responsible for the supervision of a home health aide must be the same individual who prepares written patient care instructions for the home health aide.

§484.80(g)(2) Requires home health agencies to provide services ordered by the physician in the plan of care as long as the home health agency is permitted to perform the services under state law and the services are consistent with training received by the home health aide to provide the services.

§484.80(g)(3) Home health aides duties are defined to include: Provision of hands on personal care; performance of simple procedures as an extension of therapy or nursing services; assistance in ambulation or exercises; and assistance in administering medications ordinarily self-administered.

§484.80(g)(4) Requires that home health aides be members of the interdisciplinary team; report changes in a patient's condition; and, complete appropriate records in compliance with home health agency policies and procedures.

§484.80(h)(1) Requires a home health supervisor (RN or therapist) to make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide would not have to be present at the time of the onsite visit.

§484.80(h)(4) Requires a supervisor to ensure the care provided by the home health aide is safe and effective, including, but not limited to: following the plan of care; maintaining open communication with the patient, representatives, caregivers and family; demonstrating competency with assigned tasks; complying with infection prevention and control policies and procedures; reporting changes in the patient's condition; and, honoring patient rights.

484.105 – Condition of participation: Organization and administration of services

§484.105(c) This section was revised to specify that one or more qualified individuals must provide oversight of all patient care services and personnel.

484.110 – Condition of participation: Clinical records

§484.110(e) A patient's clinical records must be made readily available to a patient or appropriately authorized individual upon request.

Conclusion

The practical impact of the new Conditions of Participation is yet to be seen. They should, however, provide welcome additional tools to ensure Medicare-covered home health care is properly provided and that patient rights are respected.

¹ CMS issued a Press release on January 9, 2017 stating that the revised Conditions of Participation “are the minimum health and safety standards a home health agency must meet in order to participate in the Medicare **and Medicaid** programs.” (CMS Press Release, *CMS Finalizes New Medicare and Medicaid Home Health Care Rules and Beneficiary Protections*, 1/9/2019)

² The revised conditions of participation rules were originally expected to be effective July 13, 2017.

<https://www.gpo.gov/fdsys/pkg/FR-2017-01-13/pdf/2017-00283.pdf>. Due to a six-month delay in the effective date, <https://www.gpo.gov/fdsys/pkg/FR-2017-07-10/pdf/2017-14347.pdf>, the new effective date for the revised rules is January 13, 2018.

7. Barriers to Home Care Created by CMS Payment, Quality Measurement, and Fraud Investigation Systems

Medicare payment policies, quality measures, and fraud investigations – not coverage laws – have improperly morphed Medicare’s home health coverage into primarily a short-term, acute care benefit, creating barriers for those with longer-term and chronic conditions. Through policies that drive behavior of home health agencies, CMS has created an environment that discourages agencies from providing home care equally to all who qualify. This is wrong and contrary to Medicare law and Congressional intent.

Payment Policies – The Home Health Prospective Payment System (PPS)

Medicare’s PPS pays home health agencies a bundled amount for the set of services provided during each 60-day episode of care. PPS was implemented in 2000, following an interim prospective payment system developed in the late 1990’s to replace per visit fee-for-service payments to home health agencies. While developing PPS, CMS analysis calculated PPS would work by balancing profitable and non-profitable cases because some patients would need more services and some would need less.

The PPS payment formula provides greater reimbursement for increased covered therapy services, no greater reimbursement for increased nursing services, and minimal reimbursement for covered unskilled services, such as those provided by home health aides. Further, the PPS calculations provide higher payment for the first 120 days of care, lower payment thereafter. After PPS was introduced, home health agencies adjusted to favor those cases that would be most profitable. Because home health agencies are not required to admit all beneficiaries, they can choose to serve the more profitable cases – and they have. Caring for those with longer-term and chronic conditions is often unprofitable. Thus, many people with long-term and chronic conditions who need relatively less therapy, and relatively more home health aide services, often cannot access the home care they need.

Although Medicare home health coverage laws have remained largely unchanged over the past several decades, services provided by home health agencies have changed dramatically to maximize profits under PPS. While the percentage of beneficiaries using home health services has remained fairly stable since Medicare payment systems changed, the amount and kind of care has changed because of PPS. Between 1997 and 2015, therapy visits have increased significantly (from 10% of all visits in 1997 to 37% of all visits in 2015) and home health aide visits have declined dramatically (from 48% of all visits in 1997 to 10% of all visits in 2015).¹ Payment incentives have driven the therapy increase, payment disincentives have driven the home health aide decline. PPS has improperly redefined the home care benefit and left many Medicare beneficiaries with little or no access to the services they need.

Payment Policies – The Home Health Value Based Purchasing (HHVBP) Model

The HHVBP Model began on January 1, 2016 for nine states.² The Model authorized Medicare to make payments beginning in calendar year 2018 based on performance data measurements gathered since 2016. Accordingly, payments will be incrementally adjusted (upward or downward) up to 3% in 2018; up to 5% in 2019; up to 6% in 2020; up to 7% in 2021; and, up to 8% in 2022.

HHVBP is expected to expand beyond the nine states in the Model. It has had a further chilling effect on access to home health for those who need care, but who are not able to improve – those with longer-term, debilitating, and chronic conditions. The HHVBP Model compares home health agency performance on quality measures against the performance of other competing home health agencies within the same state and size cohort. The scoring methodology is based on performance on specified quality measures. Of ten enumerated quality measures, six are improvement-based (improvement in ambulation; improvement in bathing; improvement in bed transferring; improvement in dyspnea; improvement in management of oral medications; improvement in pain interfering with activity). Another quality measure requires discharge from home health. Thus, seven of the

ten quality measures that determine HHVBP Model payments or penalties discriminate against patients with long-term and chronic care needs who will not improve. (The other three quality measures are: drug education for all medications, flu immunizations received, and pneumococcal vaccines received.)

Rewards and penalties (up to plus or minus 8%) of the HHVBP Model will further drive home health agencies to serve only Medicare beneficiaries who will improve, thus leaving those beneficiaries in need of longer-term care for chronic needs without access to Medicare-covered care.

Quality Measurements – The Home Health Quality Reporting Program

CMS touts a “quality” system based on a star-rating measurement to assist Medicare beneficiaries to compare the quality of services provided by home health agencies.³ CMS states that the purpose of the star-rating system is to help beneficiaries learn how often best practices are used “when caring for patients and whether patients improved in certain important areas of care.”

Rather than create a quality reporting system that measures quality of care for all patients who qualify under the law, CMS has implemented a “one-size-fits-all” system that encourages care for some patients (short-term and post-acute care) and discourages care for other patients (longer-term and chronic care). According to this competitively ranked, simplistic, and discriminatory quality measurement system, a four or five star rating means that an agency performed “better” than other agencies on care practice and outcome measures. The result of achieving a four or five star rating, however, means that an agency has likely avoided serving patients with longer-term conditions who would otherwise not score well on care practice and outcome measures. Those measures are as follows:

Managing Daily Activities

- How often patients got better at walking or moving around
- How often patients got better at getting in and out of bed
- How often patients got better at bathing

Managing Pain and Treating Symptoms

- How often patients had less pain when moving around
- How often patients’ breathing improved
- How often patients’ wounds improved or healed after an operation

Preventing Harm

- How often the home health team began their patients’ care in a timely manner
- How often the home health team taught patients (or their family caregivers) about their drugs
- How often patients got better at taking their drugs correctly by mouth
- How often the home health team checked patients’ risk of falling
- How often the home health team checked patients for depression
- How often the home health team made sure that their patients have received a flu shot for the current flu season.
- How often the home health team made sure that their patients have received a pneumococcal vaccine (pneumonia shot)
- For patients with diabetes, how often the home health team got doctor’s orders, gave foot care, and taught patients about foot care

Preventing Unplanned Hospital Care

- How often home health patients had to be admitted to the hospital
- How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital
- How often home health patients, who have had a recent hospital stay, had to be re-admitted to the hospital

- How often home health patients, who have had a recent hospital stay, received care in the hospital emergency room without being readmitted to the hospital

Some of the measures are achievable for every patient (e.g. beginning care in a timely manner, making sure flu and pneumonia shots are delivered) but what if the patient had a stroke resulting in permanent paralysis or has a disease that won't get better? What if they can't put medicines in their mouth, get out of bed, walk around, or bathe themselves? What if their breathing doesn't improve because they have COPD, or their wounds won't heal because they have diabetes? Should those patients be discriminated against by CMS "quality measurements"? Regrettably, that is the impact of CMS's quality system. It penalizes home health agencies by giving them lower "star" ratings if they provide services to beneficiaries who cannot achieve those measures.

In addition to the care practice and outcome measures, Home Health Compare provides patient survey results obtained through an instrument called Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAPHS) from patients who have been served by a home health agency. The questions on the HHCAPHS survey, with percentage of positive answers tallied and ranked up to five stars, are as follows:

- How often did the home health team give care in a professional way?
- How well did the home health team communicate with patients?
- Did the home health team discuss medicines, pain, and home safety with patients?
- How do patients rate the overall care from the home health agency?
- Would patients recommend the home health agency to friends and family?

CMS care practice and outcome measures seem to conflict with the HHCAPHS beneficiary survey. As an example, home health services provided by the Connecticut Hospice scored highly on the HHCAPHS survey (4 stars out of 5), but scored poorly on CMS quality measures (1.5 stars out of 5) because the characteristics of individuals served by CT Hospice (patients not expected to improve) negatively influence CMS quality measurements.

Patient surveys should be designed, along with care practice and outcome measures, to recognize appropriate care for all Medicare beneficiaries. The current measurement criteria do not advance access to home care for all. They are misleading and discriminatory.

CMS Fraud Investigations

Home health agencies fear triggering investigations for Medicare fraud when they serve patients for long periods of time. Fraud triggers are often primarily based on length of care, not because care is determined to be unnecessary or not covered under the law. Focusing on length of care as a fraud trigger is likely contributing to artificially inflated claims of fraudulent activity by CMS. Cases meeting the legal criteria for Medicare home health should not be targeted for fraud. Such investigations conflict with the law and interfere with the legitimate pursuit of real fraudulent activity.

The Center for Medicare Advocacy has been informed by multiple home health agencies that Medicare contractors' conduct trainings during which presenters incorrectly state that there is no coverage for maintenance care, that patients should be discharged if their condition is "stable or not changing," and that Medicare home health is intended to be for short-term and post-acute care. Home health agencies under fraud investigation, that have only above average length of care cases targeted, have been told by CMS that "CMS received credible allegations that [the agency] is billing for medically unnecessary services, as well as falsely representing the level of service purportedly provided, thereby inflating the value of claims submitted to Medicare and misrepresenting services or products. In addition, it is alleged that [the agency] is billing for home health services for beneficiaries that are not homebound." Every possible coverage criteria is questioned, with

no direct query about the reason for the length of care, although the cases listed for investigation are all longer-term and chronic care cases.

The harsh reality for agencies under fraud investigations is that all Medicare payments to an agency are suspended while the agency prepares rebuttals and other challenges. Rather than manage these challenges and risk losing such a significant payment source, agencies choose to discharge patients who need and qualify for continued Medicare-covered services.

Conclusion

Medicare home health coverage is equally a long-term, chronic care benefit and a short-term, post-acute care benefit, as defined by Medicare law and Congressional intent. While Medicare coverage laws remain substantially unchanged, over the past two decades PPS has failed to balance payments for all who qualify for coverage. Instead, PPS has driven agencies to serve patients who generate the greatest profit margins, leaving many who need care with limited or no services. The dramatic impact of PPS – from home health as a benefit that provided primarily (low cost) home health aide services to a benefit that provides primarily therapy services, is driven by payment systems that conflict with coverage laws. Further, PPS has created usage data that does not reflect patient care needs. Agencies have delivered what they are most highly compensated for, and they have neglected the needs of patients who may diminish their profit margins.

The additional impact of newer models and systems – HHVBP, quality reporting measurements, more aggressive fraud investigations, and CMS' newly proposed home health groupings model – will accelerate barriers to home health care for people with long term and chronic conditions. Coverage under the law will become wholly unrecognizable compared to services and coverage actually available. CMS must properly effectuate coverage laws and create an environment (through revised payment models, quality measures, and fraud policies), that encourage agencies to provide care equally for all who qualify under Medicare law.

¹ Id at page 36, Table 9-1.

² Authorized by Section 1115A of the Social Security Act and finalized in the CY 2016 HH PPS final rule. Fed. Reg. Vol. 81, No. 128

³ <https://www.medicare.gov/HomeHealthCompare/About/What-Is-HHC.html>

8. Proposed CMS Payment Rules Will Worsen the Home Care Crisis

If proposed new payment rules are adopted by the Centers for Medicare and Medicaid Services (CMS), beneficiaries with longer term and chronic care needs will face greater access barriers to Medicare home care benefits. In a proposed 2018 rule, CMS introduced the Home Health Groupings Model (HHGM) as a model for future home health payment reform.¹ Public response to the proposed HHGM, by beneficiary advocates and home health agencies alike, raised significant concerns about the potential devastating impacts of the HHGM on access to care.

In the 2018 final rule, CMS reported that the agency was not finalizing implementation of the HHGM.² Despite this CMS decision, which recognized significant beneficiary and provider concerns, Congress recently passed some provisions of the HHGM into law.³ Most notably, under the law Medicare home health episodes of care were reduced from a 60-day period to a 30-day period, effective January 1, 2020.

What is HHGM?

I. Introduction

The HHGM, as proposed by CMS, encourages home health agencies, through weighted payment incentives, to provide brief periods of home care services to people who return to their homes following a hospitalization or nursing home stay. The HHGM would pay a home health agency at a significant premium for home care provided within the first 30 days (as much as 40% more than the HHGM would pay an agency to provide care to a person who does not have hospitalization or nursing home stay before starting home care services, and if he or she needs services beyond 30 days). The totality of the HHGM provisions (episode timing, admission source, clinical groupings, functional levels, and comorbidity adjustment) create the payment weights that determine reimbursement to providers.

II. Episode Timing

In addition to reducing a home health episode from 60 to 30 days, the first 30-day episode in the HHGM would be considered an “early” episode while subsequent episodes would be “late”. Under the existing prospective payment system (PPS), the first two 60-day episodes (120 days) are considered “early.” Agencies are paid more for “early” episodes than they are for “late” episodes. Thus, in the HHGM, agencies would be paid more for the first 30 days while currently they are paid more for the first 120 days.

III. Admission Source

The greatest discriminator of all the HHGM payment criteria is admission source. Whether the episode timing is “early” or “late,” admissions to home care from an institution (such as a hospital or nursing home) would be most highly compensated under the HHGM, even considering adjustments for clinical grouping, functional impairments, and comorbidity. Community admissions (beginning care for individuals who are at home), would be significantly devalued, further jeopardizing access to care for people with chronic conditions and others who, fortunately, avoid hospital and skilled nursing facility stays.

IV. Clinical Groupings

The HHGM would narrow clinical groupings to six (musculoskeletal rehabilitation, neuro/stroke rehabilitation, wounds - wound aftercare and skin/non-surgical wound care, behavioral health care, complex nursing interventions, and medication management – teaching – assessment). All other diagnosis codes would be distributed within these six categories for payment weighting.

V. Functional Levels

The HHGM would score a person's functional needs as simply low, medium or high. There would be small payment weight differences relative to the significant cost for someone who requires considerable assistance with functioning.

VI. Comorbidity Adjustment

The comorbidity adjustment in the HHGM is "yes or no." There would be no distinction in payment, weighting whether the person has one or multiple comorbidities.

Impact of the HHGM on Medicare Beneficiaries

The HHGM would significantly diminish access to Medicare-covered home care for people who are clinically complex and have chronic illnesses and impairments. People who qualify for (and need) coverage and care for longer than 30 days but have not been admitted to home health care from a prior institutional stay will find it even harder to obtain, and retain, home care.

Implementing Medicare coverage laws should be the goal of all payment and quality measures, particularly those enacted into law. If adopted in their present form, however, HHGM payment provisions will conflict with Medicare coverage criteria and will determine who will have access to care, and who will be denied care – even among those who qualify under the law.

Every home health care case should be individually assessed to determine appropriate Medicare coverage. As CMS and the courts have agreed, there should be no "rules of thumb" in Medicare. CMS states that "[e]pisodes have more visits, on average, during the first 30 days compared to the last 30 days. Costs are much higher earlier in the episode and lesser later on."⁴ (FR 35294) Again, while this is true for some people, it is not true for those who live day-in and day-out for months and, often, years with chronically complex conditions. The "average visits" analysis of CMS is not only an inaccurate approach, because it considers all patients to be the same, it is painfully insulting to people who cannot "improve" back to functioning within a 30 day episode of care – people who equally qualify under the law for home care coverage.

Relatively small payment weight consideration is provided under the HHGM for care to individuals with comorbidities or functional impairments. Payments may be based on the needs of some patients - those who do not need care for very long and who had an institutional stay within 14 days of needing home care are projected to need the highest payment. But, care needs are not defined by the point of entry into care (institution or community). Nor are they defined by the length of time to achieve "lesser" care needs (30 days). The HHGM discriminates against people with chronic conditions, the very people CMS purports it seeks to protect.

The following is an example of how the HHGM would provide payment incentives for HHAs to only serve people with short-term, post-institutional/acute care home care needs⁵:

Complex nursing interventions (clinical group), Low (functional level), with a Comorbidity Adjustment, Timing (early or late)("early" is first 30 days of care) and Admission Source (community or institution)
= Payment weight

Early, Institutional = 1.3549 (payment weight)
Late, Institutional = 1.2367
Early, Community = 1.1840
Late, Community = 0.7937

A "late, community" beneficiary (with a payment weight of .7937), who may have greater care needs than a "early, institutional" beneficiary (with a payment weight of 1.3549) would have significant difficulty accessing

care, based on lower reimbursement to home care agencies for significant care needs, even though the beneficiary qualifies for home care under Medicare law.

Finally, an overarching concern about the development of the HHGM is how payment models based on “average” needs create arbitrary rules of thumb that in turn eliminate access to care. With the assistance of technology, coverage and payment determinations based on individualized assessments should be more readily available than ever, and are required.

Conclusion

While Congress has enacted 30-day Medicare home health episodes effective January 1, 2020, CMS should revisit the impact remaining provisions of the HHGM will have on beneficiaries and their access to care. A home health payment system that employs accurate payment algorithms may be efficient, given the millions of beneficiaries who seek access to home health, however, a one-size-fits-all approach process creates rules of thumb that significantly and illegally limit access to care. The existing payment system, PPS, created winners and losers among Medicare beneficiaries – some people have access to care, others do not. CMS should not allow the HHGM to create a new set of winners and losers. Instead, CMS should develop margin neutral payment programs that allow equal incentives to provide Medicare-covered home health care to all who qualify under the law. The HHGM model, or any payment program, must be carefully developed in order to ensure equal access to care.

¹ <https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf>

² <https://www.gpo.gov/fdsys/pkg/FR-2017-11-07/pdf/2017-23935.pdf>

³ Bipartisan Budget Act of 2018, H.R. 1892, 115th Cong. 50202 (2018) (to be codified at 42 U.S.C. §1395I(g)) at <https://www.congress.gov/bill/115th-congress/house-bill/1892/text>.

⁴ <https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf>, page 35294

⁵ <https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf> (Table 42, FR 35328-35329)

9. Statistical Trends and Published Articles with Studies and Research from 2002-2017

- A. Introduction
- B. Evolution of Medicare Home Care
- C. Statistical Trends
- D. Patient Quality, Value and Access
- E. CMS Quality and “Star” Ratings
- F. Staffing
- G. Mergers and Acquisitions
- H. Payment Reforms
- I. Center for Medicare Advocacy Discussion of Published Article Information

A. Introduction

The Center for Medicare Advocacy reviewed key articles, published between 2002 and 2017, that cite data and research and provide theories/conclusions about the evolution and current status of the Medicare home health benefit. This Issue Brief quotes or paraphrases these articles by topic in Sections 2 through 8. An endnote for each of Sections 2 through 8 provides citations to articles referenced. Section 9 is a Center for Medicare Advocacy discussion of the impact this information has on current Medicare beneficiary access to home health care.

B. Evolution of Medicare Home Care ¹

Medicare has always included a home health benefit, but over time changes in laws, regulatory rules, and administrative practices have influenced its provisions and use. Originally, beneficiaries with a recent hospital or nursing home stay could receive up to 100 visits under Part A with no beneficiary cost sharing. Those who did not have an institutional stay, or who had exhausted their 100 visits under Part A, could receive up to 100 visits under Part B; however, Part B services were subject to cost sharing – the Part B deductible and 20% coinsurance.

In 1972, the coinsurance requirement was eliminated from Part B home health services. By the OBRA (Omnibus Reconciliation Act) of 1980, Congress removed the prior institutional stay requirement for Part A, the 100 visit cap for both Parts A and B, and the application of the Part B deductible to home health. OBRA made it easier for for-profits to participate in Medicare by eliminating the requirement that they be licensed by their state. A combination of regulatory practices and other policies effectively constrained the benefit’s use through most of the 1980’s.

A clarification and expansion of eligibility and coverage rules in 1989 sparked a period of rapid growth in Medicare home health use and spending. Rule revisions confirmed that eligibility based on intermittent skilled nursing could usually be established if a beneficiary needed skilled nursing services at least once in 60 days. Rules further clarified that a beneficiary’s condition did not need to improve to qualify for services. Also, skilled nursing services were defined to include observation and management of patient care, as well as direct services. Daily skilled care was allowed for up to 21 days, or longer in exceptional circumstances.

Between 1988 and 1996, the proportion of beneficiaries using the home health benefit more than doubled, from 4.8% to 10.7%. In the same time period, the average number of visits nearly tripled, from 24 visits per user, to 74 visits. Home health spending increased from \$83 per beneficiary to \$528. As a result, home health grew from 2.4% of total Medicare payments in 1988 to 10% in 1996. The home health benefit was one of the few parts of Medicare under which payment was still largely based on the provider’s costs, rather than on prospectively established rates. An agency had an incentive to expand its volume of visits, so long as the cost of additional visits was below its average Medicare dollar limit. Cost-containment concerns centered on agency fraud and over-utilization of the benefit.

After enactment of the 1997 Balance Budget Act (BBA), the traditional, cost-based payment system for Medicare home care was changed to an interim prospective payment system (IPS), imposing predetermined per-episode reimbursement limits. The BBA's aim was to control the price of home health services and constrain the volume of services, largely by changing the financial incentives of home health agencies. Dramatic decreases in home health use occurred, particularly by persons with impairments in activities of daily living, health and memory. In many ways the policy design did not create incentives to eliminate inappropriate use of the benefit. Rather, it generated incentives for agencies to cut the amount of services provided to the most potentially high-cost patients, regardless of the legitimacy of their claim and need for home health care. Home health agencies responded to IPS by reducing care to relatively unhealthy beneficiaries. Some studies demonstrated increases in skilled nursing facility use and emergency room use post-BBA.

In two years, between 1997 and 1999, under the interim prospective payment system (IPS), average home health visits per beneficiary fell by 54%. Spending per beneficiary fell by 52%. The largest drop in the likelihood of obtaining any home health care at all occurred in three beneficiary groups: those age 75 or over, enrollees with Medicaid, and residents of rural areas. The proportion of users with home health episodes lasting at least 6 months also fell by nearly one-half, from 31% in 1997 to 17% in 1999.

At the turn of the 21st century, the prospective payment system (PPS) introduced the case-mix adjustment, a structure intended to reimburse agencies based on expected service needs for different categories of patients rather than on actual cost to deliver services, arbitrary criteria or agency cost history. Its base rate, however, was established by still using expenditures from the greatly reduced IPS. Some agencies were forced to close if they could not manage to balance low and high-cost patients.

Patient need for services, and Medicare coverage for those who qualify, has not significantly changed since 2000, but access to those services for vulnerable Medicare beneficiaries has been dramatically affected. The combination of incentives in the policy and gaming behaviors at the practice level have the potential to generate fraud in two directions – either over or under use. Medicare home health care has been refocused on post-acute management rather than on chronic illness care. In the process, home care episodes have been shortened with fewer visits per episode and, in particular, far fewer home health aide visits.

Medicare home health policy focuses on controlling costs rather than on responding to the legitimate needs of beneficiaries by improving quality and efficient delivery of care. Changes to home health care policies have altered the profile of users and the practice of home health providers. Agencies strategically altered their admissions and service delivery practices in response to these changes, in order to continue to provide services while maintaining fiscal stability. Thus, both policy and market response to the policies have been critical to benefit use and access to necessary home care. Assumptions changed regarding the goal of the Medicare home health benefit (acute care versus long-term care) and the appropriate target population for service (post-acute care versus chronic care), and currently continue.

C. Statistical Trends ²

a. Utilization

Between 1997 and 2016, visit type as a percent of total visits changed as follows: skilled nursing from 41% to 51%; therapy from 10% to 39%; and, home health aides from 48% to 10%. Number of visits per user decreased from 73 to 33. Average visits per episode between 1998 and 2016 changed as follows: skilled nursing from 14.1 to 9.4; therapy 3.8 to 7.5; and home health aides 13.4 to 1.8. (Note: not all episodes use all types of care.) The total number of traditional Medicare home health episodes increased 60% between 2002 and 2015 and episodes

per home health user increased from 1.6 to 1.9. (Note: an episode = 60 days of services.) Since 2001, episodes not preceded by a hospitalization increased from half to two-thirds of total episodes.

b. Access

In 2018, the Medicare Payment Advisory Commission (MedPAC) reported that beneficiary access to home health care was generally adequate as over 99% of beneficiaries lived in a ZIP code where Medicare home health care services operated, and 86% lived in a ZIP code with 5 or more agencies. The number of agencies nationwide in 2016 (12,204), was higher than the previous peak in the 1990s when supply exceeded 10,900 agencies. In 2016, 88% of all agencies were for-profit owned.

c. Spending and Payments

Medicare home health spending has risen significantly, increasing from \$8 billion in 2001 to over \$18 billion in 2016. Between 2002 and 2016, Medicare spending for home health care increased 80%. Between 2001 and 2015, marginal annual profit for home health agencies averaged 16.4%, suggesting a significant financial incentive for home health agencies to increase their volume of [traditional] Medicare patients. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by lowering the number of visits provided, and cost growth has been lower than the annual payment updates for home health care.

D. Patient Quality, Value, and Access³

An equitable health care system should be driven by patient-need. Thus, patients who are sicker and more impaired should receive greater health care services. Patients with greater health, functional, and mental impairments may have experienced reduced access to home health care after the implementation of IPS in 1997. There was a significant increase in the percentage of home health patients who had a skilled nursing facility admission within 120 days of admission to home health (from 7.8% to 8.8%). Visits to an emergency room increased from 17% to 19%; visits to an emergency room for the same body system diagnoses as the home health care increased from 7.2% to 8.2%. The number of deaths rose from 9.0% to 9.7%.

Patients with clinically complex conditions and social vulnerability factors, such as living alone, had substantially higher service delivery costs than other home health patients. Thus, socially vulnerable patients with complex conditions represent less profit – lower-to-negative Medicare margins – for home health agencies. This financial disincentive could also reduce patients' access to care as Medicare payments decline.

One of the most notable drivers of Medicare service use and profit margin is the availability of a caregiver to provide assistance with functional limitations and essential medical care. There were substantially lower Medicare margins for episodes in which a caregiver was not available in the home to provide assistance with activities of daily living, instrumental activities of daily living, or medical procedures.

Left unchecked, the financial disincentives within the current payment system could lead to reduced access for less profitable groups of patients. Instead, these patients could face options that are considerably more costly than home health care. Further, Medicare beneficiaries above the poverty line, but with limited financial and social resources, may continue to have difficulty obtaining needed home health care.

Seeking improved functional status is a domain that appears to be more consistently unmanageable in a population with a high burden of chronic illness and frailty. Heterogeneity of circumstance, social determinants, frailty, and other local influences shape home care, which is inherently provided in environments that are uncontrolled and often unpredictable. Under such conditions, because of how and what is measured, optimal performance must sometimes remain elusive.

Non-profit agencies showed greater improvements on quality measures than for-profits. For-profit agencies had higher costs but poorer performance than non-profit agencies.

Overall, there is a pervasive lack of true integration of home health care into the main fabric of total health care delivery. The need to “knit the fabric” of health care together is simply not yet urgent enough in a world where patient-centered, safe-care should rule.

E. CMS Quality Criteria and “Star Ratings”⁴

CMS has tested models that focus on reimbursement for agencies based on outcomes of care. However, these models currently measure quality (through a series of outcome indicators) on global aggregate data. Very little attention is paid to ensuring quality for subgroups of patients who are most needy and vulnerable. CMS needs to ask the question, quality for whom, and ensure that impact assessment does not overlook need in evaluating the effectiveness of home health care.

CMS criteria for selecting quality measures include the following: a measure must apply to a substantial portion of home health patients; a majority of agencies must have sufficient data to report; the measure shows a “reasonable amount of variation among agencies”; agencies can improve their performance on the measure; the measure has “high face validity and clinical relevance”; and the measure is stable over time and doesn’t experience variation.

Claims-based measures (such as the emergency department use without hospitalization measure), are generally viewed as less prone to manipulation when compared to a process measure. When CMS proposes measures, they purportedly seek to ensure that there are no unintended consequences.

A study of over 11,000 Medicare-certified home health agencies between 2011 and 2015, serving over 92% of all zip codes, found that agencies with longer tenures as Medicare-certified providers were more likely to have high-performing scores. Agencies only offering some home health services, proprietary ownership, or long travel distances to reach patients, had lower performance. Agencies serving low-income counties and counties with lower proportions of women and senior residences and greater proportions of Hispanic residents were more likely to attain lower quality performance scores. Since 1997, there have been greater than average reductions in the number of home health visits among beneficiaries who were older than 75, female, non-white, and those living in rural areas.

F. Staffing⁵

The number of employees per agency declined 16% between 1996 and 2002. Low home health care reimbursement rates are expected to increase the shortage of qualified home health aides, therapists and nurses.

Demand for home health aides is expected to rise rapidly over the next several years, but factors like low pay and lack of training have made it one of the hardest jobs to fill. The projected growth for the home health aide profession between 2014 and 2024 is 38%. Home health aides and other home care workers are already leaving the industry in droves, attracted to jobs that pay similarly, if not better, but take less of a physical and emotional toll. Some studies have shown that more training in this workforce leads to less turnover, better patient outcomes and satisfaction, and likely more attraction for the job in the long term. There is a connection between training, quality of care, better health outcomes and lower health care costs.

G. Mergers and Acquisitions⁶

Of all the health care sectors, home health posted the highest trading multiples for mergers and acquisitions in 2016. Purchase volume increased 8% in 2015, and deal value increased 121%. Home health volume and valuations increased, are likely due to the continued acceleration of value-based care models. The models are designed to increase home health volume by diverting patients from more expensive and sometimes unnecessary in-patient post-acute facilities. Home health agencies are becoming an even more important factor in reducing costs and improving patient outcomes in the post-acute care continuum. Buyers are seeking home health assets with the size and scale to satisfy this additional demand.

H. Payment Influences ⁷

The provision of home health care is “quite sensitive” to the structure of reimbursement. Medicare home care payment policy and practice may ultimately jeopardize access to quality care for vulnerable populations. Shifting risk to agencies has historically led to adaptive gaming practices, and changes in delivery of services, to reduce the agency’s financial risk or enhance profit. Gaming has been demonstrated throughout the Medicare program’s history; agencies tend to modify their practice in reaction to policy changes to either capitalize on generous aspects of changes or to counteract financial harm due to restrictive changes. It is very challenging to predict how agencies will react to proposed changes. The impact of such policy estimations on vulnerable patient groups, those with greater and legitimate need for care, is overlooked.

Socially vulnerable patients with complex conditions represented less profit – lower-to-negative Medicare margins – for home health agencies. Further, research has shown that policies decreasing Medicare’s payments to home health care providers are linked to greater reductions in services for beneficiaries who have greater functional, health, and cognitive impairments than those for healthier beneficiaries with fewer functional and cognitive impairments.

In 2010, CMS imposed a new home health agency-level cap on outlier payments (an added payment meant to encourage agencies to serve high-cost beneficiaries, still currently in effect). Agencies are held to 10% of total payments for outlier claims in an effort to combat fraudulent behavior by agencies. U.S. General Accounting Office (GAO) studies show much of fraudulent practice from outlier payments happens from a limited number of agencies. But the remedy makes all agencies subject to the outlier payment limit. Such sweeping policies do not necessarily eliminate fraudulent providers from the system. They raise the real prospect that legitimate, high-need, and thus high-cost, beneficiaries will receive fewer visits if all agencies have to cut their services to counteract reductions in base rates or stay below the 10% outlier limit. (Note: Section 3131(b)(2) of the Affordable Care Act states that the total amount of additional payments or payment adjustments for outlier episodes are not to exceed 2.5 percent of the estimated total annual home health PPS payments.)

Episodes that did not involve restorative care had significantly lower Medicare margins. Similarly, episodes of care that were provided to patients who were moderately or very impaired had Medicare margins that were significantly lower than episodes provided to patients with no functional impairment. The current payment system encourages agencies to deliver the maximum volume of therapy services for which a patient is eligible and to restrict the number of visits by skilled nurses and home health aides. These payment methods may leave certain groups of patients with high service costs and inadequate reimbursement. These groups include patients who do not qualify for therapy and those who require a large number of skilled nursing visits.

Payment reforms that shift reimbursement from fee-for-service towards episode-based payment predict a decline in the likelihood of use and costs. Payment reforms under the current and previous payment systems (PPS and IPS, respectively) showed little evidence of “cherry-picking” patients based on observable characteristics in data, and limited effects on costs in other post-acute care settings, hospital readmissions, and mortality. [Note: data does not capture information about people who are refused services.] Provider behavior might be more responsive to reimbursement at the margin. Estimates from the PPS show offsetting effects of

reduced marginal reimbursement and increased average reimbursement. Home health agencies adopted a nuanced response to expected service utilization under the PPS and were more likely to target the therapy visit threshold to maximize payment and also increased the number of 60-day episodes. Still, the amount of care provided (measured by average visits per home health patient), remained well below pre-IPS levels. If payments increased, any reductions in care translated to higher margins for providers (as in the PPS) rather than savings to Medicare.

Changes in per-patient average reimbursement predicts what services will be provided and, to a lesser extent, probability of admission to home health care. Bundled payment and accountable care organizations that further reduce marginal reimbursement are likely to impact provider behavior. Additionally, payments have declined as a result of rebasing – an exercise that reflects data on costs and use of services – and decreased Medicare home health payments by 3.5% per year in the period 2014-2017. Thus, home health payment reductions could accelerate the unintended consequences of reducing access for less profitable patients.

Attempts to revise Medicare’s home health PPS should focus on inefficiencies within the current model. Policy makers should examine how payment formulas could be redesigned to account for higher service delivery costs among those beneficiaries who require significant nursing care. Also, adding measures of the patient’s socioeconomic status to calculations of reimbursements might redress some of the observed inefficiencies.

I. Center for Medicare Advocacy Discussion of Published Article Information

Policy and practice should be aligned to effectuate Medicare coverage laws. The home health benefit, as intended by Congress, including all covered disciplines – nursing, therapies, home health aides, and medical social services – should not be undermined by administrative policies and industry incentives. In the 1997 Balanced Budget Act, which developed the payment system that exists today, Congress reviewed Medicare home health coverage and chose not to limit it to a short-term, acute care benefit.

The Center for Medicare Advocacy focuses on the impact of laws, regulations, policies and procedures on Medicare beneficiaries, particularly those with longer-term conditions and serious illnesses. How are these systems working, or not working, for all people who are served by the program? How do they affect chronically ill beneficiaries? While providers must be fairly reimbursed to deliver care, ultimately the guiding principles of CMS should be to provide health care for all qualified beneficiaries and efficient, effective management of public funds.

The home health care delivery system has become a profit-making enterprise, as evidenced by the flood of mergers and acquisitions and for-profit corporations that have taken over the industry. There is an inherent tension between profit and care delivery. Too often the result is the sickest and most vulnerable people are denied access to care. The data shows agencies have lowered the number of visits provided under PPS, while consistently making more than 16% profit annually from traditional Medicare. If the PPS system was intended to provide bundled payments that balanced lower cost patients with higher cost patients, for-profit agencies, which comprise 88% of agencies today, have adapted to the payment system and serve those who are in relatively less need of care, and most profitable. Access to services for people most in need is denied.

The existence of one or many home health agencies in a ZIP code area is of no use if beneficiaries who need care find each one denying even an assessment for services. While studies may have shown limited evidence of patient “cherry-picking”, this is misleading as the system would not be able to identify all the patients rebuffed from services. Similarly, viewing data in aggregate does not help subgroups that are on the margins of care.

Barriers to home health care access are also created by quality measures that inform the CMS star rating system but do not measure achievement of patient goals. Thwarted by a requirement that quality measures must apply

to a substantial portion of home health patients, “improvement” is mandated by CMS to meet almost all measures. This creates real access barriers for patients with longer-term or chronic illnesses and provides more disincentives for agencies to serve patients with the greatest needs.

One issue we have not seen studied, and is concerning for potential home health patients, is what appears to be a rapidly growing number of home health agency “spin-off” affiliates that offer a variation of home health aide services. Medicare covers personal care services by home health aides, up to 28-35 hours a week, but home health agencies report they don’t provide home health aides in their Medicare-certified enterprises. Instead, they state that they can provide similar services (“personal care assistants” or “companions”) through a private-pay affiliate. The Medicare PPS system provides little to no incentive for home health agencies to staff home health aides, assistance from whom is often the key to people with longer-term and chronic conditions ability to remain in their homes.

Finally, a note must be made about the influence of Medicare fraud audits on home health agencies. CMS appears to aggressively audit cases of patients with longer-term and chronic impairments. Based on our work the Center for Medicare Advocacy has significant concerns that the reviews are not accurately based on Medicare law, regulations, or policy and are sometimes without basis in (or sometimes contrary to) law, regulations, or policy. Such erroneous audits (applying inappropriate law and criteria to inaccurate facts), establishes dangerous precedents and can reduce beneficiary access to legal Medicare coverage. These kinds of audits can also create misleading and illegal standards that may interfere with the effective identification of true fraudulent barriers to Medicare program integrity.

CMS must create effective regulations and policies that allow equal access for all patients who qualify for care, especially for those who most need those services.

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10. Plans to Address and Resolve the Medicare Home Care Crisis

There is a crisis in access to Medicare-covered home health care. Earlier editions of this [Issue Brief Series](#) have detailed the home health benefit and the access obstacles facing patients, particularly those with longer term and chronic conditions. This *Brief* summarizes what is at stake, some of what's been done thus far, and what's needed to remove the obstacles.

Under the law, beneficiaries qualify for home health coverage when they are under the care of a physician, are homebound, and need skilled nursing or therapy care. There is no required end-point to coverage; it can continue so long as the beneficiary meets the coverage criteria. In practice, however, beneficiaries are regularly unable to obtain the coverage, and care, provided by law.

In recent years, access to the benefit has rapidly diminished and a growing number of beneficiaries have been unable to obtain home health services, even when they meet Medicare coverage criteria, (See *CMA Issue Brief #5*). While the Centers for Medicare & Medicaid Services (CMS) online and print materials now more accurately reflect Medicare home health coverage law, (See *CMA Issue Brief #4*), CMS continues to administer the benefit as if it is for patients with acute care needs. Further, although some beneficiary protections have been expanded, (See *CMA Issue Brief #6*), CMS payment policies, quality measures, and fraud investigations create disincentives for home health agencies to provide care to all who qualify; patients with longer-term needs are particularly disfavored, (See *CMA Issue Brief #7*). Recently proposed rules would only accelerate this trend towards turning Medicare home health coverage into a short-term, post-acute care benefit – contrary to clearly expressed Congressional intent, (See *CMA Issue Brief #8*).

The Center for Medicare Advocacy (the Center) continues to develop strategies to raise awareness about the crisis in access to Medicare home care and to seek solutions. A combination of actions are necessary, including Administrative and Congressional, strategic collaboration with providers, development of stories and media attention, and, potentially, litigation.

- The Administration and CMS should rescind proposed payments rules and develop a model intended to effectuate coverage laws, by giving home health providers appropriate financial incentives to serve all qualifying Medicare beneficiaries. Quality measures and fraud investigation triggers should also be redesigned to ensure that all patients who qualify under the law have equal access to care. The Administration, and those who advise CMS, including the Medicare Payment Advisory Commission (MedPAC), should fully understand Medicare coverage law and work to ensure the benefit is administered to implement the promise of the law: to allow homebound patients to receive necessary care at home. Oversight of the program must aim to ensure equal access to coverage for all who qualify, regardless of their conditions or ability to improve. Underserving patients who qualify should cause as much concern as overserving. Considerations should include capping maximum allowable profit margins, thus removing incentives to serve some beneficiaries who are more profitable than others.
- Members of Congress should recognize that constituents are losing access to legally covered home care and act to ensure that coverage laws are implemented as intended – for all who qualify. Congress should insist that CMS corrects policies that restrict access to

such services. Congress and the Administration should ensure that Medicare-certified home health agencies are ready to provide all services covered under the Medicare benefit. Congress should also consider lifting the 2.5% statutory cap on provider access to outlier payments.

- Home health agencies are generally willing to provide services to all beneficiaries when they are properly reimbursed. While some Medicare-certified agencies provide services to beneficiaries with longer-term and chronic conditions, many will not for fear of claim denials, fraud investigations, audits, and financial penalties. Too often, agencies lose money, get reduced quality measures, and are targeted by audits based on criteria that do not accurately reflect the Medicare law. As a result, providers turn away beneficiaries who have chronic conditions in favor of more profitable short-term, acute care cases. Equalizing access to care may not be the home health industry's primary concern, but the industry should join with beneficiary advocates to oppose these policies that lead to inequities in access to care. The Center will continue to work with home health agencies to understand and honor coverage laws, to gain more confidence that care provided to people with longer-term conditions will be covered, and to help prevent unfair oversight practices.
- Media stories have helped raise awareness about the crisis in access to home health care. Some published articles have generated responses from CMS, such as a recommendation (made in the Federal Register) that agencies use outlier payments to cover higher-cost patients. While it may be appropriate in some cases to use outlier payments, they are currently underfunded and statutorily capped at 2.5% of all Medicare home health expenditures (already maximized by home health agencies). Additionally, outlier payments are not appropriate for all beneficiaries who have longer-term or chronic conditions. Many of these patients are actually less costly to agencies than short-term acute care patients.
- Finally, as we strategize ways to resolve the inequities in access to Medicare-covered home care, the Center must also consider the possibility of strategic litigation. Some of the identified access barriers may conflict with Medicare law, the Administrative Procedures Act, and/or anti-discrimination laws. The Center for Medicare Advocacy is committed to doing all we can to advance fair access to Medicare home care.

Conclusion

The Center for Medicare Advocacy welcomes assistance and inquiries from other advocates concerned about the crisis in access to Medicare-covered home care. We encourage beneficiaries to appeal denials when they are not able to obtain coverage for all the home health services they need and for which they qualify under the law. We also urge beneficiaries to let us know about their difficulties, and success, in accessing care at <http://www.medicareadvocacy.org/submit-your-home-health-access-story/>. Working together, we will achieve appropriate and fair access to Medicare home health care.