

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

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

—————
SEPTEMBER 19, 2023
—————



Printed for the use of the Committee on Finance

—————
U.S. GOVERNMENT PUBLISHING OFFICE

COMMITTEE ON FINANCE

RON WYDEN, Oregon, *Chairman*

DEBBIE STABENOW, Michigan	MIKE CRAPO, Idaho
MARIA CANTWELL, Washington	CHUCK GRASSLEY, Iowa
ROBERT MENENDEZ, New Jersey	JOHN CORNYN, Texas
THOMAS R. CARPER, Delaware	JOHN THUNE, South Dakota
BENJAMIN L. CARDIN, Maryland	TIM SCOTT, South Carolina
SHERROD BROWN, Ohio	BILL CASSIDY, Louisiana
MICHAEL F. BENNET, Colorado	JAMES LANKFORD, Oklahoma
ROBERT P. CASEY, JR., Pennsylvania	STEVE DAINES, Montana
MARK R. WARNER, Virginia	TODD YOUNG, Indiana
SHELDON WHITEHOUSE, Rhode Island	JOHN BARRASSO, Wyoming
MAGGIE HASSAN, New Hampshire	RON JOHNSON, Wisconsin
CATHERINE CORTEZ MASTO, Nevada	THOM TILLIS, North Carolina
ELIZABETH WARREN, Massachusetts	MARSHA BLACKBURN, Tennessee

JOSHUA SHEINKMAN, *Staff Director*
GREGG RICHARD, *Republican Staff Director*

SUBCOMMITTEE ON HEALTH CARE

BENJAMIN L. CARDIN, Maryland, *Chairman*

RON WYDEN, Oregon	STEVE DAINES, Montana
DEBBIE STABENOW, Michigan	CHUCK GRASSLEY, Iowa
ROBERT MENENDEZ, New Jersey	JOHN THUNE, South Dakota
THOMAS R. CARPER, Delaware	TIM SCOTT, South Carolina
ROBERT P. CASEY, JR., Pennsylvania	BILL CASSIDY, Louisiana
MARK R. WARNER, Virginia	JAMES LANKFORD, Oklahoma
SHELDON WHITEHOUSE, Rhode Island	TODD YOUNG, Indiana
MAGGIE HASSAN, New Hampshire	JOHN BARRASSO, Wyoming
CATHERINE CORTEZ MASTO, Nevada	RON JOHNSON, Wisconsin
ELIZABETH WARREN, Massachusetts	MARSHA BLACKBURN, Tennessee

CONTENTS

OPENING STATEMENTS

	Page
Cardin, Hon. Benjamin L., a U.S. Senator from Maryland, chairman, Subcommittee on Health Care, Committee on Finance	1
Daines, Hon. Steve, a U.S. Senator from Montana	3
Wyden, Hon. Ron, a U.S. Senator from Oregon	4
Cantwell, Hon. Maria, a U.S. Senator from Washington	6

WITNESSES

Edwards, Carrie, R.N., BSN, MHA, LSSGB, director, home care services, Mary Lanning Healthcare, Hastings, NE	7
Stein, Judith A., J.D., executive director/attorney, Center for Medicare Advocacy, Willimantic, CT	9
Mroz, Tracy M., Ph.D., OTR/L, FAOTA, associate professor, Department of Rehabilitation Medicine, University of Washington, Seattle, WA	11
Dombi, William A., J.D., president, National Association for Home Care and Hospice, Washington, DC	13
Grabowski, David C., Ph.D., professor, Department of Health Care Policy, Harvard Medical School, Boston, MA	15

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Cantwell, Hon. Maria: Opening statement	6
Cardin, Hon. Benjamin L.: Opening statement	1
Daines, Hon. Steve: Opening statement	3
Prepared statement	35
Dombi, William A., J.D.: Testimony	13
Prepared statement	36
Responses to questions from subcommittee members	45
Edwards, Carrie, R.N., BSN, MHA, LSSGB: Testimony	7
Prepared statement	47
Grabowski, David C., Ph.D.: Testimony	15
Prepared statement	54
Responses to questions from subcommittee members	59
Mroz, Tracy M., Ph.D., OTR/L, FAOTA: Testimony	11
Prepared statement	62
Responses to questions from subcommittee members	69
Stein, Judith A., J.D.: Testimony	9
Prepared statement	78
Responses to questions from subcommittee members	87
Wyden, Hon. Ron: Opening statement	4

IV

COMMUNICATIONS

Page

Hillcrest Home Care	91
International Caregivers Association	92
Justice in Aging	94
National Academy of Elder Law Attorneys	97
Private Care Association, Inc.	99
Texas Association for Home Care and Hospice	101

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

TUESDAY, SEPTEMBER 19, 2023

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. Benjamin L. Cardin (chairman of the subcommittee) presiding.

Present: Senators Stabenow, Cantwell, Carper, Casey, Whitehouse, Hassan, Lankford, Daines, Young, Barrasso, and Blackburn.

Also present: Democratic staff: Martha P. Cramer, Staff Director for the Subcommittee on Health Care of the Senate Committee on Finance and Health Policy Advisor for Senator Cardin; Michelle Galdamez, Legislative Aide for Senator Cardin; and Matt Kearney, Legislative Correspondent for Senator Cardin. Republican staff: Grace Bruno, Health Policy Advisor for Senator Daines; and Micah Robertson, Staff Assistant for Senator Daines.

OPENING STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. SENATOR FROM MARYLAND, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator CARDIN. The Subcommittee on Health Care of the Senate Finance Committee will come to order. Our hearing today is “Aging in Place: The Vital Role of Home Health in Access to Care.” First, I want to start by thanking Senator Daines for his help and cooperation in putting together this hearing. I think there is a great deal of interest among both Democrats and Republicans on the subject, and I thank him for his help.

I want to thank Senator Wyden and Senator Crapo for allowing the subcommittee to hold this hearing, and for the help in arranging for the witnesses and for the preparations for the hearings. So, thank you, Senator, our chairman. We appreciate that very much.

Now, CDC defines aging in place as the ability to live in one’s own home and community safely, independently, and comfortably regardless of age, income, or ability level. I must tell you, when I meet with seniors, who are my contemporaries, their number one fear many times is the fact that they are not going to be able to stay in their community; they are going to be put into an institution or nursing home. And they point out that if they do that, the government picks up a large part of the cost.

So what they want to do, they want to stay in their homes; they want to stay in their communities. But they believe they are going

to be forced into an institution because of a lack of other options. We have excellent continuing care facilities, but they are beyond the financial reach of most of our seniors. Now, there have been some excellent examples of communities coming together for aging in place. And I want to give a shout-out to my own community in Baltimore, which over a decade ago established a government-private partnership for aging in place, sponsored by The Associated, that has become a national model.

We have those individual examples where we have been able to combine private resources with government resources to help our seniors age in place. They recognize that if they can stay in place—that is their preference—it is less costly, and it gives them more dignity and a better quality of life.

But the number one challenge, in my view, is the failure of our Nation to have a coordinated long-term care strategy. We do not. Our committee has jurisdiction over the health-care components of Medicare and Medicaid, but it goes well beyond the jurisdiction of our committee. And because of the lack of a coordinated policy, seniors often end up in a more costly environment, in a less desirable environment, and I would suggest a more dangerous environment, for their long-term health. And that is what the purpose of this hearing is: to go over the Federal role under the jurisdiction of our committee, the Medicare and Medicaid programs.

We have, under Medicare and Medicaid, home health-care services that are provided. They are recommended by health-care professionals and carried out by health-care professionals. They may be issues such as wound care or physical occupation or speech therapy or injection and nutrition therapies. In 2021, 3 million Medicare beneficiaries participated in home health services. About a quarter of those got their services after a hospital or institutional post-acute care setting. So, what are the challenges within the confines of home health services?

Well, first is workforce. Can we get the people to provide those services? And that has been complicated greatly because of COVID-19. COVID-19 just underscored the challenges we had in our health-care workforce. They are front-line workers, and we need them. And it was a challenge during COVID, and we are still suffering from a tight labor market and not having the trained people to be able to carry out those services.

But I would also suggest that the reimbursement structure has added to the challenges for people being able to get the home health care that they need. It is a complicated formula, so I am not even going to try to outline it here today. Maybe some of our witnesses will talk about it. But it is a challenge. But I do know this, that it, in many cases, did not offer the appropriate incentives for access to care, for home health care under Medicare.

And then we have, equally important, the nonmedical benefits under Medicaid, the assistance with activities of daily life, ADL, such as bathing, dressing, the transportation, meal preparations, and the list goes on and on. They are generally provided by home care aides. In 2021, 1.9 million Americans participated in the program, and they have a similar problem that we have with the home health medical services, which is a shortage of providers. It is very

difficult to get trained people in this field, and we also have a reimbursement issue as to whether we are going to get access to care.

So, we have challenges in both the health component and in the assistance with activities of daily living. I hope that we will have an opportunity to talk about that with the witnesses we have today.

There are long wait lists, long wait lists to get home health services. In my State, for the nonmedical benefits, we have 30,000 on the wait list. That is unacceptable. We can do better than that.

So, I recognize the challenges we have with long-term care strategy coordination. But we can do better in the Medicare and Medicaid programs in providing home health services. We are not optimizing the opportunities.

I hope this panel of witnesses will help us in understanding that and what we can do, and recommending changes to the system that will provide greater access for services that our constituents desperately need and want. I want to thank all of our witnesses for being here today. I will introduce you shortly, with the assistance of at least one of my colleagues.

But now, let me yield to Senator Daines.

**OPENING STATEMENT OF HON. STEVE DAINES,
A U.S. SENATOR FROM MONTANA**

Senator DAINES. Chairman Cardin, thank you, and a big “thank you” to our witnesses for being here this morning for a conversation on home health.

The home health benefit is a critical component of the Medicare program, and it is of increasing importance as our Nation’s senior population continues to grow. In fact, in my home State of Montana, 20 percent of our population is age 65 and older. In fact, Montana is currently ranked sixth in the Nation for States with the highest percentage of residents aged 65 and older. And we know from countless surveys and research that Americans overwhelmingly, overwhelmingly prefer to age in place, which allows them to remain in the comfort of their own homes, preserve their quality of life and dignity, and retain their independence to the greatest extent possible as they grow older.

Home health care plays an essential role in allowing our Nation’s seniors to do just that: to receive certain essential health-care services in their homes, where they are the most comfortable. However, facilitating this kind of care comes with a number of unique challenges, challenges not found in a traditional institutional health-care setting—for example, accounting for the time and the resources staff need to travel in order to see patients in their homes. And in more rural States like Montana, that is a really big deal.

As is so often the case, the difficulties of providing care to patients at home are exacerbated when you get to more rural-type environments. Earlier this year, the committee hosted a thoughtful discussion on the opportunities and obstacles that exist when it comes to facilitating health care in rural communities across the country. Many of the concerns raised in that hearing, including access, transportation, and of course the big issue of workforce, are applicable to administering home health care in rural States as well.

I am glad we are joined today by panelists who can speak to these particular challenges, as well as the nuances. Another value and intention of the home health benefit is the aim to be cost-effective. By offering services such as skilled nursing, physical therapy, and occupational therapy in the home, the benefit can help provide savings to the Medicare program by avoiding unnecessary and costly institutional care.

As we are all aware, the Medicare Hospital Insurance trust fund is fragile, and the rampant inflation over the past several years has had devastating effects throughout our economy. The health-care sector in particular has felt these pressures deeply. Going forward, we need to consider how the benefit can continue to be administered effectively, while also ensuring patients are able to receive the care that they need.

The concept and the benefit of home health have evolved significantly since its inception in 1965. That was a long time ago, Mr. Chairman. As Congress deliberates the future of home health, we need to be thoughtful as to what the benefits should look like, how they can best continue to serve America's seniors. And our ultimate goal is to make certain that patients are able to receive the right care, at the right time, in the right setting, with appropriate payment. Not an easy task, but I am glad we have the opportunity to dive into these topics today.

Thanks again to our witnesses for making the trip here, for being with us to lend their expertise and their experience to this conversation. I will look forward to the discussion, Mr. Chairman, and I will turn it back to you.

[The prepared statement of Senator Daines appears in the appendix.]

Senator CARDIN. Thank you very much, Senator Daines.

With that, I will recognize the chairman of our committee, Senator Wyden, who has been a real champion on home health and on moving forward in our health-care system, and has been responsible for a lot of action in our committee to improve access to health care and affordability of health care.

Senator Wyden?

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Chairman Cardin and Senator Daines. We've got a terrific bipartisan duo here, and I am going to talk just very briefly and close by mentioning the committee's bipartisan tradition in tackling home health care, and just make a couple of points very quickly.

The first is, it is very rare in the public policy field when you have an opportunity to make sure that families and communities get more of what they want, which is care at home, than the alternative, which is institutional care. Since my days as codirector of the Oregon Gray Panthers, I have always thought that this was a pretty straightforward proposition.

When people ask about the cost of designing home health-care services, I always say you cannot afford not to. You cannot afford to pass up this kind of option: giving people more of what they want at less cost to taxpayers. So that is number one.

Number two, now is exactly the time for us to look at this issue beyond the next few weeks and towards the long term. We all know that Medicare has some long-term challenges. We have seen in the papers recently that the rate of growth has subsided a little bit. I would like to think that the Affordable Care Act has had something to do with that. We also know that the challenges are real.

So, I am only going to wrap up with this, Chairman Cardin. If you look down towards the last few seats in the dais on the Republican side, you will get a little sense of the history, because Senator Olympia Snowe, Republican of Maine, was a great champion of home care. Where Catherine Cortez Masto is sitting, there was a Senator from the other end of the country who had a full head of hair and rugged good looks—and that was me—and we were always talking about home health care. So I would just make an appeal to Chairman Cardin and Senator Daines: let us pick up on the bipartisan tradition in the Senate Finance Committee of pursuing long-term solutions to big health issues.

Let us do for this, colleagues, what we did for chronic disease, where we moved Medicare from being an institutional program to also focusing on cancer and diabetes and heart attacks and stroke and all the chronic conditions. We have excellent leadership in Chairman Cardin and Senator Daines, and I very much look forward to working with them.

And by the way, before we wrap up, let's take note of the fact that Senator Stabenow, who unfortunately I cannot talk out of retirement, has also been a terrific advocate on these issues.

So, I look forward to working with my colleagues.

Senator CARDIN. Thank you, Senator Wyden. I am glad you acknowledged Senator Stabenow—who was the previous chair of the subcommittee—and the work that she did. We are carrying on in that legacy, so let me thank our colleagues for the work that they have done.

I want to now introduce our five witnesses. I will introduce all five in order, with the help of Senator Cantwell with one, and after the introductions, you will be able to give your opening statements. We would ask that you limit them to around 5 minutes so we have time for exchanges; and without objection, your full statements will be made part of the record.

We will start with Carrie Edwards, who received her BSN in 2002 from Creighton University, and obtained her MHA in 2013 from Bellevue University. Carrie has been employed by Mary Lanning Healthcare for 24 years, currently working as the director of home care since 2010, and has worked in the home care arena since 2004.

Carrie started as an aide in the private duty agency in 1999, and enjoyed spending one-on-one time with patients and their families. I understand that you brought your daughter Caitlin with you today. Hello, Caitlin. It is nice to have you in our committee, and if I am correct, I think your class is streaming this hearing, so we have a larger audience. Thank you for giving us a larger audience. We appreciate that very much.

And our second witness is Ms. Judith Stein, who is the executive director of the Center for Medicare Advocacy, which she founded in 1986. She has focused on legal representation of older people since

beginning her career in 1975. From 1977 until 1986, she was the codirector of the legal assistance for Medicare patients, where she managed the first Medicare advocacy program in the country.

She has extensive experience in developing and administering Medicare and related advocacy projects and conferences, representing Medicare beneficiaries, producing educational material, teaching, and counseling. She is the author of the Medicare handbook. So, we have a lot to learn from Ms. Stein's presentation.

Our third witness is Dr. Tracy Mroz, and I will yield to Senator Cantwell.

**OPENING STATEMENT OF HON. MARIA CANTWELL,
A U.S. SENATOR FROM WASHINGTON**

Senator CANTWELL. Thank you, Mr. Chairman, and thank you for this important hearing. I would like to introduce Dr. Tracy Mroz from the University of Washington. She is an associate professor in the Department of Rehabilitation Medicine at the University of Washington School of Medicine.

This is an important institution in our country because it is the number one site for production of primary care physicians in the United States of America. And I am sure Dr. Mroz will tell you how important it is to have the actual physician productivity to see this growing population.

She is a health service researcher and background occupational therapist, and she spent her academic career conducting research on access and quality of the home health-care system. So, I think she will be able to give us a pretty broad range of how those issues are changing, particularly home health care in rural communities. And her impressive work has received funding from the National Institutes of Health and the Health Resources and Services Administration, the agency for health-care research and quality.

And just like my colleagues, I am anxious to hear the panel overall, but particularly Dr. Mroz, on this issue of the fact that our population reaching 65 and older is expected to double in the next 30 years. And so, we have a big challenge here, particularly not just with the production of physicians and the home delivery, but actually homes.

If we do not have affordable housing, we do not have a way to keep people in their homes, and my guess is, we will have a much more expensive Medicaid budget because of it, because then people will be in assisted living, and then it will be more costly. So this is a really important task for us. So I very much appreciate your masters of science in occupational therapy and doctor of philosophy in health services research from Johns Hopkins.

So, we will look forward to hearing your thoughts on how we tackle this very important quality of health care issue, workforce issue, housing issue, and certainly the impact on our Federal budget issue. I definitely think this panel can lead us to more affordable solutions for both the residents we are talking about, but also for our government as well.

Thank you.

Senator CARDIN. Thank you, Senator Cantwell. And, Dr. Mroz, welcome.

Mr. William Dombi is the president of the National Association of Home Health Care and Hospice. As a key part of his responsibility, Bill specializes in legal, legislative, and regulatory advocacy on behalf of patients and providers of home health and hospice care.

With over 40 years of experience in health-care law and policy, Bill Dombi has been involved in virtually all legislative and regulatory efforts affecting home care and hospice since 1976, including the expansion of Medicare home health benefits in 1980, the formation of the hospice benefits in 1983, the institution of Medicare PPS for home health in 2000, and the national health-care reform legislation in 2010. So we can blame you for all the problems it looks like we have in the system. [Laughter.]

Dr. David Grabowski is the professor of health-care policy at Harvard Medical School, where he studies long-term care and post-acute care. He has published over 235 peer-reviewed studies on this topic. He is a former member of the Medicare Payment Advisory Commission, MedPAC, and has served on several CMS technical expert panels, including one related to Medicare home health-care payments.

As you can see, we have real experts on this subject matter, and I just want to underscore what Senator Wyden said. We look forward to your suggestions as to how this committee can proceed in a bipartisan manner, to provide the type of services that the people of our community want in home health care.

And we will start with Ms. Edwards.

STATEMENT OF CARRIE EDWARDS, R.N., BSN, MHA, LSSGB, DIRECTOR, HOME CARE SERVICES, MARY LANNING HEALTH-CARE, HASTINGS, NE

Ms. EDWARDS. Mr. Chairman, Ranking Member Daines, and members of the committee, thank you for the opportunity to testify at this important hearing focusing on the Medicare home health benefits. I would like to thank Senators Stabenow and Collins for their unwavering support to ensure that Medicare beneficiaries have access to high-quality home health services, by introducing Senate bill 2137, the Preserving Access to Home Health Act. I encourage every Senator to join as cosponsors.

My name is Carrie Edwards. I serve as the director of home care services at Mary Lanning Healthcare, located in Hastings, NE. Our home health agency is a hospital-based, nonprofit rural provider. At Mary Lanning Home Health, we have over 50 years of experience bringing health-care services into the homes of central Nebraska residents. We offer a variety of services to meet patient needs right in the comfort of their own home, including skilled nursing; physical, occupational, and speech therapy; lymphedema therapy; medical social work; and home health aide services.

From my nearly 25 years of experience in the home health field, I can confirm that home is where the heart is. Most of us just feel better when we are at home. That is why I fell in love with helping people stay in their homes, even when facing significant health challenges. But our ability to deliver patient-preferred, high-quality, cost-effective lifesaving home health services is in jeopardy, and not due to any service failures of Mary Lanning Home Health,

but rather because of decisions being made right now by CMS that threaten my home health agency and thousands of other agencies across the country.

Our long history of service to the residents of Nebraska is at risk due to the significant payment reductions that CMS started in 2020, with the new payment model. Mary Lanning Home Health previously covered a 13-county, 60-mile radius of Hastings, located in Adams County. In March of this year, we had to decrease our service area to a 40-mile radius. Several months later in May, we had to make the difficult decision to further reduce our service area to only cover Adams County, which covers a 25-mile radius, including the city of Hastings. Some of the previous counties that we once served no longer have coverage by any home health provider.

So for this year, we have declined services to 50 percent of the referrals we used to see because those 55 referrals fell outside of our reduced service area. Our average daily census count was reduced by more than 60 percent since the implementation of the new payment model, from an average of 88 patients in 2020 to a census count in September 2023 of 32.

CMS's actions are also having a direct impact on our ability to retain our existing workforce. We have had three registered nurses resign due to fear that the payment cuts being proposed by CMS will force our agency to close. The three nurses did not leave nursing; instead, they went to work for other health-care providers rather than risk remaining with Mary Lanning Home Health.

Hospitals are seeing higher-acuity patients than in previous years, and our agency is providing more intensive home health services to a population that has more complex needs and increased comorbidities. When a patient is not able to be admitted to a home health agency, the result is a longer stay in the hospital, placement in a skilled nursing facility, or foregoing care altogether.

I am very proud of the quality of care we have provided at Mary Lanning Home Health. In 2022, our home health agency prevented 93.5 percent of patients we served from being readmitted to the hospital, averaging a low of 7.6 percent readmission rate that was well below the State and national averages. Year to date, we have prevented 93.7 percent of the patients we serve from being re-hospitalized, and our patients have been extremely satisfied with our level of care, as we have a five-star patient satisfaction rating on Home Health Compare.

As we look to prepare for 2024 with the pending payment reductions that CMS has proposed, and the potential for payment reduction spanning past 2030, we are doing everything possible to remain operational. There are agencies throughout Nebraska and the country that are at serious risk of closures.

If I can leave the committee with one takeaway from my testimony, it is that CMS and policymakers should be finding every way possible to make increased investments in Medicare home health services, instead of the current path of year-after-year payment cuts that are jeopardizing my agency's ability to care for Medicare beneficiaries, and for me to continue my calling to service, so that Nebraskans can safely recover at home, where most of us just feel better.

Thank you.

[The prepared statement of Ms. Edwards appears in the appendix.]

Senator CARDIN. Thank you very much for your contribution.
Ms. Stein?

**STATEMENT OF JUDITH A. STEIN, J.D., EXECUTIVE DIRECTOR/
ATTORNEY, CENTER FOR MEDICARE ADVOCACY, WILLI-
MANTIC, CT**

Ms. STEIN. Good morning, Chairman Cardin, Ranking Member Daines, and distinguished members of the committee. Thank you for inviting me to testify today. I am Judith Stein. I am the founder and executive director of the Center for Medicare Advocacy.

The Center is a national, private, nonprofit, nonpartisan law organization based in Connecticut and Washington, DC, with attorneys in Maryland, Massachusetts, and California. The Center works to advance access to comprehensive Medicare coverage, quality health care, and health equity. We provide education and direct legal assistance to help Medicare beneficiaries throughout the country. Among other things, we respond to 7,000 calls and emails annually and pursue thousands of Medicare appeals of wrongful denials of coverage and care.

Our policy work is based on the real-life experience of the beneficiaries and families we hear from every day. Our health-care system is in dire need of reform, including Medicare. I have many ideas about how to do so, and I am sure my fellow panelists and members of this committee do too. And while there are many improvements to the Medicare home health benefit that I would like to recommend, when it comes to the Medicare home health benefit, my main message today is simple: enforce the law that already exists. Currently, this is not the case.

Instead, Medicare home health coverage is incorrectly understood and implemented as a short-term acute-care benefit by those who administer the Medicare program, home health providers, and those who make Medicare coverage decisions. Under the law, Medicare home health coverage can be an important resource for Medicare beneficiaries who need health care at home. When properly implemented, the Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services, all of which add to the health, safety, and quality of life of beneficiaries and their families.

Under the law, Medicare coverage is available for people with acute and chronic conditions, and for services to improve or maintain, or slow decline of, an individual's condition. Further, coverage is available even if the services are expected to last over a long period of time.

With an intent to expand home health services, in 1980 Congress removed a 100 home health visit cap in the Omnibus Budget Reconciliation Act of 1980—removed a cap of 100 visits. Congress again recognized the ongoing nature of Medicare's home health coverage in the Balanced Budget Act of 1997, when it established a Medicare Prospective Payment System that recognized the benefit was not just short-term, and it arranged for payments under Part B—for people who have both Part A and B—for more than 100 vis-

its, and arranged that if people do not have Part B, more than 100 visits will be paid for under Part A.

Federal regulations and Medicare policy reiterate that there is no duration of time to the Medicare home care benefit. The Center, unfortunately, hears regularly from people who meet Medicare coverage criteria but are unable to access Medicare-covered home care or the appropriate amount of care.

Perhaps most glaringly, access to Medicare home health aides is disappearing. Home health aides provide help with personal hands-on care. The care is often key to the well-being of patients who want to age in place, as well as for their families and caregivers. Unfortunately, Medicare beneficiaries are often misinformed about Medicare home health coverage in general, and home health aides in particular. They are told that it is for a short term, for a few weeks, for a bath from the home health aide, just for one to three times a week.

Under the law, Medicare authorizes 28 to 35 hours a week of a home health aide's personal hands-on care. Instead, this care is being shifted to State Medicaid programs and families. Currently, statistics demonstrate the dramatic change in coverage. Home health aide utilization declined steadily over the past 2 decades by almost 94 percent.

Access to the full array of Medicare-covered home health services is lacking for beneficiaries in traditional Medicare, but it is even worse for those enrolled in Medicare Advantage. In 2021, the Center surveyed 200 home health agencies across 17 States about Medicare-covered care. When we asked the home health agencies whether things were worse when their beneficiaries and patients were enrolled in Medicare Advantage, they said Medicare Advantage plans often fight tooth and nail on the number of visits they will allow. That was from a home health agency in Connecticut.

"There is a difference. Medicare Advantage plans do not approve as much services," said an agency in Louisiana. "Abso-freakin-lutely, Medicare Advantage plans in our area are rotten," said a provider in Kansas. Today, Medicare payment policies, oversight measures, audits, and quality measures create disincentives to provide necessary, ongoing home health care.

These policies and practices must be reviewed and revised by Congress and by CMS. They must be geared to ensuring that public Medicare funds are actually used to provide the full array of home care for all people who qualify under the law. Congress must ensure that Medicare's home health payment model is structured to encourage home health agencies to provide all these services for all who qualify.

If the law was properly understood and implemented, vulnerable Medicare beneficiaries would be able to obtain the care they need to live well and safely at home. If the law was properly enforced, there would be positive, transformational change for older people, people with disabilities, and their families throughout the country.

Thank you, and I hope you will read my testimony, which I prepared with a long bibliography of all we have written about this incredibly important benefit. Thank you so much.

[The prepared statement of Ms. Stein appears in the appendix.]

Senator CARDIN. I have enjoyed your testimony so much, I will read your full statement. So, thank you very much. I appreciate that.

Ms. STEIN. Thank you.
Senator CARDIN. Dr. Mroz?

STATEMENT OF TRACY M. MROZ, Ph.D., OTR/L, FAOTA, ASSOCIATE PROFESSOR, DEPARTMENT OF REHABILITATION MEDICINE, UNIVERSITY OF WASHINGTON, SEATTLE, WA

Dr. MROZ. Good morning, Mr. Chairman, Ranking Member Daines, and distinguished members of the committee. My name is Tracy Mroz, and I am an associate professor in the Department of Rehabilitation Medicine at the University of Washington.

Thank you for inviting me to provide testimony about opportunities and challenges for home health in supporting aging in place. I will focus my comments today on the role of home health for aging in place, disparities in access to home health in rural communities, and key drivers of access to care.

Medicare's home health benefit provides an opportunity to support aging in place for the 3 million beneficiaries who receive home health annually. Admission to home health following a hospitalization, known as post-acute home health, helps bridge the transition from a hospital back to home.

Admission to home health directly from the community, known as community-entry home health, supports beneficiaries with chronic conditions who experience a change in health or functional status that does not require hospitalization, but would benefit from services to promote recovery, stabilization, or prevent further decline, so the beneficiary can remain safely at home.

Both post-acute and community-entry home health are crucial for rural beneficiaries, because they tend to be older and they are in poorer health compared to their urban counterparts. But the promise of home health to support aging in place relies on the beneficiary's ability to access this care.

While the vast majority of beneficiaries live in communities served by at least two home health agencies, the reality of access to home care for rural beneficiaries is far more nuanced. The number of agencies serving a community represents supply, which is a necessary but not sufficient measure of access to care. Rural agencies may refuse referrals for new admissions when they do not have adequate capacity. For beneficiaries who are admitted to home health, visits may be delayed or reduced due to the amount of what we call "windshield time," which is the travel time that is required when patients are dispersed widely across large geographic areas.

So it is perhaps unsurprising that there is a growing body of evidence on disparities in access to home health based on rural/urban status. Rural beneficiaries are less likely to be discharged to home health following hospitalization, and beneficiaries in the most remote rural communities are at the highest risk for unmet need.

Further, fewer than 60 percent of rural beneficiaries with a planned discharge to home health actually receive this care. Even when rural beneficiaries are admitted to home health, they face disparities in access to specific services. Rural beneficiaries who ex-

perience a stroke or have a knee replacement are less likely to receive rehab services, despite the essential role of rehabilitation for these patients.

Adequacy of financial resources and health workforce are two key drivers of access to home health for rural beneficiaries. Please refer to my written testimony for additional factors. Rural agencies cannot serve their communities without adequate resources. Even though average Medicare margins for agencies are high, more of the agencies that serve rural communities are nonprofit or governmental versus for-profit, and hospital-based versus freestanding.

These distinctions are important, because margins tend to be lower in nonprofit and governmental agencies, and hospital-based agencies often rely on their relationship with the hospital to remain financially viable. In recognition of extra costs required to serve rural beneficiaries, Medicare has intermittently provided a percentage increase in payments to home health agencies for providing that care. Rural add-on payments may help maintain supply of agencies serving rural communities, and even reduce hospitalizations, but these payments have decreased over time and are being sunsetted. Agencies are also navigating other changes that impact Medicare reimbursement.

The Patient-Driven Groupings Model implemented in January 2020, shortly before the emergency of COVID-19, presents a major redesign in reimbursement that can disincentivize community-entry home health, longer stays, and rehab service provision, which in turn may hinder opportunities to support aging in place for the most vulnerable beneficiaries.

Further, the national rollout of the home health value-based purchasing model is underway, putting lower-quality agencies at risk for severe financial penalties. This is problematic when rural beneficiaries have no other options for care. Access to home health also depends on successful recruitment and retention of qualified workers. Rural agencies have cited multiple barriers to recruiting and retaining staff, including geographic isolation, unreliable transportation, and wages that are not competitive with rural hospitals and similar jobs in urban areas.

The home health aide workforce is much lower per capita in rural communities, and is particularly fragile due to low wages, unpredictable hours, and emotionally and physically demanding work. Policies to support this workforce are urgently needed, because without a workforce, there is no care.

In conclusion, the Medicare home health benefit is currently supporting beneficiaries' ability to age in place, but the full potential of home health has not been realized, particularly for rural beneficiaries. Research suggests the need for targeted solutions that incentivize service provision for beneficiaries at risk for reduced access and poor outcomes. As agencies continue to adapt to multiple policy changes and emerge from the public health emergency, it is essential to monitor the stability of rural agencies and its impact on rural beneficiaries.

Thank you, and I look forward to the discussion.

[The prepared statement of Dr. Mroz appears in the appendix.]
Senator CARDIN. Well, I thank you very much for your testimony.
Mr. Dombi?

STATEMENT OF WILLIAM A. DOMBI, J.D., PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE AND HOSPICE, WASHINGTON, DC

Mr. DOMBI. Good morning, Chair Cardin, Ranking Member Daines, and the remainder of the host Subcommittee on Health Care. I want to thank you for the opportunity to present my views on the vital role that home health services play in our continuum of care, and the challenges faced today in preserving access to these essential services. I currently serve as president of the National Association for Home Care and Hospice, and I could probably say I was codirector with Judy Stein years ago in Medicare advocacy in Connecticut.

I come to you today to present information on the state of the Medicare home health services benefit. I may bore you with some statistics, but I think they are necessary numbers to hear. While it continues to provide significant care support for millions of beneficiaries each year, the home health agencies providing care and beneficiaries receiving care really need your help.

The Medicare home health benefit covers an increasingly essential service, and as Senator Wyden referenced, it is one of the areas that has brought the parties together, both in the House and the Senate, over many years. We actually have a poster in our office exemplifying that. Notably, it is the only benefit available under both Medicare Part A and Part B, and Congress has implemented and enacted improvements in the benefit design, standards, coverage, and care for many years.

These improvements include the elimination of cost sharing on services to incentivize patients to select care in the home; extending the scope of coverage to an unlimited number of service visits for the same purpose; refining the definition of “confined to home” to allow non-medically related absences from the home, such as attending religious services; and establishing patient rights, quality of care measures, and compliance standards that ensure care quality.

The benefit is quite a wide coverage area in skilled nursing, therapy, medical social services, and home health aide services, when meeting all the eligibility standards. These services are available to patients without regard to whether their condition is acute, chronic, or at end of life.

While the benefit design and standards of coverage present a valuable Medicare benefit, in practice the benefit’s trajectory is deteriorating. Since 2011, Medicare beneficiaries have experienced reductions in care and losses in care access not experienced in other sectors.

Statistics on your way. In 2011, 3.5 million users of home health services received an average of 36 visits per year. Ten years later, after changes in the payment model, only 3 million users, 500,000 fewer patients, were receiving home health services. A drop in average visits also accompanied that, to 25.4 million, a half-million people less 10 years later receiving services.

Since 2011, the number of home health agencies also has dropped by over 1,000 nationwide. Rural areas have been especially hit hard, as the testimony of Carrie Edwards suggests, but it is not

just rural areas. Inner cities are losing home health services as well, causing great disparities in access to care.

Senator Cardin, in Baltimore, it takes security escorts in order to bring home health care to some of the neighborhoods in Baltimore. They deserve the care, and the caregivers deserve the security in doing so, but it has reduced access to care in the end.

Medicare spending data shows the same roller-coaster journey of the benefit. Home health spending today is virtually the same as it was in 1997, despite 24 years of cost inflation. In 1997, the Congressional Budget Office estimated that 10 years later, \$40 billion a year would be spent on home health services. It is still under \$17 billion a year all these years later. It is a tell-tale sign that we cannot continue to see happening.

In comparison, inpatient hospital spending rose from \$80 billion to \$130 billion, while skilled nursing facility care, what home health is trying to avoid, rose from \$11 billion to \$27.2 billion. The future presents an outlook that calls for significant action from all stakeholders. The correlation of payment cuts and reduced access is obvious and ominous.

There are several signs that the existing difficulties in care access will continue. The American Hospital Association reports significant increases in the length of stay due to the inability to place patients in home health services. Patient referral rejections have increased by 50 percent. Only 55 percent of the referrals are actually being converted to patient admissions, and only 67 percent of discharges from hospitals actually result in admission to home health services.

CMS data shows that 52.7 percent of freestanding home health agencies are projected to have financial margins below zero with the cuts proposed for 2024. It is overall financial margins that really measure financial stability, not the incomplete analysis presented by MedPAC.

Medicare margins, to the extent they exist, are subsidizing other payers like Medicaid and Medicare Advantage. Care is going to patients, not into people's pockets. To restore and preserve the Medicare home health services benefit, we offer the following recommendations.

Number one, Congress should pass S. 2137 and H.R. 5159, the Preserving Access to Home Health Act of 2023, and we strongly support and applaud Senators Stabenow and Collins for bringing this legislation to the Senate. CMS should withdraw its proposal for the significant cuts in Medicare payment rates scheduled to take effect on January 1, 2024. They have the authority to do that, and Congress should mandate the development of a comprehensive analysis of the root causes of the ongoing deterioration of the home health services benefit.

Thank you for the opportunity to present this testimony. I look around this room, and I see Senators who, if they take a look at what is going on in their States, they will see closures. Senator Hassan, New Hampshire; Senator Whitehouse, Providence, RI, VNA—a 100-year-old operation—closing; Senator Stabenow in Michigan; Senator Lankford.

All across the country, we are seeing closures. It is *déjà vu* for me. I came to Washington in 1987 to prosecute a lawsuit against

the Medicare program to restore it to its full important purpose. I expected to stay 3 years. I am still here. I think, as I told Senator Cardin, I have become a Baltimore Orioles fan—who could not be? But I intend to stay here until we can finish this mission with all of you, to make the home health benefit the true value that it is.

So, thank you for the opportunity.

[The prepared statement of Mr. Dombi appears in the appendix.]

Senator CARDIN. Well, you know how to get my attention. All you have to do is mention the Baltimore Orioles.

Mr. DOMBI. Thirty-seven years in Washington taught me some of those things.

Senator CARDIN. Right. Last night they won in the 9th inning again.

Dr. Grabowski?

STATEMENT OF DAVID C. GRABOWSKI, Ph.D., PROFESSOR, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL, BOSTON, MA

Dr. GRABOWSKI. Good morning, Chairman Cardin, Ranking Member Daines, and distinguished members of the Subcommittee on Health Care. Thank you for the opportunity to testify today on this important topic.

I am here today speaking in my capacity as a researcher who has studied home health care for over 2 decades. Care is shifting out of institutions and into the home. This shift to home-based care is consistent with the preferences of Medicare beneficiaries and their caregivers to age in place. From a policy perspective, a key objective is to provide individuals with the necessary services to not just age in place, but to age in place safely and successfully. The Medicare home health benefit can potentially help beneficiaries to do this. Yet there have been recent reports of access issues, especially in rural areas.

I want to focus my testimony today on ways that Congress can ensure strong access to home-based services for all of our beneficiaries. First, let us talk about payment. I want to stress that Medicare fee-for-service home health-care payments are generally adequate to ensure access.

The 2023 MedPAC report to Congress found Medicare margins have reached an all-time high of 24.9 percent. Agencies serving rural areas had an even higher Medicare margin of 25.2 percent. If the Congress is going to address rural access through payment, I would recommend they do so through a rural payment add-on or some other targeted rural policy.

They should not try to solve the potential rural access problem through an adjustment to the overall payment system, which is currently paying home health agencies well above cost. Medicare adopted the Patient-Driven Groupings Model, or the PDGM, payment system for home health care right before the start of the pandemic.

I would argue that it is not yet possible to determine whether and how the model has impacted home health access, because we cannot disentangle what changes are due to the PDGM and what changes are due to the pandemic. I would caution the Congress

about making major changes to the PDGM at this time. Let us wait for more data.

Also, we know that enrollees in Medicare Advantage plans use less home health care, often from lower-rated agencies. Beneficiaries in these plans face mechanisms like prior authorization review and utilization management that are not used in fee-for-service Medicare. Because we currently have a poor understanding of home health access for Medicare Advantage enrollees, the Congress should request a comprehensive evaluation of this issue.

Next, we know that labor challenges are contributing to home health access issues. The most direct policy to increase the size of the labor force is through wage increases. Once again, Medicare fee-for-service payments are well above costs, such that most agencies should be able to pay home health-care workers the prevailing market wage rate.

If there are certain markets where this is not the case, Congress could once again consider targeted policies for home health agencies to use towards the higher cost of labor in these markets. Also, we are flying blind with respect to whether beneficiaries are accessing high-quality home health care.

Unfortunately, we have a limited set of validated quality measures in this space. Home health agencies are mandated to collect detailed assessment data, but MedPAC and others have questioned the accuracy of the assessment data because they are agency-reported and not subject to consistent audit or review. The Congress should encourage the development of improved quality measures, including the increased auditing and oversight of the existing agency-reported assessment data.

Finally, I would argue that Medicare home health care is necessary but not sufficient for Medicare beneficiaries to age in place. Many individuals receiving care in the community also have extensive long-term care needs. They typically rely on family caregivers, paid help, or Medicaid for their long-term care.

As such, there are disparities by race, ethnicity, and income as to who can age in place with Medicare home health-care services. I would encourage the Congress to pursue policies to continue to support family caregivers. I would also strongly recommend that the Congress continue to invest in policies to expand Medicaid home and community-based services. And finally, I would push the Congress to expand models that strongly integrate Medicare and Medicaid services for dually eligible beneficiaries.

In summary, access to Medicare home health care is generally strong, but there are some steps that Congress can take to further improve access. I look forward to working with the members of this subcommittee on this effort.

Thank you.

[The prepared statement of Dr. Grabowski appears in the appendix.]

Senator CARDIN. Thank you very much for your contribution. I thank all of you. We will start a 5-minute round of questions.

A couple of things you said are very disturbing, Mr. Dombi. I would have intuitively thought that we would see a significant increase in home health care over that period of time, and that would

be a success—keeping people in their home environment, less costly than institutional care—but that is not the case.

Ms. Stein, you got our attention by saying “enforce the law.” You know, something about Congress when we pass laws is, we like to see them enforced. The fact that, particularly in Medicare Advantage, they look at this as an acute-care need rather than a long-term need, I think is pretty obvious when you look at the numbers that are out there on the utilization in managed and Medicare Advantage programs.

So how do we overcome that, because, as I said in my introductory comments, we do not have a really coordinated long-term care strategy in this Nation. It goes well beyond health-care needs. We know that. How do we make the Medicare/Medicaid reimbursement programs and benefits more functional to the long-term needs of individuals who really want to stay in their community as long as they possibly can but need to be able to get the services they need?

So, enforce the law sounds great, but can you expand on that a little bit? And I will start with Ms. Stein, and we will give Mr. Dombi a chance.

Ms. STEIN. Thank you. I am happy to do so. The main thing about enforcing the law I meant to really emphasize is, to ensure that Congress knows and insists that CMS knows and implements this benefit in a way that does not constantly imply and enforce the myth that this is a short-term, acute-care benefit.

There are policies and practices that incentivize the program to be short-term and acute-care, and CMS says it all the time. We have corrected myriad handbooks and pamphlets that come from CMS indicating that this is a short-term benefit when it is not. That myth really needs to be dispelled.

Then the payment model, the quality measures, and the auditing and oversight of the benefit all need to be geared to ensure that people who qualify under the law—they are homebound, they have a physician or authorized practitioner’s order, and they need a skilled service—that they can get all the services that they need for as long as they need them.

Currently, the PDGM payment model actually creates disincentives for this to be the case. It pays more for the first 30 days of service. It pays more for people who come from a hospital or an institution. It pays less for people over the long term and if they came from their home and did not need a hospital stay.

Audits are done for outliers, as they call them, for agencies that provide services for more than 30 days. There should be oversight of underutilization, underprovision of services. There should not be a disincentive to provide services for people who need them to maintain or slow the decline of their condition.

Senator CARDIN. Let me give Mr. Dombi a chance. Let me hear about Medicare Advantage.

Mr. DOMBI. I think Medicare Advantage offers a great promise for care in the home, but it is a fully unfulfilled one at this point. Medicare Advantage should be one of the strongest partners with home health because, as Medicare fee-for-service has demonstrated, home health services bring dynamic value to the Medicare program, a value-based purchasing program.

One of the only ones that was successful at CMMI is in home health, returning billions of dollars to Medicare by keeping people out of hospitals and readmissions to hospitals through home health services. I think the plans need to wake up, you know, read the data, and understand the value that is there. And then maybe they could respect home health services not only in terms of utilization, but in terms of payment rates. Right now, Medicare Advantage plans pay about 80 to 85 percent of the cost of care.

Senator CARDIN. Dr. Grabowski, let me give you a chance. One of the studies that I have looked at on the effectiveness of home health care, studied by the National Institute on Aging, found that racial minorities showed less functional improvement as a result of home health care than White patients, giving us the clear indication that, once again, the underserved community is underserved. Your comments about that.

Dr. GRABOWSKI. Health care is local, and very similar to nursing homes, we have 11,000 home health agencies, so they very much reflect the communities in which they operate. And so, there is that huge variation we see across areas showing up in the home health-care data, and we need to do better there by not just improving their home health care and giving more support there to these individuals, but also this is about Medicaid; this is about their long-term care and, obviously, broader community resources as well.

Thanks.

Senator CARDIN. Senator Daines?

Senator DAINES. Chairman Cardin, thank you.

I will get into the topic of access as it relates to home health. Earlier this year, the Medicare Payment Advisory Committee reported to Congress that almost all beneficiaries have access to home health services based on data indicating that 98 percent of beneficiaries live in ZIP codes served by two or more home health agencies. So they are kind of claiming success here through that at least particular analysis. However, simply living near a health-care facility does not necessarily guarantee a patient's access to services.

Dr. Grabowski, could you speak to the challenge of access in home health and why living in proximity to an agency is not necessarily an ideal indicator of access in this context?

Dr. GRABOWSKI. Yes. I love the way that Dr. Mroz framed it earlier. It is necessary that you have a home health agency in your ZIP code, but it is not sufficient. And because you have one in the ZIP code does not mean they are regularly accepting new patients; it does not mean they are delivering timely visits.

So, it is great that we have this strong supply of home health agencies around the country, but it is not always clear that supply alone is an indicator that individuals have strong access. Thanks.

Senator DAINES. So, they are scoring this as a 98, which usually is an "A" on most tests, but it suggests perhaps there is a problem here.

Dr. GRABOWSKI. And I do not want to—I cannot speak for MedPAC and why they do that, but I think the issue is data. We just do not have the kind of data on timely visits, whether they are accepting new patients. So, the supply is a nice proxy for access, but it does not tell the whole story.

Senator DAINES. Well, Dr. Grabowski mentioned you, Dr. Mroz. I think you probably have some thoughts on this as well.

Dr. MROZ. Yes, thank you. So, as we mentioned, there is quite a gap between referrals to home health and actual admission to home health, and Ms. Edwards spoke to this point as well. I mentioned that fewer than 60 percent of beneficiaries with a discharge order for home health coming from the hospital actually wind up admitted to a home health agency and get that care.

So I am 100 percent a believer that the number of home health agencies that serve a ZIP code is not going to give an accurate picture. As Ms. Edwards also said—I will call out as well her personal experience in this with her home health agency. We hear it from our research too, that many home health agencies do not have the capacity to accept every referral and every admission that comes their way.

Senator DAINES. So, if—and again, it may not be the ideal proxy. Any thoughts around what might be a better proxy here as we try to evaluate access?

Dr. MROZ. Yes. We need to compare actual rates of use of home health, and we do see disparities, particularly in the most rural communities. And we also need to look at refusals—referrals that are refused. We need to talk to the home health agencies to see how much they are being asked to provide services, and whether or not they do that.

The one challenge in that though, is there are communities where they stop even referring to home health because they know their patients are not going to be accepted. So, there will still be a gap in measurement, but that is a start to moving towards a better picture.

Senator DAINES. Well, it is helpful though. That may not be a perfect analysis, but perhaps better is possible as we start to look at this, to get a more accurate picture of reality.

Since 2001, Medicare has intermittently provided an add-on payment for home health agencies serving rural communities through various reimbursement percentage increases. The most recent rural add-on payment was a 1-percent increase to home health agencies providing services in low-population-density areas for the duration of 2023.

Dr. Mroz, we are from kind of the same side of the country out there at UW. Could you share your perspective on the value of this add-on payment and how it affects the service delivery and accessibility of home health for rural patients in Medicare?

Dr. MROZ. Thank you, Senator Daines. I would be happy to comment on that. We have found in our research, and research from other universities has actually found that the rural add-on payment has great potential to both increase access to care, as well as provide the services that they need to provide, reducing hospitalizations.

So the decrease and then sunset of the rural add-on payment is of great concern. So, 1 percent—our research shows that that's probably not enough to make a difference for home health agencies to be able to serve more rural beneficiaries, and to provide the services once they are being admitted to the service.

So I will say, research also really supports targeting. Rural is not homogenous. You know this. Anyone who lives in a rural State knows this. Not every rural county is the same. So we also need to make sure that those rural add-on payments are targeted towards those beneficiaries that are truly not going to receive care otherwise.

Senator DAINES. Lastly, Ms. Edwards, I mentioned in my opening remarks some of the difficulties providers face when operating in a rural and less populous service area. Could you share with us some of the challenges you are experiencing at Mary Lanning and maybe perhaps a best practice that you put in place that might help address these challenges?

Ms. EDWARDS. Yes, I would be happy to. Thank you, Senator Daines. Our biggest challenge was, we are rural, and we still are rural, just covering one county. When we covered those 13 counties previously, that was 42,000 Medicare beneficiaries, not including the pediatric patient population that we serve.

We are one of the only home health agencies in our region that takes pediatric patients, so that impacts all patients of all ages. Now that we've decreased, there's about 7,000 Medicare beneficiaries just in Adams County. So that impacts a lot of the beneficiaries, because some of those counties are still not covered.

I would say, best practice—the tenured staff we have. They love what they do. They are focused on high-quality care, and we try to accept every referral we possibly can within our area if we are contracted with their payer type. That is always a challenge as well.

Senator DAINES. Thank you.

Senator CARDIN. Senator Blackburn?

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you to our witnesses for being here today. This is an issue I have worked on since I was in the State Senate: how we increase options and choices for seniors. And home health is an important part of that.

Right now, what we have found is, there are 74,000 Tennesseans who are on the Medicare home health benefit. Eighty-seven percent of those Tennesseans have three or more chronic conditions. So these are complex medical conditions, and they require high-quality home health care.

And we are hearing from our providers in Tennessee a tremendous amount of concern about the payment policy that CMS put in place in 2020, and how it is creating some instability and uncertainty in the process for these individuals. I have visited with many who have looked at how next year's payment rates proposed in June would make matters worse for these patients.

And as we have discussed today, and as you all have discussed in your testimonies, seniors want and deserve the ability to be able to stay in their homes. But you look at this payment policy and then you look at this historic inflation, and also the workforce challenges that we have, especially in rural areas, and you can see that this is creating what will end up being a perfect storm, in the most negative sense, for many seniors with complex medical issues.

Mr. Chairman, I will tell you, I think CMS should have been at this table today, to talk about this payment policy and about this proposed rule.

So, Ms. Edwards, let me come to you first. Just for a moment, talk about what would happen to your agency if this rule were finalized and put in place?

Ms. EDWARDS. Yes. Thank you for the question. If this payment policy goes through with additional reductions, I have no doubt that our agency would probably have to close. We have already reduced to the bare minimum that we possibly can right now, and much further would indicate a closure.

Senator BLACKBURN. Yes. You cannot work without making some money.

Mr. Dombi, when you look at small health-care agencies—we have 95 counties in Tennessee, and just about every one of them has a home health agency. They are small. Talk about the impact on these small independent providers that are out there trying to meet the needs in their community, trying to work alongside a rural hospital, trying to work alongside a long-term care facility, and trying to provide the service in-home.

Mr. DOMBI. Yes, I have the fortune and misfortune of traveling around the country and talking to the home-care providers. The word of the year for them that I heard in Georgia this week, in Texas last week, and other States over the previous weeks, is survival.

Most home health agencies are, just as you described, small operations. Even the very large companies are very local, small companies in that respect. So, their fear and anxiety are growing, and when you look at what they are doing, they are saying “no” to patients. There is no harder thing for a health-care professional to do than to say “no,” and to say, “No, you are not going to be able to come home. You are going to end up in another institutional care setting instead.”

That crushes them, and it crushes their hearts and their souls, and the families are absolutely affected by that as well. And sometimes the “no” is because they do not have capacity, but a lot of the capacity actually is due to their financial circumstances.

A home health agency reported recently to me that they made job offers to 160 nurses, and every one of the nurses said “no,” because they could get paid higher—

Senator BLACKBURN. Yes, and those health-care worker challenges are important. I want you to talk for just a moment too about the lack of interoperable electronic health records and the impact that this has. Having helped care for someone who was elderly, you see some of these gaps.

Mr. DOMBI. Yes, and this is very ironic, because so many resources have been directed towards physicians and hospitals for interoperable health records. Nothing was directed towards home care. Yet home care actually was first out of the gate and ready to go to health care with interoperable health-care records.

We have a nurse in an individual’s home right at this very moment who has point-of-care planning with her, either her phone or her iPad, with electronic connections to physicians, to hospitals, to their own office. But they do not talk the same language—the ability to respond immediately to someone’s needs in the home setting when something exacerbates and their clinical condition requires that kind of interoperability. So we are looking at saying, “Will the

rest of the world catch up with us some day, so that we can have the full value of those interoperable health-care records to provide the highest-quality care to the patients as well?"

Senator BLACKBURN. Thank you. My time has expired.

Dr. Mroz, I am going to submit a question in writing to you. Thank you.

Thank you, Mr. Chairman.

Senator CARDIN. Senator Stabenow?

Senator STABENOW. Well, thank you so much, Mr. Chairman and Ranking Member Daines, for this very, very important hearing. I have been working on these issues, I think, most of my professional life, and certainly starting in the House of Representatives. I cannot thank all of you enough for your very important testimony.

For the life of me, I can never understand how, as we move forward on health-care policy, one of the proposals is always somehow to cut home health care, even though people want more home health care; even though, during the pandemic and now afterwards, we are seeing increased needs as a result of this. But somehow home health-care payments are always a part of the equation, which I think is the opposite of what we should be doing.

So, I also want to say that we know we have serious workforce shortages that need to be addressed in so many areas, and we need to continue to be doing that. I do have to say I appreciate the support that has been given for the bill that Senator Collins and I have, the Preserving Access to Home Health Care Act. I think it would provide the certainty and stability to home health-care providers that is needed right now by preventing additional cuts. I hope, Mr. Chairman, we will be able to move forward on that as quickly as possible.

But let me start, Ms. Edwards, with you first. Thank you so much for coming and telling your story, and for supporting our legislation. One of the things that I kept thinking about though as you were talking was, you keep shrinking your service area, right?

So you had 13 counties. Now you have one county. What happens to the rest of the people in those other counties? What is happening for them?

Ms. EDWARDS. Thank you for the question. They have options for other home health agencies. Many do not serve the full county they are in. Many of them will not accept those higher-need patients for—again, like I mentioned before, they might not be in contract with the payer. So a lot of them—

Senator STABENOW. Are just not getting service.

Ms. EDWARDS [continuing]. Are not getting service.

Senator STABENOW. Or they maybe get really, really sick and they end up in a hospital, right?

Ms. EDWARDS. Or, if they are referred from the hospital, they might end up staying there longer. We have had patients in the hospital for 40, 50, sometimes 200 days because there is no place for them to go.

Senator STABENOW. And so, it is really just like the proverbial punching bag, right? If we are not providing adequate home health care for people, they could very much end up in the hospital at a higher cost of care—or not getting any care and then getting sicker, and then something else happening.

And so, home health care is incredibly important in the equation for people, and it is what people want for themselves and their families.

Ms. EDWARDS. Yes.

Senator STABENOW. Let me ask Mr. Dombi: in talking about payments—I mean, it is people, but we have to talk about reimbursement, because that is how we get the services and pay for the workers to be able to provide the services that people need. Could you talk a little bit more about the current and proposed payment policies that are cuts? Let us just call it what it is. It is cuts, and really, what does that mean for the average provider of home health services?

Mr. DOMBI. I mean, as you noted, there is an intimate relationship between payment and service. I am really tired of talking about payment policy and payment rates, but it is still essential to do so. Medicare's proposal would cut payment rates by 5.653 percent in 2024, and there is a \$3.5-billion "debt" hanging over the heads of home health agencies right now, contributing to their anxiety.

Combine that with the fact that there was a forecasting error in the inflation rate that led to rate changes for home health agencies, a shortage of 5.2 percent for the years 2021 and 2022. And particularly, labor costs rose significantly. That is now baked in permanently into the payment rate. So that 5-percent shortfall will continue ad infinitum. CMS has refused to correct that forecasting error. So, when we are looking at it, it adds up. CMS added it up itself: an \$870-million reduction in spending for home health, just in 2024.

And \$870 million will repeat itself over and over and over again for the rest of the Medicare home health benefit's life. So we are really talking about some long-term negative impacts as a result of that. And these are on top of cuts that took place in 2023. And so, the other thing that stands out is that CMS was required to create this new model in a budget-neutral fashion.

It seems really kind of elementary when you see that spending and utilization of home health has gone down from the previous 2019 model of care, in 2019. I mean, losing half a million patients over a short period of time should tell CMS this was not a neutral transition at all.

Senator STABENOW. Thank you, and thank you, Mr. Chairman. I just want to say in concluding that we know that, as we are fortunate enough to really live longer and health care is allowing us to do that, our needs on home health care are only going to grow. And so, we need to right-size this and stop putting patches on it over and over again.

So, thank you, Mr. Chairman.

Senator CARDIN. Thank you, Senator Stabenow.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. I want to thank the chairman and ranking member of the subcommittee. It is an incredible conversation that we need to have, and I have a number of questions, but I have only got 5 minutes. So, I am going to try to get through them. But let me caveat it by this.

This is such a timely conversation, because in my own family, my mother has a first cousin who can no longer live by himself. He would prefer to age in place, but he cannot. And I am assuming, and maybe I am assuming wrong, but part of the challenge may be—and, Ms. Stein, this is why I am going to ask you to address this a little bit more—is this idea that CMS is enforcing Medicare as a short-term acute-care benefit.

What he needs is some sort of assisted living, long-term care. So here is his option: if he cannot get that from Medicare, then he has to sell his house, take \$50,000, \$60,000 from whatever he sells it for, give it to the assisted living, and still pay \$5,000 a month to be eligible for assisted living, and really monitor his own medication.

This is the option we are giving seniors. This is the option for individuals if they cannot age in place because they cannot access the benefits that we are providing for them through Medicare and/or Medicaid. So can I ask, is that part of the problem we are seeing here? Is it—should we be looking at this implementation of the law, that it is incorrectly being implemented by CMS at this point in time? Is that part of the challenge we are seeing here?

Ms. STEIN. Yes, it is definitely part of the challenge.

Senator CORTEZ MASTO. Go ahead.

Ms. STEIN. Audits look to overutilization. If an agency provides care for longer than 30–60 days, then they are afraid that they will be audited for providing more care than is the norm. And of course, the more that agencies provide care for shorter periods of time, the more the norm becomes short-term.

Quality measures are based on improvement, so that people who cannot improve in ambulation but may be able to maintain what they have if they have physical therapy come in, if they have aides help them at home, their agencies will not get quality star ratings sufficiently because the quality measures are based on improvement.

So we need to have quality measures that show that they have maintained or slowed declined. We need auditing that looks at underutilization, not just so-called overutilization. We need an increase on the cap of outlier payments—outlier meaning people who get longer-term care.

And the PDGM, that payment model needs to be revised so that people who are able to avoid a hospitalization are not less popular to home health agencies because they are paid less to take care of them from home, and because they are paid less after 30 days of care.

So the payment model, the quality measures, and the auditing all need to be revised so that it looks to and tries to incentivize getting the full array of care that patients need for the length of time that they need it.

Senator CORTEZ MASTO. And does anyone on the panel disagree with what Ms. Stein has just said, as part of the challenges that we should be focused on here in Congress? Nobody disagrees with that? Okay; I thank you, because I think it is exactly what I am looking for, and I know my colleagues are as well.

Let me add one thing to this—and we have talked about it; it is the workforce issue. Let me just couch it in this way, that we have

the Guinn Center in Nevada, and it found that Nevada will need 5,300 more home health aides by 2026 to meet the growing demand for home health services.

Nevada currently has around 13,000 home health workers, the backbone of our health-care system. But in Nevada, every county is a designated health-care workforce shortage area. And so the question is, what else do we need to be doing besides—I agree. I hear from home health-care workers all the time. We have got to increase their wages and benefits.

What else should we be thinking about? What else needs to be done here to bring in and really grow that workforce? That is a challenge. Mr. Dombi, I heard what you just said about the nurses and the choices that they are making, rightfully so, based on the wages that they can get somewhere else. What else should we be thinking about here? What else needs to be done?

Mr. DOMBI. I mean, there are all those kinds of things that involve money, but I want to focus on something that does not. We really need to show respect to that workforce. We need to raise their image, celebrate the heroes that they are, delivering the care, and recognize that they are more essential to our economy, to our families and everything else, than the people who work at Dunkin' Donuts who make more money than they do.

But they are not getting that kind of respect that they deserve. I mean, they are caring for grandparents and aunts and uncles and my age group, people I went to high school with. Yes, Senator, I really am 110 years old. But you know, it may sound ethereal, but it really does matter, you know?

We need to get people to want to aspire to do that work, and I know that Carrie Edwards's daughter is one of those individuals right now, as a high school student delivering those kinds of services. We need more people like her out there to demonstrate that this is a value that our country truly, truly honors.

Senator CORTEZ MASTO. I could not agree more, Mr. Dombi. Thank you.

I know my time is up. Thank you.

Senator CARDIN. Senator Whitehouse?

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Our Rhode Island experience through COVID was pretty illuminating about telehealth. There had been a huge row about whether telehealth made sense, whether it should be paid for—a big squabble. When it became absolutely necessary to go to telehealth, period, because of COVID, a lot of the objections and concerns evaporated.

The use of telehealth proved itself very quickly, and we leapt through what had been a lot of barriers. Did anything similar happen with respect to home health care as a result of the COVID experience, Ms. Stein?

Ms. STEIN. Yes. There was telehealth provided for people who wanted to and could access it in their home. But you know, one of the things that I—

Senator WHITEHOUSE. But how did that roll into the home health service side of the equation?

Ms. STEIN. It helped for people, for instance, who needed physical therapy and could access video and follow instructions from a ther-

apist in that way. We had people who we knew were getting physical therapy. But if it is wound care—it depends on the need of the patient, and it depends on the availability, what tech they have available, and how well they can use it.

Home health aides provide hands-on personal care, so it is less effective with that kind of care.

Senator WHITEHOUSE. One other big shift in Rhode Island was when two of our major primary care providers became ACOs, Accountable Care Organizations.

Ms. STEIN. Yes, yes.

Senator WHITEHOUSE. Coastal Medical was one, Integra was another. Both of them were among the highest-performing ACOs in the country, and they ramped up home health service delivery on a patient-by-patient basis, because it was in their interest, once they were somewhat freed from fee-for-service, to make sure that each patient was getting the best care that they needed to keep them healthy and therefore to keep costs down. And so, that has worked really well.

Mr. Dombi, do you see expanding—what more can we do to have that ACO example improve the experience of patients with access to home health services?

Mr. DOMBI. You are so correct, that the successful ACOs have relied upon home health services to their own financial business benefits, in addition to the patients' benefit. And the learnings from those ACOs are now being transmitted to other ACOs, to managed care programs and the like, because it has been ambitious to bring home health-care services to the home, but it has been an underappreciated and underutilized benefit.

So, a lot of the learning that you have noted that was there is now being passed on to others, to see that kind of benefit. So, as I mentioned, the value-based purchasing program with home health in the Medicare program has shown that dynamic value.

And so, it is taking longer than we had hoped, but it would really benefit for more to take advantage of it. I want to add to what Judy was offering on telehealth services. During the pandemic in particular, there were millions of telehealth visits done by home health agencies to patients in their homes, working in concert with physicians and nurse practitioners and the like to substitute for in-person services. And they did that in the context of a program that prohibits recognition of the cost of telehealth services, as part of setting payment rates for that. So we are looking to modernize the Medicare program, to recognize that telehealth is valuable.

Senator WHITEHOUSE. Yes. So, my time is getting a little bit short. So I would like to ask any witness who cares to respond in writing, as a question for the record, about any specific recommendations that you have on how we can use the ACO model, and how we can use the telehealth means to expand home services.

Are there things that we can do with CMS regs, or things that we can do with CMMI models, or the things we can do with legislation, that would expand what appear to be two very productive gateways, both for lowered cost and for improved patient care and patient experience? And if I am not mistaken, the home health value-based program—I do not know if anybody is tracking that on the panel—it appears to have saved a lot of money.

I am getting some nods. So that actually creates—it is not just Rhode Island's experience that a well-run ACO can deliver home health services effectively to people and save money, or that telehealth can facilitate inexpensive home health service delivery, but also you've got this model program that worked and that created savings.

Mr. DOMBI. And we worked in partnership with the Department of Health and Human Services to expand nationwide the value-based purchasing this year. Medicare projects it will save \$3.5 billion over 4 years in avoidance of higher-cost care, particularly in hospitals, for that. So we would be glad to work with you.

Senator WHITEHOUSE. Thanks.

Well, Mr. Chairman, it sounds like we know of some things that work. We need to do more of them. Thank you for the hearing.

Senator CARDIN. Thanks, Senator Whitehouse.

Senator Young?

Senator YOUNG. Dr. Grabowski, I am going to ask you a series of questions. I ask that maybe you reply quickly. Some of them—I apologize if they have been asked earlier today. But you mentioned in your testimony care shifting out of institutions and into the home, and seniors want to be at home, which is no surprise, I think, to any of us.

We need to ensure policies support that trend in a sound way—which is one of the reasons we are here today—ensuring appropriate access, quality care, and consistent health outcomes. You comment that there is adequate access to Medicare fee-for-service for home health agencies, but is it timely access, sir?

Dr. GRABOWSKI. Yes. This is such an important issue, that supply does not equal access, that obviously we need better data. Are they getting timely visits, as you suggest, and I do not know that we know that nationally right now. That would be great if we could get such a data set.

Senator YOUNG. Noted and appreciated.

When a patient has been referred to home health, how long does it take for those services to begin, typically?

Dr. GRABOWSKI. They should start relatively quickly, and that is actually a measure of quality, like timely initiation of care.

Senator YOUNG. Right.

Dr. GRABOWSKI. So you would hope within 48 hours.

Senator YOUNG. Okay. Are hospitals able to routinely identify a home health agency for patients when they are ready for discharge?

Dr. GRABOWSKI. Sometimes yes, sometimes no. It can vary. There is software where they can sort of give beneficiaries a roster of places, but—

Senator YOUNG. And who is measuring this quality outcome?

Dr. GRABOWSKI. We know—

Senator YOUNG. Rewarding it, presumably.

Dr. GRABOWSKI. We have data on timely initiation of care, but we do not really know about refusals, we do not really know the process of how that happens. Kind of—that is all underneath the surface.

Senator YOUNG. Okay. Are seniors or families reasonably able to find a home health agency with availability?

Dr. GRABOWSKI. That, once again, can really vary by market. And yes, they can go on Home Health Compare and compare the star ratings, but they do not know if that particular home health agency is accepting patients at that time. So there is a lot of blurriness on the part of, I think, our patients and their family members.

Senator YOUNG. Yes. And we are, I think, appropriately asking patients to be consumer-oriented, discerning shoppers. We need to empower them to do that, I think.

Dr. GRABOWSKI. Absolutely. I would say very quickly, there is legislation that hospitals—I know not every home health patient comes through the hospital, but for those leaving the hospital, the Congress has put legislation in place that they, the hospital, should be helping them. But hospitals are not always doing that, and the hospitals do not want to play too heavy of a role in that. But they should be providing information to beneficiaries.

Senator YOUNG. Okay. So we need to persuade them and incentivize them, perhaps, to comply with existing law?

Dr. GRABOWSKI. Right; and by incentivize as well—Senator Whitehouse mentioned ACOs. That is a perfect example of an entity that is very incentivized to worry about cost and placement. As was suggested earlier, there has been a lot of transition out of skilled nursing facilities to home health agencies when you incentivize hospitals under an Accountable Care Organization, or ACO.

Senator YOUNG. All right. Thank you, Doctor.

Can you speak to the health outcomes for patients who utilize home health, compared to those that do not?

Dr. GRABOWSKI. You know, there is absolutely a benefit to home health. My only sort of tweak—and I said this in my testimony—is that I wish we had better data, and I wish the assessment data were better than the agencies report, because I think oftentimes it is—

When you track over time, a lot of the claims-based measures that we think are more objective, seem to be suggesting stagnant quality or even declining quality, where these agency-reported quality measures seem to be suggesting improvement. I worry that we do not have a great set of quality measures here.

Senator YOUNG. Sure, sure. What data is missing to ensure patient access to quality home health services?

Dr. GRABOWSKI. I think it goes back to a lot of those agency-reported measures like physical functioning. Are they improving? Are they maintaining their physical functioning? So I do not know that we have great accuracy with the current data that are being reported.

Senator YOUNG. Okay. As you answered these questions, I see some real opportunities for us to eye some things up, so to speak.

Dr. GRABOWSKI. Absolutely.

Senator YOUNG. You cautioned Congress about making major changes to the Patient-Driven Groupings Model, PDGM, that payment system, given this new system was adopted at the start of the pandemic. Based on the design of the payment model, what should we expect in terms of access under the PDGM?

Dr. GRABOWSKI. Well, the PDGM, just to back up a little bit, really changed incentives pretty dramatically. Under the old payment system, home health agencies were paid based on the amount of therapy that they delivered.

And so, as you can expect, when you pay for therapy, you get lots of therapy. Under the new system, they are paid based on patient characteristics. And so, we should see higher-acuity patients being admitted into home health. That would be the expectation.

I think it is a little early, given the pandemic, to really track what has happened under the PDGM. So I would just caution Congress about making changes until we are able to move out of the pandemic and really get a sense of how this policy is working.

Senator YOUNG. And then as we come to a close, I am going to ask you a two-part question. How long will it take for researchers to, in your words, disentangle what changes are due to the PDGM, and what is due to the pandemic? So how long will it take for that, and do you feel there is the potential for access concerns, as researchers and CMS navigate post-pandemic data?

Dr. GRABOWSKI. So, I think it will take several years. I think it will be over the next several years that we will get a sense of how things are working, so the next 2 to 3 years, when we begin to get data. I hope we are able to look at access. It has to move, as you said, as you indicated with your very first question. It has to move beyond supply and utilization-based measures, and really look at timely visits—whether agencies are able to accept new patients, what types of patients are being admitted into home health.

Senator YOUNG. Thank you, Doctor, Mr. Chairman.

Dr. GRABOWSKI. Thanks.

Senator CARDIN. Thank you, Senator Young.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman. Welcome, everybody. Nice to see you. Thank you for joining us for this important conversation. I think we would all agree that home-based health care plays an essential role in ensuring that everyone receives the care that they need, when they need it, and where they want it.

We saw the demand for home-based health care rise during the COVID-19 pandemic. Hospitals and health-care facilities were over capacity, as you will all recall. Patients preferred to receive care at home where possible and when appropriate.

One program out there that was established to meet this demand was the acute hospital care at home waiver program, known as Hospital at Home, because it allows Medicare beneficiaries to receive hospital-level health-care services in their home. Since its enactment, hospitals and health systems across, I think the last time I checked it was 34 States, including my own home State of Delaware, have utilized the Hospital at Home program to provide safe, high-quality hospital-level services in the homes of patients.

The Hospital at Home program has been a true success story. It has delivered positive outcomes. It has delivered higher reported patient satisfaction, and I understand that it has also delivered potential cost savings. Where I come from, that is a win-win-win situation.

To ensure that patients and their providers would have access to the Hospital at Home program for 2 years, beyond the duration of

the COVID-19 public health emergency, last Congress Senator Tim Scott, a member of this committee, and I introduced the Hospital Inpatient Service Modernization Act. I am proud that the Congress passed our bipartisan bill, and it was signed into law by President Biden last year.

A question, initially for Mr. Dombi and I think for Dr. Grabowski. The same question for each. Mr. Dombi, could you please share how the Hospital at Home program has continued to serve patients past the end of the public health emergency?

Mr. DOMBI. Well, you know, I will call it the demonstration program of enlightenment.

Senator CARPER. Oh, I like that.

Mr. DOMBI. I thought of it just moments ago, but—

Senator CARPER. You don't mind if I steal it?

Mr. DOMBI. It is all yours. What I meant by that is, we built the Medicare program in 1965 on a continuum of care concept that was setting-focused, and the Hospital at Home demonstration program shows that the continuum of care should be patient-focused, rather than setting-focused. The capability of delivering a high level of acuity of care to individuals in their own home, bringing high-quality results, cost savings, and certainly a lot of satisfaction—none of us wants to go out of our home for health care if there is a way of avoiding it.

So more than anything else, put aside the technical aspects of the program and the like. It is just that this has created an environment for innovation and the delivery of health care that is even wider than the Hospital at Home program. That is what I would love to be able to have conversations with this committee about instead of payment rates, for a program that actually established that care in the home is cost-effective, high-quality—the home health benefit under the Medicare program.

So I am hoping, before I am needing Hospital at Home services, to be able to have those kinds of conversations.

Senator CARPER. All right; good. Thank you.

Dr. Grabowski, same question. Could you share with us how the Hospital at Home program has continued to serve patients past the end of the emergency?

Dr. GRABOWSKI. Yes. It is an incredibly innovative program. We have a model in Boston just down the street from where I work, at Brigham and Women's Hospital. Some colleagues there have a Hospital at Home program, and when they actually put it out in the field to test it, they actually had to self-finance it, because there was no payment mechanism to support Hospital at Home for patients in the Boston market at that time.

This is a place where I think a lot of the delivery-level innovations are maybe ahead of some of the payment innovations that are out there. So I am also, similar to Mr. Dombi, very excited about this kind of model and its potential.

Senator CARPER. Good; thank you.

A follow-up question, and for each of you, for Mr. Dombi and for Dr. Grabowski. What lessons have we learned from the success of the Hospital at Home program? What should we as legislators keep in mind as we work toward making Hospital at Home a permanent program?

Mr. DOMBI. We learned, among other things, that marriage between professional services and technology actually enhances the quality of care. We have learned that we should not hold ourselves back from creativity and innovation and live in the 1965 era of the Medicare program. We should learn also to listen to the providers of health-care services. It was at Johns Hopkins that Hospital at Home was born as a concept many years ago, but it took quite a while to take off after that.

So I think we have learned a lot that could be there, and we have learned a lot still as it is unfolding on how we can refine it, improve it, and really make it the full value that is out there, including how it can be a transition to segue back to the Medicare home health benefit, a segue back to home health services, when an individual's level of care needs are satisfied from the hospital level back to the home health side.

Senator CARPER. All right; thank you for that. Same question, Dr. Grabowski. What should we as legislators keep in mind as we look at possibly making Hospital at Home a permanent program?

Dr. GRABOWSKI. Sure. The title of this hearing is "Aging in Place," and I think sometimes we have a very narrow view of aging in place. The Hospital at Home program suggests we should not limit ourselves to very particular models, but think quite broadly, because there are incredibly innovative models that are out there.

Hospital at Home, really, I think is pushing the envelope, and I hope that policy catches up with kind of some of what is happening at Hopkins and also at Harvard. Mr. Dombi called out Hopkins, but also—it may have started at Hopkins, but lots of great work is going on elsewhere.

Senator CARDIN. He was right to call out Hopkins. [Laughter.]

Mr. DOMBI. Are we dealing with a rivalry here?

Senator CARPER. All right. Thanks to all of you. Thanks for joining us today. It is a good discussion, and we appreciate it very much.

Senator CARDIN. Senator Hassan?

Senator HASSAN. Thank you, Chair Cardin, and I want to thank you and Ranking Member Daines for having this hearing. Thank you to our witnesses for being here today. Thank you, Senator Carper, for the line of questioning you just had. I would also say that if we can partner with families like mine, which have been dealing with children, who are now adults with complex medical conditions, at home for an entire generation, there is a lot of creativity and innovation to be had, and I would really look forward to working with these witnesses and all of my colleagues on improving things like Hospital at Home and implementing them.

But I did want to start with a more specific question to you, Ms. Stein. Senators Duckworth, Blackburn, Casey, and I recently urged the Centers for Medicare and Medicaid Services to conduct a comprehensive review of its coverage of mobility-assistive equipment, such as wheelchairs, canes, and scooters. CMS currently has a really narrow interpretation of what equipment should be covered and when. We were just talking about silos and specificity that reference back to very outdated models. Medicare right now covers equipment for daily activities within the home, but many people

also need equipment that is more appropriate for use outside of the home.

We are asking CMS to reassess this standard to ensure that individuals with disabilities can get the support that they need to live independently and to participate in their communities. So, Ms. Stein, can you speak to how Medicare's limited coverage of mobility equipment impacts patients and their families, as well as the implications it has for individuals' participation in their communities?

Ms. STEIN. Absolutely; thank you for the question. And I think this is a place where both Congress and CMS need to revise outdated law and policies. As you know, it is said in order to get Medicare coverage for most equipment prosthetics and orthotics, they need to be primarily for medical reasons, and primarily used in the home. And by the way, the home cannot be your SNF, your nursing home.

The definition of "home" needs to be changed by Congress. But the use in the community is incredibly important, and as an example, what we thought were the horizons for people with disabilities have fortunately been expanded. So we do not want, nor do people with various disabilities need to remain in home with their equipment. And in 2023, the equipment can often allow them to exit home to work, to be with family, whether it is mobility devices, whether it is technology so that they can speak, which Congress fortunately covered a few years ago under Medicare.

These things definitely need to be looked at. CMS has authority under its current mantle to define the medical use and the value of this equipment, where and when it can be used. They should push the envelope with regard to the use of this equipment and standardize equipment so that people can use it given their particular disabilities. And then legislation would be helpful to expand the notion of what is primarily medical use, and to be able to use it in the community.

Senator HASSAN. Well, thank you very much for that input.

Ms. STEIN. I hope that is helpful.

Senator HASSAN. That is helpful, thank you.

Ms. STEIN. And if we can help you from the Center for Medicare Advocacy, we would greatly like to offer our legal acumen and stories from our clients. This is a very important area.

Senator HASSAN. Thank you very much. We will follow up with you on that.

Mr. Dombi, I wanted to ask you a question. As you know, the Centers for Medicare and Medicaid Services are currently working to finalize a payment rule for Medicaid home health services. This rule includes important updates to the Medicaid home care benefit to preserve the quality and safety of home health care. It would require that home health organizations direct 80 percent of their Medicaid payments towards workers' wages.

So, I strongly support fair wages for essential workers such as home health aides, but I am concerned that this requirement may have really unintended consequences. New Hampshire has an unemployment rate right now just under 2 percent. It is the lowest in the country. Home health organizations face significant vacancies for positions and competition for workers. The requirements

outlined in CMS's recent proposed rule would require a level of staffing that simply may not be available in the short term.

So, can you speak to these workforce challenges and the potential impact of this rule on access to home health care?

Mr. DOMBI. Yes. We as an organization have long supported better compensation to the caregiving workforce, and I think the proposed rule has that intention. It is just not a good execution on the intention that is there. We have analyzed multiple States and whether or not their systems would lead to positive or negative outcomes as a result of it.

That 20 percent that is there goes towards such things as supervision, training of the aide, as well as the day-to-day business stuff of billing their Medicaid program on that. So, we do not find a single State that could meet that standard, and if they cannot meet that standard, what happens with the program, because the consumer of services is on the outside looking in?

So we certainly would like to work with you, work with the White House, and work with CMS to come up with better approaches to achieve the same end. I know Senator Casey, one of your colleagues, has also been very actively involved in this issue.

So I think there is—you know, so long as there is a will, there is a way, and I think we need to take a different path, but we can get there.

Senator HASSAN. Thank you very much for that, and I thank you for the indulgence, Mr. Chair. I have one more question that I will submit for the record to Dr. Mroz about the waiting lists, and I appreciate very much this hearing. Thank you.

Senator CARDIN. Thank you, Senator Hassan. Let me thank all of our witnesses again. You could tell by the number of members and their participation that this is an area of great interest to this committee. We understand the importance of home health care, and we recognize that we have not achieved the level that we need or expect for our country.

And yes, when the PDGM reforms were put in, it was before the pandemic, which made it much more challenging to understand its impact. There have been a lot of changes in our health-care system since COVID. Its intent was to deal with access and reward for those who have more complicated needs. That was certainly worthwhile and worthy, and it was to be budget-neutral.

It is questionable whether it has achieved either one of those objectives, and it may very well have cost resources that otherwise should be in home health care. Your observations here are very helpful for us. I think we all are looking for ways to make our health-care system more efficient. I appreciate Senator Whitehouse's comments about the ACO plan; that was part of our efforts to deal with that.

Telehealth is an area that this committee has taken strong bipartisan positions on to try to institutionalize a lot of the practices during COVID-19, moving forward on reimbursements for telehealth as a preferred option for a lot of health-care needs. Certainly home health can take advantage of that. That is efficiency with access to care.

My own State of Maryland has a total cost of care model, the only one in the country that deals with hospital and related costs

on the total cost of individuals, which would include home health. So there are models out there that can be looking at efficiency.

But one thing we do know is that the current reimbursement is having a major impact on the workforce: lack of confidence that there will be a future in government reimbursements for home health services. It has not provided the incentives needed for access to care in many communities. We have a lot of underserved communities, whether they are rural or minority communities.

So we have challenges with the reimbursement structure that we need to deal with. And then, as you pointed out, we look at home health care as a long-term care need. We do not look at it as acute care. That is how Congress set it up, because we want to have a more efficient overall health-care system.

And yes, we have done a lot in regards to acute care under the Affordable Care Act, but we really have not taken up long-term care, which is one of the challenges we have as a Nation. And this is just one of the reactions of not taking up a rational policy and not having the most efficient way to provide home health services that we should.

So, as Chairman Wyden indicated, this committee has a strong reputation of working in a bipartisan manner. As you can tell by the questions asked by both Democrats and Republicans, there is really no difference in our views on how we have to deal with this subject. I can assure you that this will be a major interest of our committee, and we recognize that there are urgencies out there. Ms. Edwards, your program and services in your community, obviously we see it being contracted, and that is not what we want to see.

So, I just want to thank you all again for your testimonies and contribution to this debate. As is the tradition of our committee, members will be asking questions for the record. A couple have already given you an indication of what that will look like. We would ask that you would respond to those questions in a prompt manner. We have a way of our committee putting those together and getting them out to you.

And with that, as there is no further business before the subcommittee, the subcommittee will stand adjourned, with our thanks to our witnesses.

[Whereupon, at 11:53 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. STEVE DAINES,
A U.S. SENATOR FROM MONTANA

Thank you, Mr. Chairman. And thank you to all of our witnesses joining us this morning for a conversation on home health.

The home health benefit is a critical component of the Medicare program, and it is of increasing importance as our Nation's senior population continues to grow. In my home State of Montana, 20 percent of the population is age 65 and older. In fact, Montana is currently ranked as sixth in the Nation for States with the highest percentage of residents aged 65 and above.

We know from countless surveys and research that Americans overwhelmingly prefer to "age in place," which allows them to remain in the comfort of their own homes, preserve their quality of life, and retain their independence to the greatest extent possible as they grow older. Home health care plays an essential role in allowing our Nation's seniors to do just that—to receive certain essential health-care services in their homes, where they are most comfortable.

However, facilitating this kind of care comes with a number of unique challenges, challenges not found in a traditional institutional health-care setting—for example, accounting for the time and resources staff need to travel in order to see patients in their homes.

As is so often the case, the difficulties of providing care to patients at home are only exasperated when it comes to rural America. Earlier this year, this committee hosted a thoughtful discussion on the opportunities and obstacles that exist when it comes to facilitating health care in rural communities across the country. Many of the concerns raised in that hearing—including access, transportation, and workforce—are applicable to administering home health care in rural States as well. I'm glad we are joined today by panelists who can speak to these particular challenges and nuances.

Another value and intention of the home health benefit is the aim to be cost-effective. By offering services such as skilled nursing, physical therapy, and occupational therapy in the home, the benefit can help provide savings to the Medicare program by avoiding unnecessary and costly institutional care.

As we are all aware, the Medicare hospital insurance trust fund is fragile, and the rampant inflation over the past several years has had devastating effects throughout our economy. The health-care sector in particular has felt these pressures deeply. Going forward, we need to consider how the benefit can continue to be administered effectively, while also ensuring patients are able to receive the quality care they need.

The concept and benefit of home health have evolved significantly since its inception in 1965. As Congress deliberates the future of home health, we need to be thoughtful as to what the benefit should look like, and how it can best continue to serve America's seniors.

Our ultimate goal is to make certain that patients are able to receive the right care at the right time and in the right setting, with the appropriate payment. Not an easy task, but I'm glad we have the opportunity to dive into these topics today.

Thank you again to our witnesses for being with us to lend their expertise and experience to the conversation. I look forward to the discussion.

PREPARED STATEMENT OF WILLIAM A. DOMBI, J.D., PRESIDENT,
NATIONAL ASSOCIATION FOR HOME CARE AND HOSPICE

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

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

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

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

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

- Elimination of beneficiary cost sharing on services.
- Extending the scope of coverage to an unlimited number of service visits.
- Elimination of the prior-hospitalization requirement.
- Defining the scope of “part-time or intermittent” services to include certain daily care.
- Refining the definition of “confined to home” to allow non-medically related absences from the home, such as attending religious services.
- Establishing patient rights, quality of care measures, and compliance standards that ensure care quality.

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

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

Over the last 25 years, the benefit has been subject to many changes in payment, payment models, and scope of coverage brought on by a combination of congressional action, regulatory changes, and operational shortcomings. Providers of care face multiple barriers to the provision of services that include wholesale misunderstanding of coverage standards by Medicare contractors along with reimbursement pressures that affect patient service and clinical practice. The environment surrounding the benefit operation has not been stable for many years with events such as the OIG Operation Restore Trust, the elimination of provider protections from retroactive claim denials, expanded claims audits and oversight, and a misperception by MedPAC and others that the benefit was becoming something akin to a “long-term care” program because of extended services and patient length of stay.

In addition, justifiable concerns have been raised at various points that the benefit wrongly has focused only on patients with a potential for functional restoration to the exclusion of patients whose needs are for care that maintains function or prevents accelerated deterioration in their condition.

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

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

- In 1997, with 33 million Original Medicare enrollees, there were 3.6 million unique users of home health services, receiving an average of 74 visits during the year.
- Following the onset of a payment model reform known as the Interim Payment System, 500,000 fewer beneficiaries received home health services, with the average visits per patient dropping to 51 in 1999.
- By 2011, after several years of stability under another payment system reform, 3.5 million users of home health services out of 36.5 million enrollees received an average of 36 visits per year.
- However, by 2021 after two more changes to the payment model, only 3.0 million users out of 36.4 million enrollees, a drop of 500,000 patients, received an average of 25.4 visits.
- Since 2011, the number of available home health agencies has dropped by over 1,000 nationwide. Rural areas have been especially hit, as the testimony of Carrie Edwards suggests. Closures are occurring across the country, including providers that had been in operation for decades.

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

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

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

The evidence is mounting that patients in need of home health services are dealing with major barriers to access to care today, some of which may reach a point where they are insurmountable. The deep labor shortages, particularly in nurses and home health aides are getting worse rather than improving. Home health agencies are spending greater time recruiting and retaining staff because of their precar-

ious financial status that does not permit competitive compensation to clinicians in comparison to hospitals and other care settings.

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

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

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

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

To understand the true financial status of home health agencies facing the proposed rate cuts in 2024 requires a comprehensive review of the state of the industry. Using the cost reports filed with CMS and available directly from CMS, NAHC undertook such an analysis. Notably, NAHC examined both the data on Original Medicare home health services costs and revenue along with the data on the overall financial status of home health agencies that includes all costs and all payers of care. The results are very concerning. It shows that 52.7 percent of freestanding home health agencies are projected to have financial margins below zero with the cuts proposed for 2024. (Appendix, Table 3.) The actual percentage is likely to be greater because the data does not include “hospital-based” home health agencies where the margins are typically lower.

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

To the extent that there is a financial margin in traditional Medicare home health services, it primarily is used to subsidize longstanding payment shortfalls from Medicare Advantage plans and State Medicaid programs, a financial deficit facing most health-care sectors. However, home health agencies, unlike most other sectors, do not have a material level of commercial insurance revenue that can offset finan-

cial losses from Medicare Advantage or Medicaid. As a result, Medicare margins primarily go towards patient care, not profit.

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

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

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

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

I can be reached at wad@nahc.org and 202-236-6992.

APPENDIX

TABLE 1

YEAR	TRADITIONAL MEDICARE ENROLLEES	USERS (1000s)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (1000s)	PAYMENTS PER PERSON	PAYMENTS PER EPISODE
1990	N/A	1967.1	36	N/A	\$3,713,652	\$1,892	N/A
1991	N/A	2242.9	45	N/A	5,369,051	2,397	N/A
1992	N/A	2506.2	53	N/A	7,396,822	2,955	N/A
1993	N/A	2874.1	57	N/A	9,726,444	3,389	N/A
1994	34,076	3179.2	66	N/A	12,660,526	3,987	N/A
1995	34,062	3469.4	72	N/A	15,391,094	4,441	N/A
1996	33,704	3599.7	74	N/A	16,756,767	4,660	N/A
1997	33,009	3557.5	73	N/A	16,718,263	4,704	N/A
1998	32,349	3061.6	51	31.6*	10,456,908	3,420	N/A
1999	32,179	2719.7	42	N/A	7,936,513	2,921	N/A
2000	32,740	2461.2	37	N/A	7,215,958	2,936	N/A
2001	33,860	2402.5	31	21.4*	8,513,702	3,545	N/A
2002	34,977	2544.4	31	20*	9,550,683	3,765	\$2,329 *
2003	35,815	2681.1	31	18.39**	10,069,628	3,770	N/A
2004	36,345	2835.6	31	18.0**	11,402,560	4,039	N/A
2005	36,685	2975.6	32	18.21**	12,779,158	4,314	\$2,366 *

TABLE 1—Continued

YEAR	TRADITIONAL MEDICARE ENROLLEES	USERS (1000s)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (1000s)	PAYMENTS PER PERSON	PAYMENTS PER EPISODE
2006	35,647	3026.2	34	18.45**	13,912,750	4,619	N/A
2007	35,490	3099.5	37	18.19**	15,565,441	5,046	\$2,566 *
2008	35,320	3171.6	38	19.1**	16,872,735	5,361	2,705 *
2009	35,360	3281.1	40	18.7**	18,733,108	5,747	N/A
2010	35,910	3434.4	37	18.0**	19,407,218	5,688	N/A
2011	36,458	3463.9	36	17.0**	18,362,264	5,357	\$2,916 *
2012	37,214	3459.6	34	17.0**	18,025,554	5,256	N/A
2013	37,613	3452.0	32	16.79	17,924,989	5,193	\$2,687
2014	37,790	3417.2	32	16.66	17,736,862	5,190	2,703
2015	38,025	3454.4	32	16.60	18,203,863	5,280	2,762
2016	38,610	3451.5	31	16.63	18,117,018	5,249	2,780
2017	38,668	3392.9	31	16.60	17,830,844	5,255	2,823
2018	38,665	3365.9	31	16.67	17,934,054	5,328	2,876
2019	38,577	3281.4	31	16.57	17,850,864	5,440	2,952
2020 ***	37,776	3054.5	27.57	9.27	17,082,332	5,592	1,881
2021 ***	36,356	3018.5	25.44	8.27	16,872,835	5,590	1,818

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

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

**Data from CMS HHA cost reports.

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

TABLE 2

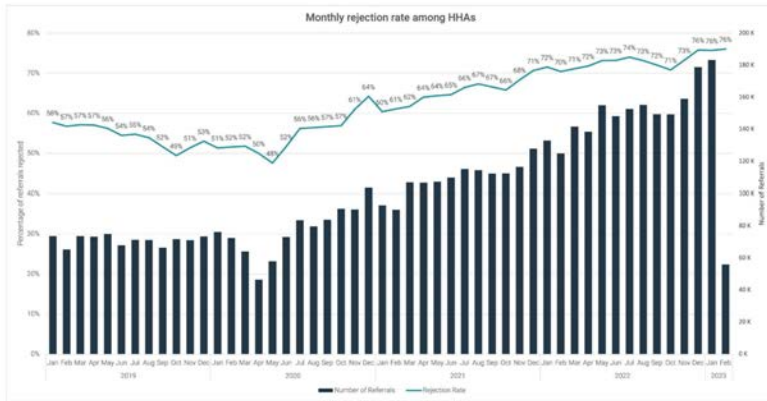
YEAR	MBI REDUCTION	PRODUCTIVITY ADJUSTMENT	BUDGET NEUTRALITY AND CASE MIX WEIGHT ADJUSTMENT**	REBASING REDUCTION
FY 2001			11.577%	
FY 2002				
FY 2003	1.1%		7%	
FY 2004				
CY 2005	0.8%			
CY 2006	0.8%			
CY 2007				
CY 2008			2.75%	
CY 2009			2.75%	
CY 2010			2.75%	
CY 2011	1.0%		3.79%	
CY 2012	1.0%		3.79%	
CY 2013	1.0%		1.32%	
CY 2014				\$80.65 (3.5%)
CY 2015		0.5%		\$80.65 (3.5%)
CY 2016		0.4%	0.97%	\$80.65 (3.5%)
CY 2017		0.3%	0.97%	\$80.65 (3.5%)
CY 2018	2.0%		0.97%	
CY 2019		0.8%	1.69%	
CY 2020 PDGM begins			4.36%	
CY 2021		0.3%		
CY 2022		0.5%		
CY 2023	5.2% forecast error	0.20%	3.925%	
CY 2024 (Proposed)		0.30%	5.653%	
TOTAL REDUCTIONS *	12.9%	3.3%	54.265%	\$322.60 (14.0%)

Source: <https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-prospective-payment-system-regulations-and-notice>.

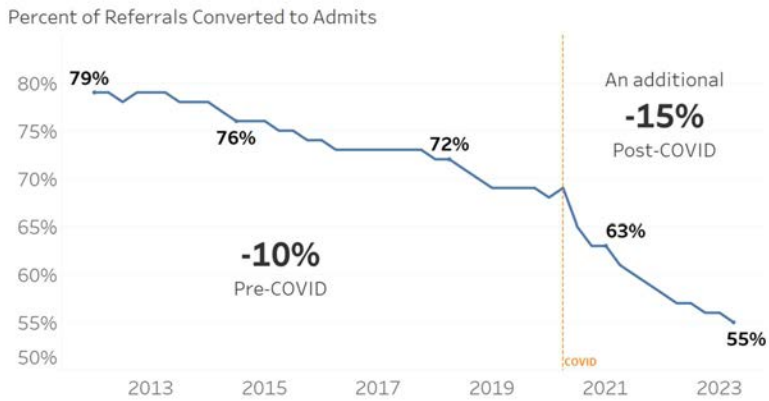
*This represents the sum of the cuts. However, the cumulative impact is much greater as each cut affects the base rate on a permanent basis.

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

TABLE 3

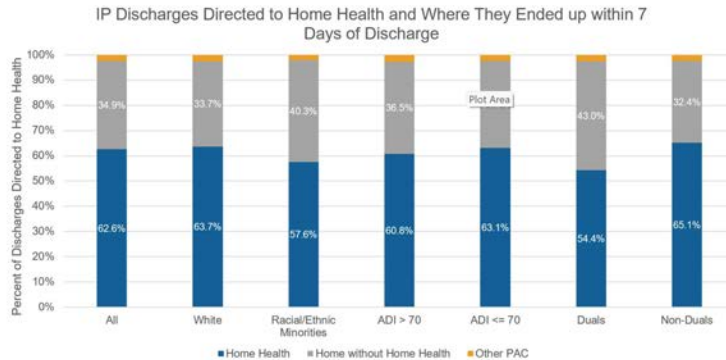


Source: July 25, 2023, WellSky Evolution of Care report, available at: <https://careporthealth.com/about/results/the-evolution-of-care-2023/>



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

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



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

State	HHAs	Overall Financial Projected Status	Percentage
Alabama	84	Percent of margins below 0%	47.6%
Alaska	6	Percent of margins below 0%	50.0%
Arizona	91	Percent of margins below 0%	65.9%
Arkansas	53	Percent of margins below 0%	47.2%
California	774	Percent of margins below 0%	58.3%
Colorado	65	Percent of margins below 0%	61.5%
Connecticut	28	Percent of margins below 0%	53.6%
Delaware	7	Percent of margins below 0%	42.9%
District of Columbia	4	Percent of margins below 0%	0.0%
Florida	484	Percent of margins below 0%	57.0%
Georgia	58	Percent of margins below 0%	48.3%
Guam	2	Percent of margins below 0%	50.0%
Hawaii	6	Percent of margins below 0%	16.7%
Idaho	34	Percent of margins below 0%	55.9%
Illinois	265	Percent of margins below 0%	53.2%
Indiana	87	Percent of margins below 0%	54.0%
Iowa	28	Percent of margins below 0%	39.3%
Kansas	38	Percent of margins below 0%	50.0%
Kentucky	37	Percent of margins below 0%	32.4%

State	HHAs	Overall Financial Projected Status	Percentage
Louisiana	98	Percent of margins below 0%	49.0%
Maine	11	Percent of margins below 0%	63.6%
Maryland	19	Percent of margins below 0%	21.1%
Massachusetts	56	Percent of margins below 0%	42.9%
Michigan	178	Percent of margins below 0%	55.1%
Minnesota	25	Percent of margins below 0%	48.0%
Mississippi	24	Percent of margins below 0%	16.7%
Missouri	57	Percent of margins below 0%	70.2%
Montana	7	Percent of margins below 0%	42.9%
Nebraska	19	Percent of margins below 0%	52.6%
Nevada	84	Percent of margins below 0%	50.0%
New Hampshire	5	Percent of margins below 0%	60.0%
New Jersey	26	Percent of margins below 0%	38.5%
New Mexico	22	Percent of margins below 0%	63.6%
New York	54	Percent of margins below 0%	51.9%
North Carolina	63	Percent of margins below 0%	30.2%
North Dakota		Insufficient Data	
Ohio	156	Percent of margins below 0%	56.4%
Oklahoma	134	Percent of margins below 0%	41.8%
Oregon	22	Percent of margins below 0%	45.5%
Pennsylvania	115	Percent of margins below 0%	41.7%
Puerto Rico	18	Percent of margins below 0%	50.0%
Rhode Island	14	Percent of margins below 0%	64.3%
South Carolina	35	Percent of margins below 0%	60.0%
South Dakota	4	Percent of margins below 0%	50.0%
Tennessee	65	Percent of margins below 0%	49.2%
Texas	703	Percent of margins below 0%	51.9%
Utah	51	Percent of margins below 0%	51.0%
Vermont	3	Percent of margins below 0%	66.7%
Virgin Islands	2	Percent of margins below 0%	100.0%
Virginia	116	Percent of margins below 0%	54.3%
Washington	47	Percent of margins below 0%	46.8%
West Virginia	29	Percent of margins below 0%	62.1%

State	HHAs	Overall Financial Projected Status	Percentage
Wisconsin	32	Percent of margins below 0%	37.5%
Wyoming	11	Percent of margins below 0%	45.5%
National		Percent of margins below 0%	52.70%

QUESTIONS SUBMITTED FOR THE RECORD TO WILLIAM A. DOMBI, J.D.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. The Bipartisan Budget Act of 2018 instructed CMS to implement a new home health payment system in a budget-neutral manner.

In your opinion, has the agency implemented the new system as Congress intended?

Answer. No, CMS has not implemented the new system in a budget-neutral manner as Congress intended. Consequently, fewer Medicare beneficiaries are accessing home health services and those receiving care are getting less care. The law requires CMS to compare what Medicare would have been expended for home health services without the changes in provider behavior that occurred under the new payment model with the amount of actual expenditures under the new payment model. Instead, CMS compared the amount that would have been expended under the old payment model with the provider behavior changes that were triggered by the new payment model with the actual expenditures under the new payment model. Those behavior changes would not have occurred under the old payment model. As such, the CMS budget neutrality methodology compares actual spending to a projected spending amount that would not have occurred.

Many of my Oklahoma HHAs think that there is no way this payment system can be budget-neutral since payment cuts have been so significant.

Question. Does the home health industry have an appropriate level of data from CMS to understand how CMS is making payment decisions?

If not, what exact data points would be helpful for you all to have to best be able to engage in a helpful and constructive conversation with CMS?

Answer. CMS's failure to implement the new payment system in a budget-neutral manner stems from the use of a methodology that is both noncompliant with the law and illogical. That was confirmed earlier this year when CMS revealed more details on the methodology employed along with the data used in that methodology.

Congress required CMS to set payment rates at a level that would result in spending equivalent to the level of spending that would have occurred in the absence of a change in the payment model. Congress permitted CMS to make assumptions about any provider behavioral changes that could occur through incentives and disincentives under the new payment model with later adjustments for any actual behavioral changes. However, CMS took behavioral changes that would only occur under the new model into account when determining the level of spending that would have occurred under the preexisting payment model. In other words, the CMS budget neutrality assessment methodology relied on provider behavior changes that would not have occurred under the preexisting payment model to determine the level of spending that would have occurred under that earlier system. CMS does not need to supply more data. Instead, CMS must use a compliant budget neutrality methodology.

Question. What percentage of Medicare beneficiaries who are referred to home care actually receive it? Where do most patients end up if they are not able to receive the care for which they were referred?

Answer. According to CareJourney, a health care data analytics company, during Q-1 to Q-3 2022, 62.6 percent of individuals referred to home health services were admitted to care within 7 days, 34.9 percent went home without home health services, and 2.5 percent were admitted to another type of post-acute care setting. It is believed that the difficulties in placing patients in home health services led to fewer referrals at the outset, thereby deflating the potential number of patients unable to access home health care. Still, nearly 35 percent of referred patients lost access to home health care.

Question. Durable Medical Equipment (DME) providers are facing similar payment adjustment problems that are disincentivizing providers from remaining in nonurban areas. I am a cosponsor of my colleagues Senators Thune and Stabenow's bill—the Competitive Bidding Relief Act—which would ensure the continuation of an adjusted Medicare rate for certain DME providers that are not considered urban or rural, allowing them to be paid fairly.

What are the implications in the home health space of the problems within the DME and oxygen provider industry? How much do these two industries rely on one another?

Answer. A significant portion of home health patients utilize DME, including oxygen. Home health patients can access DME through the home health benefits or separately from a DME supplier. In the event that DME is unavailable for patients in need of DME, it is highly likely that the patient will not be admitted to care by the home health agency as it will not be an overall safe care setting.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What specific recommendations do you have on how we can use the ACO model and telehealth to expand home health, including changes with CMS regulations, CMMI models, and legislation, to lower costs and improve patient care?

Answer. Recommendations:

- Permit waiver of the “homebound” requirement for home health eligibility within the ACO model. With the care management coming from an ACO, the flexibility of providing home health services to the non-homebound patient population can save Medicare spending while assuring protection against abuse.
- Permit waiver of the physician/practitioner requirement of a face-to-face visit to certify home health eligibility. The ACO care management is a sufficient program integrity check, allowing the cost of the face-to-face encounter to be avoided.
- Allow telehealth virtual visits to be considered “visits” under the Medicare home health payment model for ACO patients. Currently, home health agencies are discouraged from using virtual visits as the reimbursement system does not recognize such for calculation of the payment amount as it is prohibited under the Medicare statute, 42 U.S.C. 1395fff(e).
- Provide guidance and support for home health agencies to be part of an ACO as a partner or participant. The ACOs that have made appropriate use of home health services have shown a great degree of success in contrast to those that do not fully integrate with home health.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. In your written testimony, you mentioned that the pandemic has exacerbated home health labor challenges, with the number of workers per beneficiary declining over time not only in the home and community-based services workforce but in other post-acute and long-term care settings. These declining direct care ratios, which are a result of a shrinking home health workforce, make it more difficult for beneficiaries to have meaningful one-on-one care. The vast majority of older adults indicate they prefer to age at home, even when, or especially when, they have health complications. In your testimony, you suggest increasing the size of the labor force through wage increases and that Congress continue to invest in policies to expand Medicaid HCBS.

Could you speak to the importance of expanding HCBS and the impact that significant investment in the direct care workforce will have on patient care?

Answer. Health care at home, particularly Medicaid HCBS, has proven to be a wise investment for Medicaid programs and the patient served by those programs. Significant savings have been achieved with high quality of care. However, there are several hundred thousand individuals on wait lists for a combination of reasons including staff shortages. A major reason for the difficulties in accessing HCBS is that the direct-care workers have many employment options that would better com-

pensate them for the work they do. The need for a strong HCBS program nationally is a societal issue, not just one for those facing the need for care.

Currently, family, friends, and others are often called on to care for an individual who has an unmet care need due to professional staff shortages. This leads to impacts on the economy as the substitute caregivers take time away from their own jobs to fill the void. It also puts significant pressure on already-stressed family and friends. Support for Medicaid HCBS would reduce the stresses on our economy as well as informal caregivers. It would also stabilize long term care resulting in savings accruing through reduced institutional care spending.

Question. In your testimony, you mention the importance of increased coordination between programs to support beneficiaries that are dually eligible for both Medicare and Medicaid. You also spoke to the fragmentation in care and coverage that occurs when benefits are not integrated across programs and spoke to the variability of the types of programs that are available to dually eligible individuals.

In your research, what have you found as being most important to a more coordinated approach to care, and how can these programs improve their alignment to better serve dually eligible beneficiaries?

Answer. A coordinated Federal-State effort to take Medicare and Medicaid out of their respective silos, including both care and the providers of care, into a single care planning process with coordinated reimbursement to the provider would reduce administrative costs for those programs as well as the care providers while increasing the value of the services to the patients. This could be done with a focus on home care patients alone without needing to integrate the whole of Medicare and Medicaid.

PREPARED STATEMENT OF CARRIE EDWARDS, R.N., BSN, MHA, LSSGB,
DIRECTOR, HOME CARE SERVICES, MARY LANNING HEALTHCARE

Chairman Cardin, Ranking Member Daines, and members of the committee, thank you for the opportunity to testify at this important hearing focusing on the Medicare home health benefit, which provides skilled medical care to older adults and individuals with disabilities. Home health allows eligible individuals to receive care in their homes instead of at more costly institutional sites of service.

I would also like to thank Senators Debbie Stabenow (D-MI) and Susan Collins (R-ME) and Representatives Terri Sewell (D-AL) and Adrian Smith (R-NE) for their unwavering support to ensure that Medicare beneficiaries have access to high-quality home health services by introducing the Preserving Access to Home Health Act (S. 2137/H.R. 5159). I encourage every member of the Senate to join as cosponsors of S. 2137 to ensure that Medicare beneficiaries in their state have access to home health services.

My name is Carrie Edwards. I serve as the director of home care services at Mary Lanning Healthcare, located in Hastings, NE. Our home health agency is a hospital-based, nonprofit, rural provider. Mary Lanning Home Health offers a variety of services to meet patient needs right in the comfort of their own home, including skilled nursing; physical, occupational, and speech therapy; lymphedema therapy; medical social work; and home health aide services. We are the only home health agency within 60 miles that will accept pediatric patients that have complex medical needs that can be cared for in the home instead of an institutional setting.

From my nearly 25 years of experience in the home health field, I can confirm that home is where the heart is for the millions of older adults and individuals with disabilities that are able to receive home health-care services in their home and community, even despite their health issues. Most of us just feel better when we are home.

That's why I fell in love with helping people stay in their homes even when facing significant health challenges.

At Mary Lanning Home Health, we have over 50 years of experience bringing health-care services into the homes of central Nebraska residents. But our ability to deliver patient-preferred, high-quality, cost-effective, lifesaving home health services is in jeopardy, and not due to any service failures at Mary Lanning Home Health, but rather to decisions being made right now by CMS that threaten my home health agency and thousands of other home health agencies across the country.

I am extremely concerned that our long history of service to the residents of Nebraska is at risk due to the significant payment reductions that CMS started in 2020 when the new payment model, the Patient-Driven Groupings Model (PDGM), was implemented, and what appears to be a lack of appreciation by CMS and others of the role home health plays in the broader health-care delivery system.

I want to stress that we are at an inflection point within the home health delivery system.

If CMS does not retract the payment cuts being proposed for 2024, if the administration allows the payment cuts to proceed, and if Congress does not act to reverse CMS's policy to impose double-digit payment reductions, we could likely see the complete collapse of the home health payment system.

Mary Lanning Home Health has seen our average daily census count reduced by more than 60 percent since the implementation of PDGM, from an average of 88 patients in 2020 to a census count in September 2023 of 32. It's not because there is not a need and demand for home health services, but rather due to a perfect storm of a workforce crisis, high inflation, and Medicare payment reductions for home health services that are not only putting a financial strain on our agency but also limiting our ability to recruit and retain the nurses, therapists, and home health aides that are vital to our ability to deliver care in the home.

Mary Lanning Home Health previously covered a 13-county, 60-mile radius of Hastings, which included Adams, Buffalo, Clay, Fillmore, Franklin, Hall, Hamilton, Howard, Kearney, Merrick, Nuckolls, Thayer, and Webster counties. In March of this year, we had to decrease our service area to 40 miles. Several months later, in May, we had to make the difficult decision to further reduce our service area to cover only Adams County, which covers a 25-mile radius including the city of Hastings.

Some of the previous counties that we served have no coverage by any home health provider. One home health provider moved their office from Hastings because they were down to one registered nurse. They have now joined with their partnered location in Grand Island. Several other home health agency providers do not accept Medicaid patients or only take patients who are in-network or those that require too much care.

Hospitals are seeing higher-acuity patients than in previous years, and our agency is providing more intensive home health services to a population that has more complex needs and increased comorbidities. We have limited admitting patients that require too much skilled care because we simply lack the workforce to provide the high-quality care necessary for a successful home health outcome.

When a patient isn't able to be admitted to our home health agency, the result is either longer lengths of stay in the acute setting, placement in a skilled nursing facility, or foregoing post-acute care all together.

The decision for a home health agency to reduce its service area, especially in rural counties, is incredibly difficult since we know there will be patients living in those areas that need our services. However, reducing our service area is the only path forward that allows our home health agency to remain financially viable and continue to serve some patients who need home health services, albeit in a reduced geographic location.

As I noted, reducing our service area from 13 counties to one was necessary to survive and provide care to some patients in our area. We very much wish we did not have to take this drastic step, particularly because we knew there would be no alternative home health agencies for the affected areas.

The drastic reduction in our service area just to remain operational is having a direct impact on Medicare beneficiaries. This year alone, we have declined services to 55 referrals because the patients were outside our reduced service area. That is a rejection rate of over 50 percent through August of this year. Our dedicated staff is heartbroken because their mission is patient care, but we had no choice.

Since 2020, our traditional Medicare home health agency payments have been cut by more than 8 percent. The annual payment updates in 2021 and 2022 didn't begin to cover the dramatic rise in labor costs due to the increased demand in nursing services caused by the COVID-19 pandemic and the ongoing workforce shortage, or the rapid rise in our supply costs due to the surge in inflation. As Medicare payments for services started to be cut, our revenue started to decline. From 2020 to 2022, we experienced a 15-percent reduction in revenue for our services.

CMS's actions to reduce home health payments are also having a direct impact on our ability to retain our existing workforce.

We have had three registered nurses resign due to fear that the looming payment cuts being proposed by CMS will force the agency to close. The three nurses did not leave nursing; instead, they went to work for other health-care providers rather than risk remaining with Mary Lanning Home Health.

We are now down to three full-time registered nurses and one part-time registered nurse. Since we have reduced our service area, we have reduced our costs as much as possible. We have eliminated a billing and coding specialist and are now providing those functions within a shared service arrangement with our hospice. We had our registered nurse clinical manager resign, and that position has been eliminated. We no longer provide on-call availability after 4:30 p.m. during the week and now have a voicemail set up for follow-up the next morning.

The instability that is being created within the home health program by CMS is forcing the home health workforce to seek employment elsewhere rather than risk working at a home health agency that could close at any time due to insolvency. Think about what I just said: the Medicare program is failing to fulfill its promises to Nebraskans and the millions of Medicare beneficiaries who need home health services.

Inpatient stays are expensive. Daily room and board costs can reach \$3,000 per day, and this does not count medications, tests, and treatments. The cost is significantly higher if a patient is rehospitalized and admitted to the ICU. The loss of home health services is highly likely to trigger these added costs to the Medicare program.

In 2022, Mary Lanning Home Health prevented 93.5 percent of the 1,059 patients we served from being readmitted to the hospital, averaging a 7.6-percent readmission rate that was well below the State and national averages. Year to date through July 2023, Mary Lanning Home Health has prevented 93.7 percent of the 558 patients we served from being rehospitalized. We have a 5-star patient satisfaction rating on Home Health Compare.

In addition to the skilled care provided within the home health benefit, our clinicians assist patients with transitioning to their home after being hospitalized by teaching and training new medications and advocating for adaptations in the home for patient safety.

The high-quality home health services we provide are not only patient-preferred but also improve patient outcomes and provide savings to the Medicare program. And you don't have to take my word for the savings to the program; CMS's own data has confirmed the value of the home health program through its Home Health Value-Based Purchasing (HHVBP) Model, which has reduced Medicare spending by hundreds of millions of dollars already.

As we look to prepare for 2024, with the pending payment reductions that CMS has proposed and the potential for payment reductions spanning past 2030, we are doing everything possible to remain operational.

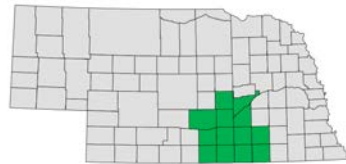
There are agencies throughout Nebraska and the country that are at serious risk of closure.

I understand that some have already closed or reduced service areas, as we have at Mary Lanning Home Health. Agencies simply cannot cut expenses any more than we have already and remain viable without impacting the quality of care and the level of services we provide.

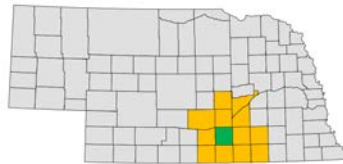
At Mary Lanning Home Health, the only alternative we will have if CMS does not reverse course is for the agency to close or hope that another home health provider comes to take over our service area. We should not have to hope that Medicare adequately supports the vital and essential care covered under the home health services benefit.

**Mary Lanning Healthcare Home Health
Change in Home Health Service Area**

**January 1, 2023
13 County Service Area**



**May 1, 2023
Adams County Only**



Nebraska County	Medicare Eligible	Traditional Medicare Enrolled	Medicare Advantage Enrolled	Traditional Medicare Enrolled % of Medicare Eligible	Medicare Advantage Enrolled % of Medicare Eligible
Adams	7,015	4,865	2,150	69%	31%
Buffalo	9,280	6,328	2,952	68%	32%
Clay	1,522	1,162	360	76%	24%
Fillmore	1,569	1,197	372	76%	24%
Franklin	837	606	231	72%	28%
Hall	11,061	6,848	4,213	62%	38%
Hamilton	2,301	1,705	596	74%	26%
Howard	1,545	1,104	441	71%	29%
Kearney	1,310	869	441	66%	34%
Merrick	1,904	1,387	517	73%	27%
Nuckolls	1,295	1,128	167	87%	13%
Thayer	1,398	1,111	287	79%	21%
Webster	910	630	280	69%	31%
Total	41,947	28,940	13,007		

Nebraska Medicare Enrollment by County*As of September 15, 2023*

Nebraska County	Medicare Eligible	Traditional Medicare Enrolled	Medicare Advantage Enrolled	Traditional Medicare Enrolled % of Medicare Eligible	Medicare Advantage Enrolled % of Medicare Eligible
Adams	7,015	4,865	2,150	69%	31%
Antelope	1,651	1,251	400	76%	24%
Arthur	110	110	0	100%	0%
Banner	270	253	17	94%	6%
Blaine	120	120	0	100%	0%
Boone	1,438	974	464	68%	32%
Box Butte	2,617	2,397	220	92%	8%
Boyd	655	569	86	87%	13%
Brown	735	711	24	97%	3%
Buffalo	9,280	6,328	2,952	68%	32%
Burt	1,910	1,354	556	71%	29%
Butler	1,898	1,475	423	78%	22%
Cass	5,742	3,758	1,984	65%	35%
Cedar	2,083	1,381	702	66%	34%
Chase	918	857	61	93%	7%
Cherry	1,365	1,353	12	99%	1%
Cheyenne	2,407	2,196	211	91%	9%
Clay	1,522	1,162	360	76%	24%
Colfax	1,609	1,281	328	80%	20%
Cuming	2,225	1,797	428	81%	19%
Custer	2,706	2,065	641	76%	24%
Dakota	3,508	2,027	1,481	58%	42%
Dawes	1,810	1,588	222	88%	12%
Dawson	4,431	3,672	759	83%	17%
Deuel	557	500	57	90%	10%
Dixon	1,243	751	492	60%	40%
Dodge	8,435	5,567	2,868	66%	34%
Douglas	95,335	54,191	41,144	57%	43%
Dundy	504	455	49	90%	10%
Fillmore	1,569	1,197	372	76%	24%

Nebraska Medicare Enrollment by County—Continued*As of September 15, 2023*

Nebraska County	Medicare Eligible	Traditional Medicare Enrolled	Medicare Advantage Enrolled	Traditional Medicare Enrolled % of Medicare Eligible	Medicare Advantage Enrolled % of Medicare Eligible
Franklin	837	606	231	72%	28%
Frontier	618	510	108	83%	17%
Furnas	1,369	1,122	247	82%	18%
Gage	5,744	3,913	1,831	68%	32%
Garden	625	545	80	87%	13%
Garfield	477	326	151	68%	32%
Gosper	544	442	102	81%	19%
Grant	183	183	0	100%	0%
Greeley	607	463	144	76%	24%
Hall	11,061	6,848	4,213	62%	38%
Hamilton	2,301	1,705	596	74%	26%
Harlan	915	725	190	79%	21%
Hayes	205	191	14	93%	7%
Hitchcock	803	703	100	88%	12%
Holt	2,651	2,117	534	80%	20%
Hooker	251	227	24	90%	10%
Howard	1,545	1,104	441	71%	29%
Jefferson	2,005	1,394	611	70%	30%
Johnson	899	684	215	76%	24%
Kearney	1,310	869	441	66%	34%
Keith	2,253	1,772	481	79%	21%
Keya Paha	273	252	21	92%	8%
Kimball	1,035	976	59	94%	6%
Knox	2,329	1,519	810	65%	35%
Lancaster	55,926	37,778	18,148	68%	32%
Lincoln	8,191	5,869	2,322	72%	28%
Logan	170	145	25	85%	15%
Loup	176	125	51	71%	29%
Madison	7,464	4,744	2,720	64%	36%
McPherson	101	87	14	86%	14%

Nebraska Medicare Enrollment by County—Continued*As of September 15, 2023*

Nebraska County	Medicare Eligible	Traditional Medicare Enrolled	Medicare Advantage Enrolled	Traditional Medicare Enrolled % of Medicare Eligible	Medicare Advantage Enrolled % of Medicare Eligible
Merrick	1,904	1,387	517	73%	27%
Nance	684	509	175	74%	26%
Nemaha	1,609	1,311	298	81%	19%
Nuckolls	1,295	1,128	167	87%	13%
Otoe	3,917	2,814	1,103	72%	28%
Pawnee	635	477	158	75%	25%
Perkins	712	612	100	86%	14%
Phelps	2,157	1,744	413	81%	19%
Pierce	1,591	1,112	479	70%	30%
Platte	6,949	5,527	1,422	80%	20%
Polk	1,372	1,127	245	82%	18%
Red Willow	2,564	2,374	190	93%	7%
Richardson	2,185	2,017	168	92%	8%
Rock	397	328	69	83%	17%
Saline	2,693	1,932	761	72%	28%
Sarpy	29,698	19,149	10,549	64%	36%
Saunders	4,651	3,095	1,556	67%	33%
Scotts Bluff	8,508	6,199	2,309	73%	27%
Seward	3,732	2,782	950	75%	25%
Sheridan	1,381	1,221	160	88%	12%
Sherman	893	616	277	69%	31%
Sioux	282	258	24	91%	9%
Stanton	1,108	720	388	65%	35%
Thayer	1,398	1,111	287	79%	21%
Thomas	202	166	36	82%	18%
Thurston	998	727	271	73%	27%
Valley	1,085	777	308	72%	28%
Washington	4,649	2,830	1,819	61%	39%
Wayne	1,612	1,194	418	74%	26%
Webster	910	630	280	69%	31%

Nebraska Medicare Enrollment by County—Continued

As of September 15, 2023

Nebraska County	Medicare Eligible	Traditional Medicare Enrolled	Medicare Advantage Enrolled	Traditional Medicare Enrolled % of Medicare Eligible	Medicare Advantage Enrolled % of Medicare Eligible
Wheeler	174	137	37	79%	21%
York	3,289	2,634	655	80%	20%

Source: Centers for Medicare and Medicaid Services, State County Penetration Data for Medicare Advantage, September 2023.

PREPARED STATEMENT OF DAVID C. GRABOWSKI, PH.D., PROFESSOR,
DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

Chairman Cardin, Ranking Member Daines, and distinguished members of the Subcommittee on Health Care, thank you for the opportunity to testify today on this important topic. I am a professor of health care policy at Harvard Medical School. I am here today speaking in my capacity as a researcher who has studied home health care for over 2 decades.

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

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

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

Importantly, utilization of home health services does not necessarily equate directly to access. For example, just because a home health agency may see one pa-

¹ Barnett, M.L., Mehrotra, A., Grabowski, D.C. Postacute Care—The Piggy Bank for Savings in Alternative Payment Models? *The New England Journal of Medicine* 2019;381(4):302–303. (In eng). DOI: 10.1056/NEJMp1901896.

² Huckfeldt, P.J., Escarce, J.J., Rabideau, B., Karaca-Mandic, P., Sood, N. Less Intense Postacute Care, Better Outcomes for Enrollees in Medicare Advantage Than Those in Fee-For-Service. *Health Affairs* 2017;36(1):91–100. (Research Support, NIH, Extramural). (In eng). DOI: 10.1377/hlthaff.2016.1027.

³ Werner, R.M., Bressman, E. Trends in Post-Acute Care Utilization During the COVID–19 Pandemic. *J Am Med Dir Assoc* 2021;22(12):2496–2499. DOI: 10.1016/j.jamda.2021.09.001.

⁴ Geng, F., McGarry, B.E., Rosenthal, M.B., Zubizarreta, J.R., Resch, S.C., Grabowski, D.C. Choosing Home: Patients and Caregivers Prioritize Post-Acute Care at Home over Facilities—A Discrete Choice Experiment. Unpublished working paper: Harvard University; 2023.

⁵ Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Washington, DC: March 2023.

⁶ Quigley, D.D., Chastain, A.M., Kang, J.A., et al. Systematic Review of Rural and Urban Differences in Care Provided by Home Health Agencies in the United States. *J Am Med Dir Assoc* 2022;23(10):1653 e1–1653 e13. DOI: 10.1016/j.jamda.2022.08.011.

tient in a ZIP code does not mean they regularly accept new patients or provide timely visits. Moreover, it is important to acknowledge a lag in the fee-for-service Medicare data, and the extenuating circumstances of the last several years with the pandemic and accompanying labor shortages.

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

Medicare fee-for-service payments are adequate to ensure access: The 2023 MedPAC report⁵ to Congress found Medicare margins for freestanding HHAs reached an all-time high in 2021 of 24.9 percent. (The Medicare home health margin is calculated by MedPAC using the following formula: (Medicare payments – Medicare allowable costs)/Medicare payments.) From 2001 to 2019, Medicare margins for freestanding HHAs averaged 16.4 percent. In 2020, this increased to 20.2 percent. MedPAC has consistently recommended a reduction in the base payment rate for home health agencies, including a 7-percent reduction for Calendar Year 2024. In 2021, freestanding agencies serving rural areas had a higher Medicare margin (25.2 percent) relative to those serving urban areas (24.8 percent).

If the Congress is going to address rural access through payment, I would recommend they do so through a rural payment add-on⁷ or some other targeted rural policy. They should not try to solve a potential rural access problem through an adjustment to the overall fee-for-service payment system, which is currently paying home health agencies well above costs.

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

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

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

Enrollees in Medicare Advantage plans use less home health care, often from lower-rated agencies. A growing share of home health patients are enrolled in Medicare Advantage plans. Beneficiaries in these plans use less home health, partly because of mechanisms like prior authorization and utilization management that are not allowed in fee-for-service Medicare.⁹ The plans can also use networks to steer patients to certain home health agencies. Research has shown that enrollees in Medicare Advantage typically use lower star-rated agencies relative to their fee-

⁷Mroz, T.M., Patterson, D.G., Frogner, B.K. The Impact of Medicare's Rural Add-on Payments on Supply of Home Health Agencies Serving Rural Counties. *Health Aff* (Millwood) 2020;39(6):949–957. DOI: 10.1377/hlthaff.2019.00952.

⁸Navathe, A.S., Grabowski, D.C. Will Medicare's New Patient-Driven Postacute Care Payment System Be a Step Forward? *JAMA Health Forum* 2020;1(6):e200718. DOI: 10.1001/jamahealthforum.2020.0718.

⁹Skopec, L., Zuckerman, S., Aarons, J., et al. Home Health Use in Medicare Advantage Compared to Use in Traditional Medicare. *Health Aff* (Millwood) 2020;39(6):1072–1079. DOI: 10.1377/hlthaff.2019.01091.

for-service counterparts.¹⁰ Medicare Advantage plans also pay home health agencies below the fee-for-service Medicare rate. When you factor in care from all payers (including Medicaid and other sources), the overall margin for HHAs was estimated at 11.9 percent in 2021, which is well below the Medicare margin of 24.9 percent.

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

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

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

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

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

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

¹⁰ Schwartz, M.L., Kosar, C.M., Mroz, T.M., Kumar, A., Rahman, M. Quality of Home Health Agencies Serving Traditional Medicare vs Medicare Advantage Beneficiaries. *JAMA Netw Open* 2019;2(9):e1910622. DOI: 10.1001/jamanetworkopen.2019.10622.

¹¹ Huckfeldt, P.J., Sood, N., Escarce, J.J., Grabowski, D.C., Newhouse, J.P. Effects of Medicare payment reform: Evidence from the home health interim and prospective payment systems. *Journal of Health Economics* 2014;34:1–18. (In eng). DOI: 10.1016/j.jhealeco.2013.11.005.

¹² Rowland, C. Seniors are stuck home alone as health aides flee for higher-paying jobs. *Washington Post* 2022.

¹³ Oldenburg, A. Nationwide Caregiver Shortage Felt By Older Adults. AARP. 2022. (<https://www.aarp.org/caregiving/basics/info-2022/in-home-caregiver-shortage.html>).

¹⁴ Dill, J., Henning-Smith, C., Zhu, R., Vomacka, E. Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas. *J Appl Gerontol* 2023;42(8):1800–1808. DOI: 10.1177/07334648231158482.

¹⁵ Kreider, A.R., Werner, R.M. The Home Care Workforce Has Not Kept Pace With Growth in Home and Community-Based Services. *Health Aff (Millwood)* 2023;42(5):650–657. DOI: 10.1377/hlthaff.2022.01351.

¹⁶ McGarry, B.E., Grabowski, D.C., Barnett, M.L. Severe Staffing and Personal Protective Equipment Shortages Faced By Nursing Homes During the COVID–19 Pandemic. *Health Aff (Millwood)* 2020;39(10):1812–1821. DOI: 10.1377/hlthaff.2020.01269.

¹⁷ Brazier, J.F., Geng, F., Meehan, A., et al. Examination of Staffing Shortages at US Nursing Homes During the COVID–19 Pandemic. *JAMA Netw Open* 2023;6(7):e2325993. DOI: 10.1001/jamanetworkopen.2023.25993.

¹⁸ Geng, F., Mansouri, S., Stevenson, D.G., Grabowski, D.C. Evolution of the home health-care market: The expansion and quality performance of multi-agency chains. *Health Serv Res* 2020;55 Suppl 3(Suppl 3):1073–1084. DOI: 10.1111/1475–6773.13597.

¹⁹ Fowler, A.C., Grabowski, D.C., Gambrel, R.J., Huskamp, H.A., Stevenson, D.G. Corporate Investors Increased Common Ownership in Hospitals and the Postacute Care and Hospice Sectors. *Health Affairs* 2017;36(9):1547–1555. (In eng). DOI: 10.1377/hlthaff.2017.0591.

²⁰ Donlan, A. CMS to Publicly Release All Ownership Info of Home Health, Hospice Agencies. *Home Health Care News* 2023.

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

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

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

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

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

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

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

²¹Zallman, L., Finnegan, K.E., Himmelstein, D.U., Touw, S., Woolhandler, S. Care for America's Elderly and Disabled People Relies on Immigrant Labor. *Health Aff* (Millwood) 2019;38(6):919–926. DOI: 10.1377/hlthaff.2018.05514.

²²Grabowski, D.C., Gruber, J., McGarry, B.E. Immigration, the Long-Term Care Workforce, and Elder Outcomes in the U.S. NBER Working Paper #30960. National Bureau of Economic Research 2023.

²³Fashaw-Walters, S.A., Rahman, M., Gee, G., Mor, V., White, M., Thomas, K.S. Out of Reach: Inequities in the Use of High-Quality Home Health Agencies. *Health Aff* (Millwood) 2022;41(2):247–255. DOI: 10.1377/hlthaff.2021.01408.

²⁴Sterling, M.R., Grabowski, D.C., Shen, M.J. Obtaining and Paying for Home Care—Navigating Patients Through the Complex Terrain of Home Care in the US. *JAMA Intern Med* 2023;183(8):755–756. DOI: 10.1001/jamainternmed.2023.2072.

²⁵Grabowski, D.C., Norton, E.C., Van Houtven, C.H. “Informal Care.” In: Jones AM, ed. *The Elgar Companion to Health Economics, Second Edition*. Cheltenham, UK: Edward Elgar Publishing, Inc; 2012:318–328.

²⁶Tumlinson, A. What I Learned From My Family's Home Health Experience. *Health Affairs Forefront* 2022 (<https://www.healthaffairs.org/content/forefront/i-learned-my-family-s-home-health-experience>).

²⁷Burns, A., O'Malley Watts, M., Ammula, M. A Look at Waiting lists for Home and Community-Based Services from 2016 to 2021. 2022. (<https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-home-and-community-based-services-from-2016-to-2021/>).

²⁸Genworth Financial. Cost of Care Trends and Insights. 2022. (<https://www.genworth.com/aging-and-you/finances/cost-of-care/cost-of-care-trends-and-insights.html>).

²⁹Pearson, C.F., Quinn, C.C., Loganathan, S., Datta, A.R., Mace, B.B., Grabowski, D.C. The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources for Housing and Health Care. *Health Affairs* 2019;38(5):851–859. (In eng). DOI: 10.1377/hlthaff.2018.05233.

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

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

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

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

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

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

³⁰ Golberstein, E., Grabowski, D.C., Langa, K.M., Chernew, M.E. Effect of Medicare home health-care payment on informal care. *Inquiry* 2009;46(1):58–71. (In eng). (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19489484).

³¹ Werner, R.M., Van Houtven, C.J. In the Time of COVID-19, We Should Move High-Intensity Postacute Care Home. *Health Affairs Forefront* 2020 (<https://www.healthaffairs.org/content/forefront/time-covid-19-we-should-move-high-intensity-postacute-care-home>).

³² Lage, D.E., Jernigan, M.C., Chang, Y., et al. Living Alone and Discharge to Skilled Nursing Facility Care after Hospitalization in Older Adults. *Journal of the American Geriatrics Society* 2018;66(1):100–105. (In eng). DOI: 10.1111/jgs.15150.

³³ The White House. Fact Sheet: Biden-Harris Administration Announces Most Sweeping Set of Executive Actions to Improve Care in History. April 18, 2023. Accessed on June 22, 2023. (<https://www.whitehouse.gov/briefing-room/statements-releases/2023/04/18/fact-sheet-biden-harris-administration-announces-most-sweeping-set-of-executive-actions-to-improve-care-in-history/>).

³⁴ McGarry, B.E., Grabowski, D.C. Medicaid home and community-based services spending for older adults: Is there a “woodwork” effect? *J Am Geriatr Soc* 2023. DOI: 10.1111/jgs.18478.

³⁵ Miller, E.A., Beaugard, L.K. Enhancing Federal Revenue under the American Rescue Plan Act: An Opportunity to Bolster State Medicaid Home and Community-Based Services Programs. *J Aging Soc Policy* 2022:1–15. DOI: 10.1080/08959420.2021.2022952.

³⁶ Grabowski, D.C. Improving Care Integration for Dually Eligible Beneficiaries. *N Engl J Med* 2023;388(15):1347–1349. DOI: 10.1056/NEJMp2215502.

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

QUESTIONS SUBMITTED FOR THE RECORD TO DAVID C. GRABOWSKI, PH.D.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. In your testimony, you discussed the need to pair the home health-care benefit with long-term care services.

Can you say more about this relationship and why it is so important for allowing individuals to age in place?

Answer. The Medicare home health-care benefit largely consists of skilled, therapy services. These services are important for aging in place, but many home health-care recipients also require extensive assistance with long-term care needs such as bathing, dressing, and toileting. The Medicare benefit includes some home health aide services but not enough to allow most individuals to age in place safely and effectively. For this to occur, Medicare home health care must be paired with long-term care services. Currently, families must either provide this long-term care themselves, pay for services in the private market, or receive services via Medicaid coverage. Each of these routes is challenging. Caregiving places a huge financial and health burden on family members. Private duty services are expensive and not affordable for many families. And finally, Medicaid services are limited and often have long waiting lists. Thus, investing in support for family caregivers and additional Medicaid services are key policy priorities.

Question. What gaps exist in quality measurement for home health care, and what can we do to address them?

Answer. Two major gaps exist in home health care quality measurement. First, many of the most important home health measures on the Care Compare *Medicare.gov* website are reported by the agencies themselves. They are not subject to any oversight or auditing. It is troubling that these agency-reported measures have shown improvement in recent years, while claims-based measures have largely declined. Because of uncertainty about the accuracy of the measures, groups such as the Medicare Payment Advisory Commission (MedPAC) have not used agency-reported measures in evaluating home health quality. I would strongly encourage increased oversight and monitoring of these agency-reported assessments such that these data can be used for policy purposes. Second, the five-star rating on Care Compare based on patient satisfaction is largely topped out in that many agencies have relatively high satisfaction scores. The share of HHA patients providing a positive score ranges from 78 percent to 88 percent depending on the measure. I would encourage the Congress to investigate the use of more meaningful measures that provide a signal to consumers and policymakers.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. Home health providers in my State have expressed concerns that the impending and continuous CMS reimbursement cuts coming down from CMS will squeeze providers to urban areas and more patients to higher acuity locations of care such as skilled nursing facilities.

Do you share these concerns? Do the current area wage index adjustments make up for the CMS cuts to ensure that access to home care in rural America is not impacted?

Answer. I do think we need to continue to monitor home health-care access in rural areas. I am encouraged by the large operating margins that rural home health agencies report from Medicare. As I suggested in my testimony, rural margins are larger than urban margins. If we are having a rural payment crisis, it is in a select group of agencies. Thus, I would encourage Congress to focus any payment reforms on areas where there is truly an access crisis. Most rural home health agencies appeared to be doing well as of the March 2023 MedPAC report.

Question. According to MedPAC “access” standards, it appears that an entire county has access to home health services if one HHA has served one patient in that county at all.

Do you think these standards accurately display access to home health in America?

Answer. To ensure access, I would argue that it is necessary that Medicare beneficiaries have an HHA operating in their county. However, it is far from sufficient. This measure doesn't tell us whether HHAs are accepting new patients or whether patients have timely access to nurse visits. MedPAC reports this measure due to data constraints. MedPAC can look at home health use, but it is not privy to measures about patient referrals or visit delays.

Question. From your previous experience at MedPAC, how would you recommend those access standards change?

Answer. I would like to see new access measures reported to CMS and used by MedPAC to evaluate home health access. These measures might include HHA denial and acceptance data of new Medicare patients, survey data on visit timeliness, and hospital data on challenges related to HHA discharges.

Question. Does CMS have their own standards, or do they rely on MedPAC's standards?

Answer. I am not aware of the standards CMS applies in evaluating Medicare home health-care access.

Question. CMS is still using 2019 base data sets to operate from in making additional payment adjustments.

Do you think those data are sufficient and accurate enough for CMS to continue using?

Answer. The tradeoff here is that the 2019 data pre-date the pandemic and the shift to the Patient-Driven Groupings Model (PDGM) in January 2020. Thus, I think it is okay to trade off use of older data to minimize bias from the 2020 changes.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What specific recommendations do you have on how we can use the ACO model and telehealth to expand home health, including changes with CMS regulations, CMMI models, and legislation, to lower costs and improve patient care?

Answer. Our team has found that ACOs generate savings for the Medicare program by shifting post-acute patients out of skilled nursing facilities and into home health agencies. This shift has not been found to impact quality negatively. Telemedicine was used widely in home-based care at the start of the pandemic. There is incredible opportunity for risk-bearing models like ACOs to further incorporate such innovations in the delivery of care moving forward.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. In your written testimony, you mentioned that the pandemic has exacerbated home health labor challenges, with the number of workers per beneficiary declining over time not only in the home and community-based services workforce but in other post-acute and long-term care settings. These declining direct care ratios, which are a result of a shrinking home health workforce, make it more difficult for beneficiaries to have meaningful one-on-one care. The vast majority of older adults indicate they prefer to age at home, even when, or especially when, they have health complications. In your testimony, you suggest increasing the size of the labor force through wage increases and that Congress continue to invest in policies to expand Medicaid HCBS.

Could you speak to the importance of expanding HCBS and the impact that significant investment in the direct-care workforce will have on patient care?

Answer. The expansion of Medicaid HCBS has been one of the most important changes in long-term care over the past few decades. Most disabled older adults prefer to receive care in the community. Our research suggests that States that have invested in HCBS have fewer individuals receiving care in nursing homes and more individuals receiving long-term care overall. Some of this HCBS expansion has been cost saving in that each dollar spent on HCBS is associated with lower nursing home use. Moving forward, State Medicaid programs should consider further HCBS

expansion to maximize their long-term care spending and allow older adults to age in place.

Question. In your testimony, you mention the importance of increased coordination between programs to support beneficiaries that are dually eligible for both Medicare and Medicaid. You also spoke to the fragmentation in care and coverage that occurs when benefits are not integrated across programs and spoke to the variability of the types of programs that are available to dually eligible individuals.

In your research, what have you found as being most important to a more coordinated approach to care, and how can these programs improve their alignment to better serve dually eligible beneficiaries?

Answer. One step would be to increase the use of passive enrollment. A key barrier to boosting enrollment in integrated models has been the voluntary nature of the Medicare program. Medicaid can mandate participation in a particular plan, but Medicare must allow beneficiaries to choose their type of coverage. Many dual-eligibles have opted to remain covered under traditional Medicare, rather than enroll in an integrated Medicare Advantage plan. Passive-enrollment policies could increase participation by making integrated care the default and requiring dual eligibles to “opt out” of this model.

Another approach would be to improve program alignment. Financing in integrated models is not always aligned across Medicare and Medicaid; dual beneficiaries may be enrolled in one plan for their Medicaid coverage and another plan (sponsored by a different company) for their Medicare coverage. This lack of financial alignment prevents meaningful care integration because Medicare and Medicaid dollars aren’t pooled across the two companies and put toward their most efficient use. Moreover, care won’t be integrated as extensively if different plans cover services under each program. All integrated care models could be required to rely on coverage from a single company rather than Medicare and Medicaid coverage from separate companies.

Third, standard dual-eligible special needs plans (D-SNPs) could be converted to fully integrated dually eligible special needs plans (FIDE-SNPs). Many dually eligible beneficiaries are enrolled in D-SNPs that don’t meaningfully integrate Medicaid benefits. D-SNPs are designated as FIDE-SNPs when Medicaid-covered long-term care and behavioral health services are covered by the same legal entity as the other components of the plan under a capitated contract with the State. Congress could make such integration a requirement for all D-SNPs. Many States don’t have capitated Medicaid plans that would permit such integration, but the goal would be to encourage States to begin to capitate Medicaid-covered long-term care, thereby making care integration possible. In the meantime, it’s unclear whether most D-SNPs offer much upside for dual-eligibles relative to traditional Medicare Advantage plans. Congress could therefore eliminate “Medicare-only” D-SNPs and work with States to transition D-SNPs to FIDE-SNPs, where possible.

Fourth, CMS could improve the data and measures used to evaluate care of dual-eligibles. Studies of these integrated programs have generally found that, as compared with nonintegrated care, they are associated with better or similar outcomes, but they have higher total costs. Evidence regarding the performance of integrated plans is limited, however. An important limitation is the lack of valid quality measures for assessing these programs. Analyses using process-based measures of quality that aren’t tied to clinical outcomes have come to mixed conclusions regarding which plans are associated with the highest quality of care. Future research could incorporate measures related to enrollee satisfaction and claims-based outcomes. Data regarding Medicare Advantage encounters are improving, which could permit a more meaningful evaluation of measures such as hospitalizations for dual eligibles receiving care under various models.

Finally, it will be important to move toward a unified approach to integrated care. Access to a strongly integrated care model for dually eligible beneficiaries is largely a function of whether their State has a capitated Medicaid long-term care program. Nine States that currently have such programs implemented Medicare-Medicaid plans through the CMS demonstrations. Twelve States with managed long-term care programs have FIDE-SNPs in place in at least some markets. The program of all-inclusive care for the elderly (PACE) is in operation in most States but covers a small fraction of the dually eligible population, in part because of the requirement that team-based care be provided through designated PACE centers. Dual-eligibles living in most markets don’t have meaningful access to integrated care models. One option for moving toward a more unified approach would be to combine current

Medicare and Medicaid funding in a new program; another proposal would retain the existing Medicare and Medicaid programs but require States to adopt a fully integrated coverage model. Either approach would break down the current administrative silos. The goal would be for all States to begin to capitate Medicaid-covered long-term care services so that a single plan could manage all health and long-term care services. Such an approach isn't feasible in the short term, but if the goal is to enroll more dually eligible beneficiaries in integrated care models, Congress could take steps to make it a reality in the future.

PREPARED STATEMENT OF TRACY M. MROZ, PH.D., OTR/L, FAOTA, ASSOCIATE PROFESSOR, DEPARTMENT OF REHABILITATION MEDICINE, UNIVERSITY OF WASHINGTON

Good morning, Chairman Cardin, Ranking Member Daines, and distinguished members of the committee. My name is Tracy Mroz, and I am an associate professor in the Department of Rehabilitation Medicine at the University of Washington. Thank you for the opportunity to provide testimony about opportunities and challenges for home health in supporting Americans' ability to age in place, particularly in rural America.

My expertise in this area comes from my experience as a health services researcher and an occupational therapist. I have studied access to and quality of home health care with an emphasis on care provided in rural communities for over a decade as an Investigator with the WWAMI Rural Health Research Center, funded by the Health Resources and Services Administration (HRSA)—Federal Office of Rural Health Policy, as well as through grants funded by the Agency for Healthcare Research and Quality, National Institutes of Health, and the National Institute on Disability, Independent Living, and Rehabilitation Research. I am also an Investigator with the HRSA-funded Center for Health Workforce Studies which focuses on research to inform health workforce planning and policy. My clinical background as an occupational therapist has given me frontline experience working with older adults to optimize their ability to participate in the activities they find most meaningful, from self-care and home management to work and leisure.

Based on my expertise, I will focus my comments on three main topics:

1. The role of home health in supporting aging in place for Medicare beneficiaries.
2. Disparities in access to home health in rural communities.
3. Drivers of access to care, including resource constraints, benefit requirements, and workforce challenges.

The Role of Home Health in Supporting Aging in Place

The majority of Americans prefer to age in place in their own homes.¹⁻³ Medicare's home health benefit provides an opportunity to support aging in place for the approximately 3 million fee-for-service beneficiaries who receive home health care annually.⁴ The home health benefit covers skilled nursing, rehabilitation (physical therapy, occupational therapy, and speech language pathology), medical social work, and home health aide services. These services can help facilitate beneficiaries' ability to remain in the community. For example, beneficiaries can utilize home health to receive skilled nursing services to provide medications, monitor health status, and learn about self-management of their condition. Beneficiaries can receive rehabilitation services to facilitate performance of daily activities, increase strength and balance, assess safety at home, and make recommendations for assistive devices, home modifications, and adaptive strategies to maximize function. Home health aides can provide temporary assistance with self-care and home management during the home health stay, and medical social workers can help beneficiaries coordinate resources needed to manage their care at home. Home health staff may also provide

¹ Binette, Joanne, and Fanni Farago. 2021 Home and Community Preference Survey: A National Survey of Adults Age 18-Plus. Washington, DC: AARP Research, November 2021.

² Robinson-Lane, S., Singer, D., Kirch, M., Solway, E., Smith, E., Kullgren, J., Malani, P. Older Adults' Preparedness to Age in Place. University of Michigan National Poll on Healthy Aging. April 2022.

³ The Associated Press and NORC Center for Public Affairs Research. Long-Term Care in America: Americans Want to Age at Home. May 2021. https://apnorc.org/wp-content/uploads/2021/04/LTC_Report_AgingatHome_final.pdf.

⁴ Medicare Payment Advisory Commission (MedPAC). Report to Congress: Medicare Payment Policy; Chapter 8: Home health-care services. March 2023.

training for family caregivers so that the caregivers can better support the beneficiary and reduce unmet care needs.

The home health benefit allows for direct referral from the community (community-entry home health) in addition to referral following hospitalization (post-acute home health). Regardless of entry-point into home health, home health services can support aging in place.

Post-Acute Home Health

Home health can help bridge the transition from an acute care hospital stay back to the community for a beneficiary who has been hospitalized. For example, beneficiaries may need care at home after being hospitalized following an emergent event, such as a stroke, heart attack, or fall that causes major injury. Beneficiaries may also receive home health following a planned hospitalization for a procedure, such as a total knee replacement or cancer treatment.

Community-Entry Home Health

Home health can support beneficiaries with chronic conditions who experience a change in health or functional status that does not necessitate hospitalization, but does require skilled services for recovery, stabilization, or to help the beneficiary stay safe at home. For example, beneficiaries may experience a decline in health or functional status due to an exacerbation of chronic obstructive pulmonary disease or heart failure, a flare up of multiple sclerosis symptoms, worsening arthritis, or a fall causing minor injury. Beneficiaries referred to home health from the community are more likely to be older, be dually eligible for Medicaid, have more cognitive impairment, lower functional status, and a higher need for caregiver assistance compared to beneficiaries referred to home health following hospitalization.^{5,6}

Both post-acute and community-entry home health can provide valuable supports for beneficiaries who wish to remain in their homes. Home health to support aging in place may be particularly important for Medicare beneficiaries living in rural communities because these beneficiaries tend to be older, have poorer health, and have fewer financial resources compared to their urban counterparts.⁷ However, the promise of the home health benefit as a means to support aging in place relies on the ability of beneficiaries to access home health care.

Access to Home Health in Rural Communities

While the most recent MedPAC report to Congress on Medicare Payment Policy notes that over 98 percent of Medicare beneficiaries live in a ZIP code served by at least two home health agencies, and nearly 88 percent live in a ZIP code served by five or more home health agencies,⁴ the reality of access to care for rural beneficiaries is more nuanced. The number of home health agencies serving a community represents supply, which is a necessary but not sufficient measure of access to home health. Even when a home health agency is ostensibly serving a rural community, the agency may not always have the capacity to admit new patients, provide services in a timely fashion, or provide all types of services the beneficiary needs.^{8,9} Indeed, some rural home health agencies report capacity constraints that result in only being able to cover part of their licensed service areas and they may refuse new admissions if they do not have adequate staffing to provide care at the time of referral.⁸ For beneficiaries that are admitted to home health, the number of visits they receive may be limited due to the amount of “windshield time” (*i.e.*, travel time) required by home health-care staff when driving long distances to visit patients dispersed widely across rural areas.^{8,9}

⁵Burgdorf, J.G., Mroz, T.M., Wolff, J.L. Social Vulnerability and Medical Complexity Among Medicare Beneficiaries Receiving Home Health Without Prior Hospitalization. *Innov Aging*. 2020;4(6):igaa049. Published 2020 October 3.

⁶Mroz, T.M., Andrilla, C.H.A., Garberson, L.A., Skillman, S.M., Patterson, D.G., Wong, J.L., Larson, E.H. Different Populations Served by the Medicare Home Health Benefit: Comparison of Post-acute versus Community-entry Home Health in Rural Areas. Policy Brief #165. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, July 2018.

⁷Centers for Medicare and Medicaid Services. CMS Rural Health Strategy. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>.

⁸Knudson, A., Anderson, B., Schueler, K., Arsen, E. Home is Where the Heart Is: Insights on the Coordination and Delivery of Home Health Services in Rural America. University of North Dakota Center for Rural Health and NORC Walsh Center for Rural Health Analysis, August 2017.

⁹Skillman, S.M., Patterson, D.G., Coulthard, C., Mroz, T.M. Access to Rural Home Health Services: Views from the Field. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

So, despite reports that most rural beneficiaries are served by at least one home health agency, there is a growing body of evidence on disparities in access to home health based on rural-urban status.¹⁰ Rural beneficiaries who are hospitalized are less likely to be discharged to home health compared to their urban counterparts, and this gap is wider for beneficiaries living in non-urban-adjacent rural counties compared to urban-adjacent rural counties.^{11, 12} Furthermore, when rural beneficiaries have a planned discharge to home health following hospitalization, fewer than 60 percent of them are admitted to a home health agency to receive this planned care following hospital discharge.¹³ When considering both post-acute and community-entry home health, an increasingly smaller percent of Medicare beneficiaries use home health care as rurality increases, with beneficiaries in the most remote rural communities at highest risk for unmet need, though geographic region also drives variation in utilization.¹⁴ Rural beneficiaries may also have trouble accessing high-quality home health care because a greater percentage of rural home health agencies in small rural and isolated small rural communities are considered low-quality based on Medicare's 5-star quality of care rating and perform worse on individual quality measures like hospital readmissions and emergency department visits.^{15, 16} Of note, rural home health agencies are more likely to have high-quality 5-star ratings for patients' experience of care,¹⁶ recognizing that quality of care and the experience of care are separate domains.¹⁷

Disparities in access to rehabilitation services are also evident for specific patient populations receiving home health. Rural beneficiaries who experience a stroke are less likely to receive rehabilitation services than urban beneficiaries, which is concerning because rehabilitation is a critical component of post-stroke care.¹⁸ Rural beneficiaries receive fewer physical therapy visits following total knee replacement compared to urban beneficiaries, despite physical therapy's essential role in recovery following lower extremity joint replacement.¹⁹ Beneficiaries recovering from critical illnesses that necessitate intensive care unit stays during hospitalization also receive fewer rehabilitation visits during home health if they lived in rural versus urban communities.²⁰ These findings of fewer visits of rehabilitation services may stem in part to due to specialized services being less widely available in rural counties, particularly remote rural counties.²¹

¹⁰ Quigley, D.D., Chastain, A.M., Kang, J.A., et al. Systematic Review of Rural and Urban Differences in Care Provided by Home Health Agencies in the United States. *J Am Med Dir Assoc.* 2022;23(10):1653.e1–1653.e13.

¹¹ Burke, R.E., Jones, C.D., Coleman, E.A., Falvey, J.R., Stevens-Lapsley, J.E., Ginde, A.A. Use of post-acute care after hospital discharge in urban and rural hospitals. *Am J Accountable Care.* 2017;5(1):16–22.

¹² Kosar, C.M., Loomer, L., Ferdows, N.B., Trivedi, A.N., Panagiotou, O.A., Rahman, M. Assessment of Rural-Urban Differences in Postacute Care Utilization and Outcomes Among Older US Adults. *JAMA Netw Open.* 2020;3(1):e1918738.

¹³ Mroz, T.M., Garberson, L.A., Andrilla, C.H.A., Skillman, S.M., Larson, E.H., Patterson, D.G. Post-acute Care Trajectories for Rural Medicare Beneficiaries: Planned versus Actual Hospital Discharges to Skilled Nursing Facilities and Home Health Agencies. Policy Brief. WWAMI Rural Health Research Center, University of Washington; March 2021.

¹⁴ Mroz, T.M., Garberson, L.A., Wong, J.L., Andrilla, C.H.A., Skillman, S.M., Patterson, D.G., Larson, E.H. Variation in Use of Home Health Care among Fee-for-Service Medicare Beneficiaries by Rural-Urban Status and Geographic Region: Assessing the Potential for Unmet Need. Policy Brief #169. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2020.

¹⁵ Ma, C., Devoti, A., O'Connor, M. Rural and urban disparities in quality of home health care: A longitudinal cohort study (2014–2018). *J Rural Health.* 2022;38(4):705–712.

¹⁶ Mroz, T.M., Garberson, L.A., Andrilla, C.H.A., Patterson, D.G. Quality of Home Health Agencies Serving Rural Medicare Beneficiaries. Policy Brief. WWAMI Rural Health Research Center, University of Washington; February 2022.

¹⁷ Schwartz, M.L., Mroz, T.M., Thomas, K.S. Are Patient Experience and Outcomes for Home Health Agencies Related?. *Med Care Res Rev.* 2021;78(6):798–805.

¹⁸ Iyer, M., Bhavsar, G.P., Bennett, K.J., Probst, J.C. Disparities in home health service providers among Medicare beneficiaries with stroke. *Home Health Care Serv Q.* 2016;35(1):25–38.

¹⁹ Falvey, J.R., Bade, M.J., Forster, J.E., et al. Home-Health-Care Physical Therapy Improves Early Functional Recovery of Medicare Beneficiaries After Total Knee Arthroplasty. *J Bone Joint Surg Am.* 2018;100(20):1728–1734.

²⁰ Falvey, J.R., Murphy, T.E., Gill, T.M., Stevens-Lapsley, J.E., Ferrante, L.E. Home Health Rehabilitation Utilization Among Medicare Beneficiaries Following Critical Illness. *J Am Geriatr Soc.* 2020;68(7):1512–1519.

²¹ Probst, J.C., Towne, S., Mitchell, J., Bennett, K.J., Chen, R. Home Health Care Agency Availability in Rural Counties. South Carolina Rural Health Research Center, University of South Carolina; June 2014.

Drivers of Access to Home Health

Resource Constraints

Even though historically high average Medicare margins for home health agencies, including rural home health agencies, have received much attention,⁴ it is important to know that averages can mask the reality that while some home health agencies are very profitable, others are less so. To fully understand the resources of rural home health agencies, the wider context of the rural home health market must be considered. Compared to urban home health agencies, a significantly higher percentage of rural agencies are nonprofit or governmental versus for-profit and hospital-based versus freestanding.^{15,16} These distinctions are important because margins tend to be lower in nonprofit and governmental agencies and margins are only reported for freestanding.⁴ Half of Critical Access Hospitals and three-fifths of other rural hospitals offer home health-care services either on their own or as part of a health system or joint venture, in order to increase access to care in rural communities.²² Furthermore, hospital-based agencies often rely on their relationship with the hospital to remain financially viable.⁸ Some rural home health agencies also rely on local foundations, county general funds, levies, and county-wide health district funds to bolster their financial resources and maintain their current coverage areas.⁸

In recognition of the extra costs often required to serve rural beneficiaries, Medicare has intermittently provided a percentage increase in payments to home health agencies for care provided to rural beneficiaries. When active, the rural add-on payment has varied over the past decade and has been as high as 10 percent when initially implemented to as low as 1 percent, the current rural add-on percentage. Rural add-on payments are in the process of being sunsetted following a phaseout process in which rural add-on payment percentages were changed from a single percentage for caring for all rural beneficiaries to targeted amounts based on the utilization and population density of the community in which the rural beneficiary lived due to the Bipartisan Budget Act of 2018.²³ Concerns have been raised about the impact of targeting, reduced amounts, and eventual sunset of rural add-on payments on access to care for rural beneficiaries. While research supports targeting of the rural add-on payment in terms of its effect on home health agency supply, only higher rural add-on payments (*e.g.*, 5 percent, 10 percent) have historically led to supply changes in non-urban-adjacent rural communities that have kept pace urban communities.²⁴ However, even a lower 3 percent rural add-on payment resulted in reductions in rehospitalizations for rural beneficiaries receiving post-acute home health.²⁵ Together these findings suggest a reconsideration of the sunset of rural add-on payments, with the caveat that the appropriate number of home health agencies serving a community depends both on capacity of the home health agencies and the outcomes achieved by providing services.

Moreover, the impact of decreasing rural add-on payments and their eventual sunset are unclear in part due to the overlapping implementation of a new payment system, the Patient-Driven Groupings Model (PDGM), in January 2020 and the emergence of the COVID-19 pandemic shortly thereafter. PDGM represents a massive shift in reimbursement for home health agencies, the intent of which is to base payments on patient characteristics at admission and remove the prior incentive for rehabilitation services under which higher volumes of rehabilitation visits resulted in higher payments. PDGM also introduces admission source into payment calculations for the first time such that post-acute home health is incentivized over community-entry home health and multi-episode home health stays (*e.g.*, longer than the initial 30-day payment episode of care) are paid less after the first 30 days of care. Thus, PDGM may result in decreases in rehabilitation services, fewer beneficiaries accessing home health via community-entry, and shorter stays, but the impact is not yet known.

²² Croll, Z., Gale, J. Community Impact and Benefit Activities of Critical Access, Other Rural, and Urban Hospitals, 2021. Flex Monitoring Team—University of Minnesota, University of North Carolina at Chapel Hill, University of Southern Maine, May 2023.

²³ Bipartisan Budget Act of 2018, Pub. L. No. 115–123.

²⁴ Mroz, T.M., Patterson, D.G., Frogner, B.K. The Impact of Medicare's Rural Add-On Payments on Supply of Home Health Agencies Serving Rural Counties. *Health Aff* (Millwood). 2020;39(6):949–957.

²⁵ Loomer, L., Rahman, M., Mroz, T.M., Gozalo, P.L., Mor, V. Impact of higher payments for rural home health episodes on rehospitalizations. *J Rural Health*. 2023;39(3):604–610.

Additional research is also needed on the impact of the COVID–19 pandemic on home health agencies, staff, and patients, both to understand short- and long-term consequences and opportunities of the public health emergency as well as to better prepare for future disasters by learning from the responses to the pandemic.^{26–30} Much of the home health evidence base relies on studies performed with data prior to implementation of PDGM, the emergence of the COVID–19 pandemic, and changes to rural add-on payments. Therefore, studies using the most current data are urgently needed to understand the impact of these overlapping events as well as payer mix on the stability of rural home health agencies and their ability to provide needed care for rural beneficiaries.

To be clear, not all rural home health agencies are facing resource constraints and struggling to remain operational to serve their communities. Many are profitable. Rather, the financial constraints of rural home health agencies that are struggling deserve further attention with respect to how resource availability impacts access to and quality of care for rural beneficiaries. Payment policies should be monitored for unintended consequences and revised to ensure that rural home health agencies that admit less profitable patients and face increased costs to deliver care have the resources to serve rural beneficiaries in their communities and support their ability to remain at home.

Benefit Requirements

Beneficiaries are required to be “homebound” in order to be eligible for the home health benefit. To be considered homebound, the beneficiary must need the aid of supportive devices (e.g., wheelchair, walker) or the help of another person to leave their home or leaving home is medically contraindicated, and the beneficiary must be unable to leave the home or leaving home requires considerable and taxing effort. While the homebound requirement does allow for short, infrequent trips outside the home, this allowance may not be sufficient for rural beneficiaries to maintain their homebound status when resources to meet their basic needs require long travel times and may even lead some beneficiaries to be unwilling to agree to the homebound requirement even if advisable.⁹ Rural home health agencies have also reported challenges in interpretation of the homebound requirement, which may also reduce access for rural beneficiaries.⁸

Recent changes to other home health requirements may mitigate some of the challenges that rural beneficiaries face in accessing care. The original face-to-face requirement for physicians to certify a beneficiary for home health is burdensome in some rural communities due to the more limited physician supply and travel distances.^{8,9} However, during the COVID–19 pandemic the practitioners permitted to certify a beneficiary for home health was expanded to non-physician practitioners, including nurse practitioners, clinical nurse specialists, and physician assistants.^{31,32} In addition, the use of telehealth services was permitted for the face-to-face encounter with a beneficiary’s home allowed as a originating site of care (versus a provider’s office); this allowance will continue through December 2024.^{31,32} Whether these changes will increase or help maintain access to home health care in rural communities longer-term remains to be seen; nevertheless, these changes were welcomed by rural home health agencies as they decreased barriers for certification of home health.

²⁶ Franzosa, E., Wyte-Lake, T., Tsui, E.K., Reckrey, J.M., Sterling, M.R. Essential but Excluded: Building Disaster Preparedness Capacity for Home Health Care Workers and Home Care Agencies. *J Am Med Dir Assoc.* 2022;23(12):1990–1996.

²⁷ Shang, J., Chastain, A.M., Perera, U.G.E., et al. COVID–19 Preparedness in U.S. Home Health Care Agencies. *J Am Med Dir Assoc.* 2020;21(7):924–927.

²⁸ Sterling, M.R., Tseng, E., Poon, A., et al. Experiences of Home Health Care Workers in New York City During the Coronavirus Disease 2019 Pandemic: A Qualitative Analysis. *JAMA Intern Med.* 2020;180(11):1453–1459.

²⁹ Tyler, D.A., Squillace, M.R., Porter, K.A., Hunter, M., Haltermann, W. COVID–19 Exacerbated Long-standing Challenges for the Home Care Workforce [published online ahead of print, 2022 November 3]. *J Aging Soc Policy.* 2022;1–19. doi:10.1080/08959420.2022.2136919.

³⁰ Videon, T.M., Rosati, R.J., Landers, S.H. COVID–19 infection rates early in the pandemic among full time clinicians in a home health care and hospice organization. *Am J Infect Control.* 2022;50(1):26–31.

³¹ Centers for Medicare and Medicaid Services. COVID–19 Emergency Declaration Blanket Waivers for Health Care Providers. <https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf>.

³² Centers for Medicare and Medicaid Services. Home Health Agencies: Flexibilities to Fight COVID–19. <https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf>.

Workforce Challenges

Access to home health is dependent on the ability of home health agencies to recruit and retain qualified workers. Rural home health agencies have cited multiple barriers to recruiting and retaining home health staff, including geographic isolation, workers' desire to spend more time caring for patients versus driving to their homes, and lack of competitive wages compared to other types of rural care settings like hospitals and similar jobs in urban areas.^{8,9} In addition, small volume home health agencies may not have enough patients to support full-time staff.^{8,9} Needing to contract with local hospitals to fill vacancies for therapists due to the inability to hire for full-time status can be more expensive for home health agencies and lead to delays in care when therapists' caseloads are already full or they need to prioritize hospital patients over home health patients.^{8,9} Even when nurses and therapists are available to work in a rural community, home health requires a level of experience and independence for providers such that newer graduates may be underqualified or unwilling to take available positions.^{8,9}

The home health aide workforce is particularly fragile. Wages for home health aides are usually low and hours may be unpredictable or insufficient, leading to economic precarity for these workers.^{9,33} The additional barrier of unreliable transportation for low income workers may be especially challenging for home health aides in rural communities.⁹ Also, home health aides are often managing their own chronic conditions while working and many express an intent to leave the profession after experiencing on-the-job injuries.^{33–35} The emotion demands of their work may also impact their well-being, further leading to challenges with retention.^{36,37} The fragility of the home health aide workforce is concerning for rural home health agencies as there is a significantly lower home health aide workforce in rural areas, with only 32.9 home health aides per 1,000 older adults, as compared with urban areas where there are 50.4 home health aides per 1,000 older adults.³⁸

Other Considerations

While outside the primary focus of my comments, it is worth briefly noting several other considerations for home health policy. First, I have emphasized home health for rural beneficiaries in my comments, but there are other inequities in home health that must be highlighted. Research has shown disparities in home health utilization, timeliness of care, patient outcomes, and admission to high-quality home health agencies based on race, ethnicity, and socioeconomic status of beneficiaries.^{39–45} It is critical that these inequities are addressed to ensure all Medicare beneficiaries have the ability to benefit from home health.

³³ Stone, R., Wilhelm, J., Bishop, C.E., Bryant, N.S., Hermer, L., Squillace, M.R. Predictors of Intent to Leave the Job Among Home Health Workers: Analysis of the National Home Health Aide Survey. *Gerontologist*. 2017;57(5):890–899.

³⁴ Cho, J., Toffey, B., Silva, A.F., et al. To care for them, we need to take care of ourselves: A qualitative study on the health of home health aides. *Health Serv Res*. 2023;58(3):697–704.

³⁵ McAuley, W.J., Spector, W., Van Nostrand, J. Home health-care agency staffing patterns before and after the Balanced Budget Act of 1997, by rural and urban location. *J Rural Health*. 2008;24(1):12–23.

³⁶ Franzosa, E., Tsui, E.K., Baron, S. "Who's Caring for Us?": Understanding and Addressing the Effects of Emotional Labor on Home Health Aides' Well-being. *Gerontologist*. 2019; 59(6):1055–1064.

³⁷ Tsui, E.K., Wyka, K., Beato, L., Verkuilen, J., Baron, S. How client death impacts home care aides' workforce outcomes: an exploratory analysis of return to work and job retention. *Home Health Care Serv Q*. 2023;42(3):230–242.

³⁸ Dill, J., Henning-Smith, C., Zhu, R., Vomacka, E. Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas. *J Appl Gerontol*. 2023;42(8):1800–1808.

³⁹ Fashaw-Walters, S.A., Rahman, M., Jarrin, O.F., et al. Getting to the root: Examining within and between home health agency inequities in functional improvement [published online ahead of print, 2023 June 25]. *Health Serv Res*. 2023;10.1111/1475–6773.14194.

⁴⁰ Fashaw-Walters, S.A., Rahman, M., Gee, G., Mor, V., White, M., Thomas, K.S. Out of Reach: Inequities in the Use of High-Quality Home Health Agencies. *Health Aff (Millwood)*. 2022;41(2):247–255.

⁴¹ Karmarkar, A.M., Roy, I., Lane, T., Shaibi, S., Baldwin, J.A., Kumar, A. Home health services for minorities in urban and rural areas with Alzheimer's and related dementia [published online ahead of print, 2023 April 27]. *Home Health Care Serv Q*. 2023;1–17.

⁴² Li, J., Qi, M., Werner, R.M. Assessment of Receipt of the First Home Health Care Visit After Hospital Discharge Among Older Adults. *JAMA Netw Open*. 2020;3(9):e2015470. Published 2020 September 1.

⁴³ Rosati, R.J., Russell, D., Peng, T., et al. Medicare home health payment reform may jeopardize access for clinically complex and socially vulnerable patients. *Health Aff (Millwood)*. 2014;33(6):946–956.

Continued

Second, the impact of value-based care models, including accountable care organizations, bundled payment models, and the newly expanded Home Health Value-Based Purchasing (HHVBP) program, needs to be considered in conjunction with other policies. The final evaluation of the nine-State demonstration of the HHVBP does not suggest HHVBP had a differential impact on access to care for rural beneficiaries;⁴⁶ however, given regional variation in home health, it will be important to monitor the impact of the nationwide expansion of HHVBP on access to home health for rural beneficiaries. Also, since rural home health agencies have lower performance on certain quality measures included in total performance scores for HHVBP compared to urban home health agencies and a higher percentage of rural home health agencies have lower overall quality of care ratings, particularly agencies in small rural and isolated small rural communities,^{10, 15–16, 47} there will be rural home health agencies at risk for penalties under HHVBP. While the threat of penalties is meant to incentivize home health agencies to improve quality, penalties imposed on lower resourced home health agencies may actually decrease their ability to improve quality. For rural communities that are served by only one or two home health agencies, loss of one agency may drastically reduce access to home health care within that community. So, careful monitoring is warranted to ensure payment adjustments do not diminish opportunities to implement quality improvement initiatives in these lower performing agencies and do not hasten closures in underserved communities where low-quality home health agencies are the only option for care.

Third, continued growth in enrollment in Medicare Advantage plans may have ramifications for home health care. Much of the research thus far on home health utilization comparing beneficiaries enrolled in Medicare Advantage to fee-for-service Medicare has found lower utilization among Medicare Advantage beneficiaries, particularly when plans include cost sharing,^{48, 49} but regional variation exists in these differences.⁵⁰ In addition, Medicare Advantage beneficiaries are more likely to receive care from lower quality home health agencies.⁵¹ Even though the rate of growth in enrollment in Medicare Advantage plans is increasing more rapidly in rural counties, enrollment in Medicare Advantage is still lower for rural versus urban beneficiaries and distribution of plan types (*e.g.*, HMO, PPO) differ by rural-urban status.^{52, 53} Continued research on Medicare Advantage's impact on access to home health and specific services as well as patient outcomes by rural-urban status is needed.

Fourth, research is needed to understand how dually eligible beneficiaries utilize Medicare's home health benefit and Medicaid's home and community-based services, whether there is substitution or duplication of services, and whether there are opportunities for integration of services. Since Medicaid's home and community-based services vary by State and may be subject to waiting lists, it is possible that Medicare's home health benefit may provide dually eligible beneficiaries with key supports to remain at home. There may also be opportunities to learn from innovative programs available to some Medicaid beneficiaries, such as the Community Aging

⁴⁴ Smith, J.M., Jarrin, O.F., Lin, H., Tsui, J., Dharamdasani, T., Thomas-Hawkins, C. Racial Disparities in Post-Acute Home Health Care Referral and Utilization Among Older Adults With Diabetes. *Int J Environ Res Public Health*. 2021;18(6):3196. Published 2021 March 19.

⁴⁵ Towne, S.D., Jr, Probst, J.C., Mitchell, J., Chen, Z. Poorer Quality Outcomes of Medicare-Certified Home Health Care in Areas With High Levels of Native American/Alaska Native Residents. *J Aging Health*. 2015;27(8):1339–1357.

⁴⁶ Arbor Research Collaborative for Health. Home Health Value-Based Purchasing Final Evaluation Report. September 2023. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/hhvbp-seventh-ann-rpt>.

⁴⁷ Chen, H.F., Landes, R.D., Schuldt, R.F., Tilford, J.M. Quality Performance of Rural and Urban Home Health Agencies: Implications for Rural Add-On Payment Policies. *J Rural Health*. 2020;36(3):423–432.

⁴⁸ Loomer, L., Kosar, C.M., Meyers, D.J., Thomas, K.S. Comparing Receipt of Prescribed Post-acute Home Health Care Between Medicare Advantage and Traditional Medicare Beneficiaries: an Observational Study. *J Gen Intern Med*. 2021;36(8):2323–2331.

⁴⁹ Skopec, L., Zuckerman, S., Aarons, J., et al. Home Health Use in Medicare Advantage Compared to Use in Traditional Medicare. *Health Aff (Millwood)*. 2020;39(6):1072–1079.

⁵⁰ Waxman, D.A., Min, L., Setodji, C.M., Hanson, M., Wenger, N.S., Ganz, D.A. Does Medicare Advantage enrollment affect home healthcare use? *Am J Manag Care*. 2016;22(11):714–720.

⁵¹ Schwartz, M.L., Kosar, C.M., Mroz, T.M., Kumar, A., Rahman, M. Quality of Home Health Agencies Serving Traditional Medicare vs Medicare Advantage Beneficiaries. *JAMA Netw Open*. 2019;2(9):e1910622.

⁵² Shane, D., Ejughemre, U., Ullrich, F., Mueller, K. Distributional Analysis of Variation in Medicare Advantage Participation Within and Between Metropolitan, Micropolitan, and Noncore Counties. August 2023, RUPRI Center for Rural Health Policy Analysis, Brief 2023–8.

⁵³ Lazaro, E., Ullrich, F., Mueller, K. Medicare Advantage Enrollment Update 2022. RUPRI Center for Rural Health Policy Analysis, Brief No. 2023–3.

in Place—Advancing Better Living for Elders (CAPABALE) program, an interdisciplinary short-term intervention to address difficulty performing activities of daily living through nursing, occupational therapy, and handyman services, that has been successful in helping older adults remain in their homes.⁵⁴

Finally, while spending on home health is expected to grow year over year by an average of nearly 8 percent annually from 2022–2031, it remains a relatively small percentage of overall health-care expenditures.⁵⁵ Post-acute care costs are higher for beneficiaries who could be served by a home health agency but instead receive care in a skilled nursing facility due to lack of access to home health.⁵⁶ Emerging research on small populations also suggests that increased spending on home health may be associated with reduced overall health-care spending due to reductions in expensive hospital admissions.^{57–59} While research on a national scale that uses current data on home health agencies operating under PDGM is needed, there may be a tradeoff between increased spending on home health and potential cost savings elsewhere for Medicare.

CONCLUSIONS

The Medicare home health benefit is currently supporting beneficiaries' ability to age in place, but the full potential of home health may not be realized, particularly for rural beneficiaries. Research on home health suggests the need for targeted solutions that incentivize service provision to beneficiaries at risk for reduced access and poorer outcomes, including rural beneficiaries, and do not create or exacerbate challenges for home health agencies that disproportionately serve the most vulnerable patients. As home health agencies continue to adapt to multiple policy changes and emerge from the public health emergency, it remains essential to monitor access to and outcomes of home health services and “apply a rural lens to programs and policies” in alignment with the CMS Rural Health Strategy.⁷

QUESTIONS SUBMITTED FOR THE RECORD TO TRACY M. MROZ, PH.D., OTR/L, FAOTA

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Are there COVID-era waivers that if made permanent would be helpful in making access to home health care easier for rural beneficiaries?

Answer. There are three COVID-era waivers for home health that have expired that have the potential to make access to home health easier for rural beneficiaries if made permanent: (1) allowance for required face-to-face encounters to be conducted via telehealth with the patient's home as an originating site, (2) permission for home health agencies to complete the initial assessment remotely via telephone or medical record review to establish eligibility for home health, and (3) the ability of rehabilitation professionals to perform the initial and comprehensive assessments when skilled nursing services are included in the plan of care.

Since completion of the required face-to-face encounter may be challenging in rural communities due to the limited supply of allowed practitioners and long travel distances for patients to see available practitioners, the ability for the face-to-face encounter to be conducted via telehealth with the patient's home as an originating site increases access to home health for rural beneficiaries. While the originating site waiver was originally slated to end following the COVID–19 Public Health

⁵⁴ Community Aging in Place Advancing Better Living for Elders (CAPABLE). <https://capablenationalcenter.org/>.

⁵⁵ Office of the Actuary in the Centers for Medicare and Medicaid Services. National Health Expenditure Projections—Table 10. Home Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: CY 2015–2031. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>.

⁵⁶ Werner, R.M., Coe, N.B., Qi, M., Konetzka, R.T. Patient outcomes after hospital discharge to home with home health care vs to a skilled nursing facility. *JAMA Intern Med.* 2019;179(5): 617–23.

⁵⁷ Howard, J., Kent, T., Stuck, A.R., Crowley, C., Zeng, F. Improved cost and utilization among Medicare beneficiaries dispositioned from the ED to receive home healthcare compared with inpatient hospitalization. *Am J Accountable Care.* 2019;7(1).

⁵⁸ Racsa, P., Rogstad, T., Stice, B., et al. Value-based care through postacute home health under CMS PACT regulations. *Am J Manag Care.* 2022;28(2):e49–e54.

⁵⁹ Xiao, R., Miller, J.A., Zafirau, W.J., Gorodeski, E.Z., Young, J.B. Impact of Home Health Care on Health Care Resource Utilization Following Hospital Discharge: A Cohort Study. *Am J Med.* 2018;131(4):395–407.e35.

Emergency (PHE), this allowance has been extended through December 2024 through the Consolidated Appropriations Act of 2023. Permanent allowance of the patient's home as the originating site for a telehealth visit for the face-to-face encounter may be especially important to increase or maintain access to home health care for beneficiaries living in the most remote rural communities and health professional shortage areas.

During the PHE, home health agencies were permitted to conduct initial assessments remotely via telehealth or medical record review to determine eligibility for home health (*i.e.*, homebound status and care needs). Since the initial assessment visit must be held within 48 hours of referral or within 48 hours of a patient's return home, or on the ordered start of care date, flexibility in completing the initial assessment remotely via telehealth or medical record review may allow rural home health agencies to accept referrals when capacity does not allow for an in-home visit to complete the initial assessment within 48 hours but does allow for a start of care visit within a reasonable timeframe based on patient needs.

Rehabilitation professionals, including occupational therapists, physical therapists, and speech-language pathologists, are already permitted to complete the initial and start of care comprehensive assessments for cases in which only therapy services are included in the plan of care (*i.e.*, skilled nursing services are not included). Rehabilitation professions are also permitted to complete all comprehensive assessments subsequent to the start of care comprehensive assessment for cases which include nursing services. The waiver to allow rehabilitation professionals to complete initial and start of care comprehensive assessments for cases in which skilled nursing is included in the plan of care expired following the PHE. Making a permanent change to allow rehabilitation professionals to complete the initial and start of care comprehensive assessments for cases in which skilled nursing is included in the plan of care provides flexibility for rural home health agencies in allocating staff for completing the start of care comprehensive assessment. This flexibility may enable rural home health agencies to accept referrals they have otherwise declined when they are experiencing capacity constraints with nurses but have rehabilitation professionals available to complete the start of care comprehensive assessment.

Note that several other COVID-era waivers and flexibilities have already been made permanent which are considered helpful for access to care for rural beneficiaries. These include the expansion of allowed practitioners to order and certify eligibility for home health services to non-physician practitioners (nurse practitioners, physician assistants, and clinical nurse specialists) and the ability to provide some home health services via telehealth. Making the three flexibilities described above permanent will serve to further promote access to care for rural beneficiaries.

Question. What is the role of rehabilitation services in home health to support aging in place, both for post-acute and community-entry home health?

Answer. Rehabilitation services, including occupational therapy, physical therapy, and speech language pathology, play an important role for supporting aging in place for Medicare beneficiaries. Post-acute home health care following an acute hospitalization serves as a bridge to facilitate the transition from the hospital back to the community. For patients receiving post-acute home health care, rehabilitation services address new or worsening functional limitations resulting from the illness, injury, and/or surgery that was the reason for the hospitalization as well as secondary loss of function resulting from long hospital stays when applicable. In these cases, rehabilitation services often focus on restoring function to prior levels before hospitalization or maximizing function within the context of new limitations that are expected to persist.

Community-entry home health care supports beneficiaries with chronic conditions who experience a change in health or functional status that does not necessitate a hospitalization, but does lead to a need for skilled services. Like rehabilitation services during post-acute home health, rehabilitation services during community-entry home health can promote return to the level of functioning that was present prior to the status change that led to home health referral or maximize function with the context of limitations that may have increased due to that status change. Rehabilitation services during community-entry home health for patients with conditions with expected trajectories of functional decline (*e.g.*, neurodegenerative conditions like multiple sclerosis, Parkinson's disease, and amyotrophic lateral sclerosis) may focus on temporary stabilization or slowing functional decline as well as compensatory strategies to support participation in daily activities and safety as functional

limitations increase over time. It is important to note that even when entry point into home health care differs, the overall goal of rehabilitation is the same—assess and address the functional limitations which impact the patients' ability to do what they need and want to do to successfully age in place in their homes.

The three rehabilitation services available through the home health benefit have distinct focus areas that complement each other. Depending on their needs, patients may benefit from one, two, or all three rehabilitation services. Occupational therapy focuses on participation in activities of daily living, including basic self-care tasks like dressing and bathing, more complicated tasks like meal preparation, medication management, household chores, and money management, and social and leisure activities. Physical therapy focuses on safe functional mobility, including walking, managing stairs and curbs, and transfers with or without a mobility device (*e.g.*, cane, walker, crutches) as well as factors related to functional mobility including strength, range of motion, balance, endurance, and pain management. Speech-language pathology services focus on addressing language and communication impairments, including improving communication between patients and their family caregivers and health-care providers, as well as cognition and safe swallowing. All three rehabilitation services also provide training in their areas of expertise to family caregivers so that family caregivers can support their loved ones safely and effectively with reduced caregiver burden. Together these rehabilitation services promote successful aging in place by optimizing the home health patient's ability to perform the activities they want and need to do to live safely in the community for as long as possible.

Rehabilitation services provided via the home health benefit are especially well-suited to support aging in place because they address patients' needs in their home environments, enabling assessment and tailored treatment in their actual context versus a clinic which cannot fully replicate the home environment. That is, recommendations and treatment strategies in home health not only align with patients' abilities and preferences, but also with their home environments and available resources. Some treatments may be more effective when implemented in their real-life context versus simulated in a clinic (*e.g.*, navigating their own home environment safely with a walker, using adaptive strategies and devices to prepare meals in their own kitchens). Patients may also be more comfortable and experience less stress receiving care in their homes and therefore may be better able to participate in therapy. In addition, there are no travel or time costs associated for patients for whom leaving the home is extremely challenging per the homebound criteria. For these beneficiaries who are homebound, the home health benefit provides access to rehabilitation services that may otherwise be out of reach. Rehabilitation services provided via the home health benefit may reduce overall costs of care by helping patients remain safely in their homes and avoiding hospitalizations due to challenges managing chronic conditions and accidents such as falls.

Due to value of rehabilitation services to promote aging in place, it is important to monitor access to rehabilitation services for home health patients as home health agencies adapt to multiple payment policy changes. The Patient-Driven Groupings Model (PDGM), implemented in 2020, removed the prior incentive for rehabilitation service provision in reimbursement determinations for home health agencies, but the impact of PDGM on provision of rehabilitation services to home health patients and their subsequent outcomes remains to be seen. Since PDGM has structured payments in a way that emphasizes the need for rehabilitation services for patients with neurological conditions (*e.g.*, stroke) and musculoskeletal conditions (*e.g.*, hip fractures, lower extremity joint replacement), it is possible patients with other conditions who may benefit from rehabilitation services (*e.g.*, chronic obstructive pulmonary disease, heart failure, pneumonia) will be less likely to receive them, resulting in a missed opportunity to support aging in place. Research on provision of rehabilitation services under PDGM and patient outcomes, including functional status, successful discharge to the community, and hospital admissions, is needed to assess for unintended consequences of PDGM.

The impact of the nationwide expansion of the Home Health Value-Based Purchasing model on access to rehabilitation services in home health and patient outcomes should also be monitored. In addition, since disparities in access to rehabilitation services for rural home health patients have been documented, it will be important to assess the impact of the sunset of rural add-on payments to home health agencies on utilization of rehabilitation services by rural beneficiaries. Finally, while rehabilitation services for maintaining function, slowing decline in function, and adapting to functional limitations that are expected to be long-term (often referred to collectively as maintenance therapy) are covered by Medicare under the home

health, skilled nursing facility, and outpatient benefits, there have been persistent concerns that beneficiaries who would benefit from maintenance therapy have had difficulty accessing rehabilitation services despite the clarification issued by CMS following the Jimmo Settlement Agreement in 2013. In order for the full potential of rehabilitation services to support successful aging in place to be realized, Medicare will need to ensure benefit design and payment policies do not limit access to rehabilitation services when they can provide valuable benefits both to patients and to Medicare by helping beneficiaries age in place.

Question. Can you also share what is the role of occupational therapy?

Answer. As noted in my response above on the role of rehabilitation services in home health to support aging in place, occupational therapy focuses on participation in daily living activities, ranging from basic self-care tasks like dressing and bathing to more complicated tasks like meal preparation, medication management, household chores, and money management to social and leisure activities. Successful aging in place means not only being safe in the home and community by reducing or adapting to functional limitations to enable completion of daily living tasks, but also the ability to participate in valued activities that are important for well-being and quality of life. Though the breadth of occupational therapy treatment strategies is extensive given the wide range of activities that fall within the occupational therapy scope of practice and the types of physical, sensory, cognitive, psychological, and social-emotional conditions that can impact performance of these activities, the common thread is supporting home health patients' ability to do what they want and need to do to age in place successfully.

Perhaps the best way to illustrate the role of occupational therapy services in home health to supporting aging in place is to provide some examples of these varied treatment strategies for home health patients. These examples are not meant to be exhaustive but rather are illustrative of a selection of occupational therapy approaches that can benefit multiple patient populations through the common goal of supporting participation in necessary and valued daily living activities. Common occupational therapy treatment strategies include (but are not limited to):

- Home safety assessments and recommendations for home modification to reduce environment risk for injuries (*e.g.*, falls, burns) and to increase ability to perform daily living activities.
- Recommendations for and training with durable medical equipment, adaptive equipment, assistive technology, and adaptive strategies to enable performance of daily living activities for patients adapting to temporary or permanent physical, sensory, cognitive, and psychosocial limitations.
- Energy conservation techniques such as pacing, task prioritization, planning, and simplification, use of adaptive equipment, sleep hygiene, and efficient and safe body mechanics to support performance for patients with low endurance.
- Lifestyle modification and self-management strategies to promote health, prevent and manage chronic conditions, and reduce related functional limitations.
- Fall risk assessment and education and training to reduce fall risk.
- Functional cognition training and compensatory techniques to enable patients to complete complex tasks like meal planning and online shopping, scheduling appointments, and paying bills.
- Techniques to increase engagement in activities and manage behavioral symptoms for patients with dementia.
- Education on joint protection principles to reduce pain and joint deformity, enabling less functional limitation for patients with arthritis or other conditions affecting their joints.
- Non-pharmacological pain management techniques to promote participation in daily activities for patients with chronic pain.
- Medication management strategies that fit into patients' daily habits and routines for patients with chronic conditions requiring medication.
- Therapeutic activities and exercises to increase upper extremity functioning for daily living activities.
- Caregiver training to support needs of both the patient and the caregiver.

Because of the role occupational therapy plays in supporting aging in place for Medicare beneficiaries, I recommend legislation to make occupational therapy a qualifying service for the home health benefit. Please see my response to Senator Daines for additional information on this issue as well as examples where stand-alone occupational therapy can benefit home health patients and their ability to age in place.

Question. Given the labor shortage you and others have discussed, what are some ideas for growing the home health-care workforce?

Answer. Given the longstanding challenges many home health agencies face in recruiting and retaining qualified health-care workers, uneven distribution of health-care workers, the additional challenges created by the COVID-19 pandemic, and the growing demand for home health services as the U.S. population ages, there is a clear need for policies that support a robust and well-trained home health-care workforce so that all patients can access high-quality home health care when they need it. Many Federal and State policy recommendations to strengthen the health workforce generally apply to the home health-care workforce and may also be targeted specifically to the home health-care workforce. Recommendations include:

- Invest in Health Resources and Services Administration programming to support health workforce development, training, and research.
- Invest in State workforce agencies, including support for cross-agency coordination and Federal-State partnerships.
- Expand existing and create new grants and loan forgiveness and repayment programs for health-care workers; programs can be designed to target home health-care workers directly and/or include all health-care professions that are part of the home health benefit (*e.g.*, rehabilitation therapy practitioners are not currently included as eligible professions for the National Health Service Corps Loan Repayment Program).
- Provide supports for community colleges and public 4-year colleges and universities that provide health-care professional training programs for future home health-care workers (nurses, rehabilitation therapists and assistants, medical social workers), including targeted financial supports for students and faculty loan repayment programs.
- Include or enhance didactic content on home health care as a work setting within health-care professional training programs and offer clinical training opportunities with home health agencies; provide incentives to home health-care workers for contribute to educational opportunities, including clinical training, to account for decreased patient care time.
- Support portability and streamlining of licensing for health-care workers across State lines, including license reciprocity agreements and licensure compacts.
- Streamline processes for licensure for qualified health-care workers who trained outside the U.S. and support immigration policies that expand the health-care workforce (*e.g.*, visa programs targeted towards home health-care workers).
- Establish and incentivize apprenticeship programs, career pathway programs, career ladders, and continuing education opportunities for home health-care workers including home health aides, licensed practical nurses, physical therapist assistants, and occupational therapy assistants.
- Improve wages and working conditions for low-wage health-care workers like home health aides through minimum base wages, benefits, and professional development opportunities.
- Increase funding for Medicare and Medicaid home health and home care reimbursement where needed to allow for competitive wages to recruit and retain home health-care workers, and structure policies to ensure an appropriate percentage of program payments are directed to compensation for home health-care workers over profits.
- Support collection and rapid dissemination of current workforce metrics (*e.g.*, supply and demand of specific health-care workers, retention/turnover rates) to policymakers, educators, and employers to inform policy and planning (*e.g.*, the Washington's Health Workforce Sentinel Network—<https://wa>).

sentinelnetwork.org/); include home health-care workers and home health care as a setting in these efforts.

QUESTIONS SUBMITTED BY HON. STEVE DAINES

Question. Currently the need for occupational therapy does not qualify someone to receive home health unless they are already receiving other qualifying services.

Would there be an advantage to beneficiaries and their ability to age in place if occupational therapy were to be a qualifying service for the home health benefit?

Answer. Yes, the advantage of occupational therapy as a qualifying service for the home health benefit is that beneficiaries who meet homebound criteria and would benefit from intermittent occupational therapy services alone would not be prevented from receiving these services to promote safe and successful aging in place due to lack of eligibility for home health. For example, beneficiaries with low vision may not require nursing or physical therapy services, but would benefit from occupational therapy services to provide training in adaptive strategies, devices, and technologies to increase independence and safety when performing activities of daily living, which in turn may prevent falls or other injuries. Beneficiaries with chronic conditions like diabetes, chronic obstructive pulmonary disease, and heart failure who do not need skilled nursing services for active management of their conditions or physical therapy for mobility, may benefit from occupational therapy for self-management training, adaptive strategies to increase independence in activities of daily living, and stress management and lifestyle modifications to improve well-being, all of which promote successful aging in place. Beneficiaries with dementia can also benefit from occupational therapy services for improving engagement in activities, reducing behavioral symptoms, and training for their family caregivers, but they would not qualify for home health without a concurrent need for nursing or physical or speech therapy which may not be necessary. Without occupational therapy as a qualifying service for home health, there are populations of homebound beneficiaries that may not have access to occupational therapy services and may experience poorer quality of life and greater dependence on caregivers as well as increased risk for adverse outcomes like falls, emergency department visits, and hospitalizations.

Making occupational therapy a qualifying service for home health is also an issue of parity with other rehabilitation professions. The historical reason why the need for occupational therapy services alone does not qualify beneficiaries for home health is due to occupational therapists not being licensed in all 50 States at the time the home health benefit was initially established. Occupational therapy practitioners are now licensed in all 50 States, the District of Columbia, Puerto Rico, and Guam. The home health benefit already recognizes the value of occupational therapy as a stand-alone service in that occupational therapy only is allowed as a continuing service (*i.e.*, after home health patients are discharged from qualifying services of nursing, physical therapy, and/or speech-language pathology services, the benefit will allow the home health stay to remain open for provision of occupational therapy only as long as the patient remains homebound and in need of skilled occupational therapy services). In addition, occupational therapists may open cases by performing the initial and start of care comprehensive assessments for patients whose plans of care include physical therapy and/or speech-language pathology services only (and/or rehabilitation only cases) due to the passage of the Medicare Home Health Flexibility Act as part of the omnibus spending package passed in late 2020. Allowing occupational therapy as a qualify service would not only serve as an overdue update from historical State licensing regulations and align rehabilitation services within home health, but would also remove an unnecessary barrier to accessing services through the home health benefit that have the potential to further support the ability of beneficiaries to age in place, improve patient outcomes, and decrease costly adverse events.

For these reasons, I recommend establishing occupational therapy as a Medicare home health qualifying service (suggested by the American Occupational Therapy Association as the Medicare Home Health Accessibility Act). Please see the American Occupational Therapy Association's fact sheet on the Medicare Home Health Accessibility Act for additional information (<https://www.aota.org/-/media/corporate/files/advocacy/federal/fact-sheets/medicarehomehealthaccessibilityactfactsheet2023.pdf>).

Question. Do you have policy recommendations that could help address the workforce challenges faced by home health agencies, particularly in rural communities?

Answer. In my response to Senator Cardin's question about growing the home health-care workforce, I provided recommendations to strengthen the health-care workforce generally, which includes home health-care workers, as well as ways to target the home health-care workforce specifically. Please refer to that response for recommendations that have the potential to grow the home health-care workforce and thus help address the workforce challenges faced by home health agencies, including home health agencies that serve rural communities. Here I will extend those recommendations to target the home health-care workforce in rural communities specifically per the emphasis of this question.

- Increase existing and create new loan repayment programs that include all home health-care professions (nurses, rehabilitation therapists and assistants, medical social workers) and are targeted towards practice in rural communities, without necessarily limiting practice commitments specifically to home health care since health professionals in rural communities may work across settings due to low work volumes in individual settings.
- Expand rural didactic tracks and clinical training opportunities for health-care professions educational programs within public colleges and universities (*e.g.*, HRSA's Area Health Education Center Scholars program), include home health content and training opportunities and home health-care professions in these programs, and provide scholarships and loan forgiveness programs targeted towards students who commit to practicing in rural communities.
- Expand supports for rural-serving community colleges and public 4-year colleges and universities that provide health-care professional training programs for future home health-care workers (nurses, rehabilitation therapists and assistants, medical social workers), including targeted financial supports for students and faculty loan repayment programs; note that rural-serving institutions of higher education include both institutions located in rural communities and institutions that are not classified as rural-located but contribute to rural communities such as certain large land-grant universities and regional colleges in urbanized areas.¹
- Support portability and streamlining of licensing for health-care workers across State lines, including license reciprocity agreements and licensure compacts; note that easing licensure burden may be particularly useful for increasing access to home health services in rural communities located near more populous communities across State borders.
- Streamline processes for licensure for qualified health-care workers who trained outside the U.S. and support immigration policies that expand the health-care workforce (*e.g.*, visa programs); note that these strategies may be especially helpful for increasing access to home health services in rural communities as research suggests non-U.S.-born health-care workers are more likely to work in home health and in medically underserved areas compared to U.S.-born health-care workers.²
- Consider tax incentives and housing supports (*e.g.*, mortgage assistance programs) to recruit and retain rural home health-care workers.
- Ensure rural-serving home health agencies are aware of and leveraging existing resources to support the rural health-care workforce such as the National Rural Recruitment and Retention Network (3RNet).
- Increase funding for Medicare and Medicaid home health and home care reimbursement where needed to allow for competitive wages to recruit and retain home health-care workers, and structure policies to ensure an appropriate percentage of program payments are directed to compensation for home health-care workers over profits.
 - For home health agencies that serve rural communities, extending and increasing targeted rural add-on payments will help account for the addi-

¹Koricich, A., Sansone, V.A., Hicklan, Fryar A., Orphan, C., McClure, K.R. *Introducing Our Nation's Rural-Serving Postsecondary Institutions: Moving Towards Greater Visibility and Appreciation*. Alliance for Research on Regional Colleges; January 2022.

²Commodore-Mensah, Y., DePriest, K., Samuel, L.J., Hanson, G., D'Aoust, R., Slade, E.P. Prevalence and characteristics of non-US-born and US-born health-care professionals, 2010–2018. *JAMA Netw Open*. 2021;4(4):e218396.

tional challenges and unavoidable inefficiencies of providing care to patients spread out across large geographic areas. While the Consolidated Appropriations Act of 2023 extended a 1-percent rural add-on payment for serving beneficiaries living in counties with low population density and without high home health utilization for a year beyond the planned sunset, it will expire at the end of 2023 without legislative action. Loss of the rural add-on payment may exacerbate payment cuts for home health that were implemented in the final rule for CY 2024.

- A better understanding of home health agency financial performance will also help determine how feasible it is, given current reimbursement levels, for rural-serving home health agencies to raise wages and benefits for health-care workers as a mechanism to increase recruitment and retention. A key component of understanding financial performance is examining payments from all payer sources (traditional Medicare, Medicare Advantage, Medicaid, and other payers) with respect to cost of care. The Preserving Access to Home Health Act of 2023 (S. 2137/H.R. 5159) instructs the Medicare Payment Advisory Commission to include all payers in analysis of home health agency margins and consider how payer mix impacts home health access for traditional Medicare beneficiaries. Data on all payer margins for rural-serving home health agencies will provide a more complete picture of their financial performance and ability to pay competitive wages and benefits to support recruitment and retention of home health-care workers. Monitoring of the impact of the Patient-Driven Groupings Model and the expanded Home Health Value-Based Purchasing model on financial performance of rural-serving home health agencies is also warranted.

Question. Skilled nursing facilities and home health agencies provide the majority of post-acute care for Medicare beneficiaries, yet your research and other studies have found that rural beneficiaries are less likely to receive care following an acute hospitalization.

Could you speak to this discrepancy and the importance of home health to the continuity of care and recovery for rural beneficiaries?

Answer. The discrepancy between referral to home health following acute hospitalization and receipt of home health is indeed concerning. Our research suggests that fewer than 60 percent of rural beneficiaries in the traditional Medicare program with a planned discharge to home health following an acute hospital stay actually receive home health care; the gap between planned versus actual receipt of home health services was seen across the rural continuum, including large rural, small rural, and isolated rural communities.³ Another study of both traditional Medicare and Medicare Advantage beneficiaries found a similar gap between referral to and receipt of home health services following hospital discharge as well as disparities based on race, ethnicity, and socioeconomic status.⁴

There are multiple potential explanations for why this discrepancy exists. Patients may discharge from the hospital with a referral for home health care but without arrangements made for the first visit or clear instructions on how to schedule the first visit. Home health agencies that have not received timely information about the patient may decline the referral due to capacity constraints, concerns about patient eligibility (*e.g.*, homebound status), inability to care for patients with complex needs, or preferences in patient selection. Patients may agree to home health while still in the hospital, but then refuse services once they are back home. Research has suggested 6–28 percent of patients eligible for home health refuse care for a variety of reasons such as not feeling they actually need help to manage at home, having a prior negative experience with home health care, not understanding the types of home health services provided or the purpose of home health, and not wanting health-care workers in their homes.⁵

³Mroz, T.M., Garberson, L.A., Andrilla, C.H.A., Skillman, S.M., Larson, E.H., Patterson, D.G. *Post-acute Care Trajectories for Rural Medicare Beneficiaries: Planned versus Actual Hospital Discharges to Skilled Nursing Facilities and Home Health Agencies*. WWAMI Rural Health Research Center, University of Washington; March 2021.

⁴Li, J., Qi, M., Werner, R.M. Assessment of receipt of the first home health care visit after hospital discharge among older adults. *JAMA Netw Open*. 2020;3(9):e2015470.

⁵Levine, C., Lee, T. *I Can Take Care of Myself! Patients' Refusals of Home Health Care Services*. United Hospital Fund and the Alliance for Home Health Quality and Innovation. May 2017.

Why the discrepancy between planned versus actual discharge to home health occurs will require further investigation in order to determine how best to address the issue and ensure continuity of care following hospital discharge. Strategies may include improved care coordination and transition planning processes between the hospital and home health agency, education for patients about home health and support during the hospital stay for scheduling the first visit, and education for physicians and non-physician practitioners about appropriate home health referrals and eligibility. It is unclear whether recent updates to Conditions of Participation on discharge planning requirements for hospitals, including Critical Access Hospitals, which occurred just prior to the emergence of the COVID-19 pandemic, have decreased this gap between planned versus actual discharge to home health. The percentage of hospital patients with a planned discharge to home health who receive care should be tracked longitudinally and research should examine whether certain provider and/or patient characteristics are associated with unsuccessful transitions to home health care. This metric will provide a more complete picture of home health availability for Medicare beneficiaries beyond supply of home health agencies serving a particular ZIP code, the measure of home health availability currently used by the Medicare Payment Advisory Commission which does not account for capacity of home health agencies to accept patients or other reasons for declined referrals.

In addition to better understanding of the drivers of this discrepancy between planned versus actual discharge to home health, research is urgently needed on which patient populations do not receive planned care and their outcomes. Referral to home health at hospital discharge suggests some need for continued skilled care in the community, which may include continued nursing management of a specific condition and/or rehabilitation services to optimize functional status and safety in the home. These services are important to promote successful aging in place and homebound rural beneficiaries who do not receive these services through the home health benefit may not be able to access otherwise. Not receiving planned care may result in an increased risk for adverse events such as falls, worsening of symptoms, condition exacerbation, decline in function, and safety concerns, any of which could lead to costly emergency department visits and hospital readmissions and reduce the ability of the beneficiary to remain in the community.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What specific recommendations do you have on how we can use the ACO model and telehealth to expand home health, including changes with CMS regulations, CMMI models, and legislation, to lower costs and improve patient care?

TELEHEALTH

Answer. COVID-19 waivers allowed for home health agencies to provide more services to beneficiaries via telecommunications technology as long as these services are part of the plan of care and do not serve as a substitute for necessary in-person visits per the plan of care. The permanency of this allowance beyond the COVID-19 PHE represents an important opportunity for home health agencies to expand services to include greater frequency of phone and audio-video telehealth visits to check in with patients in between in-person visits. This provides home health agencies with the potential for with greater efficiency in staff resource use, particularly in rural areas where travel times limit the number of in-person visits that can be provided by individual home health-care workers. In addition, the ability to conduct remote patient monitoring allows for more frequent monitoring of patients with acute or chronic conditions who are at high risk for exacerbations and/or complications that may lead to emergency department visits and hospitalizations. Quicker recognition of concerning changes in status may allow for patients to be successfully treated at home, thus providing the patient with a more seamless home health care experience and avoiding both the stress and the expense of needing to visit an emergency department or being admitted to the hospital.

In order for the full potential of telehealth in home health to be realized, home health-care workers will need additional training on telehealth services, home health agencies will need to work to determine best practices for telehealth in home health and integrate telehealth services into their care processes, and Medicare will need to ensure reimbursement does not disincentivize adoption of telehealth where warranted. It should also be noted that many rural communities still lack access to reliable, high-speed Internet services that are required for some telehealth serv-

ices. Infrastructure funding to ensure equitable access to broadband Internet services in rural communities will be necessary to enable successful adoption of telehealth practices into home health. Finally, an extension of the waiver or permanent change to allow a patient's home as an originating site for telehealth visits for the required face-to-face encounter for home health is a useful mechanism to expanding home health access for patients for whom face-to-face encounters present a challenge due to local availability of physicians and allowed non-physician practitioners.

ACCOUNTABLE CARE ORGANIZATIONS

The incentives to provide efficient, high-quality care to beneficiaries under the Medicare Shared Savings Program, the largest ACO in the Medicare program, have resulted in modest savings for Medicare. While ACO participation could be hypothesized to increase use of lower-cost home health services over higher-cost institutional post-acute care in skilled nursing facilities and inpatient rehabilitation facilities, research thus far has suggested reductions in skilled nursing facility use and length of stay without corresponding increases in home health use (*i.e.*, no change or reductions in home health use as well) associated with ACO participation. The focused on decreased spending for ACOs may limit the expansion of home health services unless there is a clear reduction in costs elsewhere attributable to this expansion (*e.g.*, increased home health services leading to reduced hospital readmissions). Continued evaluation of utilization of home health services under Medicare ACO models is warranted to better understand ACO factors associated with changes in home health service utilization, patient populations receiving home health services, and subsequent outcomes for beneficiaries and the Medicare program. Opportunities for expansion of home-based care services outside of home health, such as hospital at home and home-based primary care are not within my area of expertise.

PREPARED STATEMENT OF JUDITH A. STEIN, J.D., EXECUTIVE DIRECTOR/ ATTORNEY, CENTER FOR MEDICARE ADVOCACY

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

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

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

OUR EXPERIENCE ASSISTING MEDICARE BENEFICIARIES IN NEED OF HOME HEALTH CARE

The Center for Medicare Advocacy hears from people from all over the country who are trying to obtain Medicare coverage for sufficient home health care to remain safely at home. In particular, people living with longer-term and debilitating conditions find themselves facing significant access problems. For example, patients have been told (incorrectly) that Medicare will only cover one to five hours per week of home health aide services, or only one bath per week, or that they aren't homebound (because they roam outside due to dementia), or that their condition must first decline before therapy can commence (or recommence). Consequently, these individuals and their families struggle with too little care, or no care at all.

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

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

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

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

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

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

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

MEDICARE HOME HEALTH COVERAGE: REALITY CONFLICTS WITH THE LAW

Medicare home health coverage can be an important resource for Medicare beneficiaries who need health care at home. When properly implemented, the Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services, all of which add to the health, safety, and quality of life of beneficiaries and their families. Under the law, *Medicare coverage is available for people with acute and/or chronic conditions, and for services to improve, or maintain, or slow decline of the individual's condition. Further, coverage is available even if the services are expected to continue over a long period of time.*¹

Unfortunately, however, people—like Ms. S.—who legally qualify for Medicare coverage have great difficulty obtaining and affording necessary home care. There are legal standards that define who can obtain coverage, and what services are available. However, the criteria are often narrowly construed and misrepresented by providers and policymakers, resulting in inappropriate barriers to Medicare coverage for necessary care. This is increasingly true for home health aide services—

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

the very kind of personal care services vulnerable people often need to remain safely at home.

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

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

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

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

News from providers about Medicare Advantage home health coverage was only more dispiriting. When asked if there were differences in services they could provide to traditional Medicare versus Medicare Advantage patients, agencies commented that, in their experience, Medicare Advantage plans provide less to patients and require more of agencies. Common themes included, MA plans deny more, allow fewer visits, delay onset of care, require more changes to care plans, and there are major challenges from their Prior Authorization process. Comments included:

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

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

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

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

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

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

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

1. Medicare Home Health Qualifying Criteria

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

- A physician or other authorized practitioner has established a plan of care for furnishing the services that is periodically reviewed as required;
- The individual is confined to home (commonly referred to as “homebound”). This criterion is generally met if non-medical absences from home are infrequent, and leaving home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance or the help of an assistive device, such as a wheelchair or walker. (Occasional “walks around the block” are allowable. Attendance at an adult day care center, religious services, or a special occasion is also not a bar to meeting the homebound requirement.);
- The individual needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology (or, in the case of an individual who has been furnished home health services based on such a need, but no longer requires skilled nursing care or physical or speech therapy, the individual continues to need occupational therapy); and
- Such services are furnished by, or under arrangement with, a Medicare-certified home health agency.⁵

2. Medicare-Covered Home Health Services

If the qualifying conditions described above are satisfied, Medicare coverage is available for an array of home health services. Home health services that can be covered by Medicare include:⁶

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

As described above, skilled nursing, physical therapy, and speech-language pathology services are defined as “qualifying skilled services” for the purpose of establishing eligibility for Medicare home health coverage.⁷ A patient must initially require and receive one of these skilled services in order to receive Medicare for other covered home health services.⁸ Home health aide, medical social worker, and occupational therapy services⁹ are defined as “dependent services” (*dependent* upon a skilled service being in place) as are certain medical supplies.¹⁰ While occupational therapy is not considered a skilled service to *begin* Medicare home health coverage, if the individual was receiving skilled nursing, physical or speech therapy, but those services end, coverage can continue if occupational therapy continues.¹¹

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

⁴42 U.S.C. § 1395f(a)(2)(C); 42 CFR §§ 409.42 *et seq.*

⁵42 U.S.C. § 1395x(m).

⁶42 U.S.C. § 1395x(m)(1)–(4).

⁷42 CFR § 409.42.

⁸42 CFR § 409.44.

⁹Occupational therapy services can be either a qualifying service or a dependent service. Occupational therapy services that are not qualifying services under 42 CFR § 409.44(c) can be covered as dependent services if the requirements of reasonableness and necessity are met. 42 CFR § 409.45.

¹⁰42 CFR § 409.45.

¹¹42 CFR § 409.42(c)(4); Medicare Beneficiary Policy Manual, Ch. 7, § 30.4.

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

3. Medicare Home Health Coverage Can Be Long-Term

Importantly, and contrary to what is often stated, Medicare home health coverage is *not just a short-term, acute-care benefit*.¹³ Indeed, with an intent to expand home health services, Congress passed the Omnibus Budget Reconciliation Act of 1980 (OBRA 80, Pub. L. 96–499) which *removed the annual 100 home health visit limitation* for both Parts A and B, the 3-day prior hospital stay requirement, and the Part B deductible.¹⁴ In addition, effective in 2000, the Balanced Budget Act of 1997 (BBA 97, Pub. L. 105–33) implemented a prospective payment system (PPS) for home health (and in certain other care settings), and gradually transferred some home health expenditures from Part A to Part B (episodes not preceded by a hospitalization or skilled nursing facility stay or exceeded the 100-visit Part A cap). Part A also provided payment beyond 100 visits if a beneficiary was not enrolled in Part B.¹⁵

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

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

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

THE REALITY: ACCESS TO MEDICARE COVERAGE AND HOME CARE IS LIMITED

The Center for Medicare Advocacy hears regularly from people who meet Medicare coverage criteria but are unable to access Medicare-covered home health care, or the appropriate amount of care. As similarly reported in *Health Affairs* in November 2019:

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

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

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

¹² 42 U.S.C. § 1361(m).

¹³ 42 CFR §§ 409.48(a)–(b); Medicare Beneficiary Policy Manual, Ch. 7, §§ 40.1.1 and 70.1.

¹⁴ Davitt, Joan K. and Choi, Sunha (2008) “Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use,” *The Journal of Sociology and Social Welfare*: Vol. 35: Iss. 1, Article 12. Available at: <https://scholarworks.umich.edu/jssw/vol35/iss1/12>.

¹⁵ Congressional Research Service Report (2014), “Medicare Home Health Benefit Primer: Benefit Basics and Issues,” Congressional Research Service, R42998.

¹⁶ *Health Affairs*, “Financial Hardships of Medicare Beneficiaries With Serious Illness,” by Kyle, Blendon, et al., Vol. 38, No. 11, pp. 1801–1806 (November 2019). Note: The authors define “serious illness” as individuals “reported having a serious illness or condition that, over the past 3 years, had required two or more hospital stays and visits to three or more physicians.” P. 1802.

only get home health aide services a few times a week, for a short time, and/or only for a bath. Sometimes they are told Medicare simply does not cover home health aides. The Center for Medicare Advocacy has even heard of an individual being told he could not receive home health aide coverage because he was “over income”—although Medicare has no income limit.

As noted above, under the law, Medicare authorizes up to 28 to 35 hours a week of home health aide (personal hands-on care) and nursing services combined.¹⁷ While personal hands-on care *does* include bathing, it **also** includes dressing, grooming, feeding, toileting, and other key services to help an individual remain healthy and safe at home.¹⁸ In the past, this level of home health aide coverage was actually available. Indeed, the Center for Medicare Advocacy has helped many clients remain at home because these services were in place.

Currently, however, this level of coverage and care is almost never obtainable. Data demonstrate this dramatic change in coverage. Home health aide utilization has declined steadily over the past 2 decades by almost 94 percent—from a 30-day average of 6.7 visits in 1998¹⁹ to less than half a visit a month in 2022.²⁰ As a percent of total visits from 1997 to 2021, home health aides declined from 48 percent of total services to 5 percent.²¹

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

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

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

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

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

¹⁹ Medicare Payment Advisory Commission (MedPAC), “Report to Congress: Medicare Payment Policy” (March 2021), Ch. 8, page 236: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch8_sec.pdf.

²⁰ Centers for Medicare and Medicaid Services (CMS), Proposed Home Health Rule (CMS–1780–P), 88 Fed Reg 43654 (July 10, 2023), at pp. 43663, 43671.

²¹ Medicare Payment Advisory Commission (MedPAC), “Report to Congress: Medicare Payment Policy” (March 2023), Ch. 8, p. 250, available at: https://www.medpac.gov/wp-content/uploads/2023/03/Ch8_Mar23_MedPAC_Report_To_Congress_SEC.pdf; Medicare Payment Advisory Commission (MedPAC), “Report to Congress: Medicare Payment Policy” (March 2019), Ch. 9, pp. 234–235, available at: http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec_rev.pdf?sfvrsn=0.

²² *Kaiser Health News*, “Seniors Aging in Place Turn to Devices and Helpers, but Unmet Needs Are Common,” by Judith Graham (February 14, 2019), available at: <https://khn.org/news/seniors-aging-in-place-turn-to-devices-and-helpers-but-unmet-needs-are-common/>. *See also*, *Kaiser Health News*, “Home Care Agencies Often Wrongly Deny Medicare to Chronically Ill,” Susan Jaffe (January 18, 2018), <https://khn.org/news/home-care-agencies-often-wrongly-deny-medicare-help-to-the-chronically-ill/>.

As Dr. Archbald-Pannone notes,

As a geriatrician, every week I see patients who are fortunate enough to have family who are able to provide medical care and support. However, I also see more patients who do not have family available to provide full care, are in desperate need of more home care support, but cannot afford the price tag . . . Without in-home care, we're leaving our family members alone and at risk. . . . We may not be available to stay home with them, but Medicare should support trained care aides who can be.²³

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

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

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

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

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

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

²³ *The Hill*, "Family Caregivers Need Support, Medicare Should Cover In-Home Aides," by Laurie Archbald-Pannone, M.D. (November 15, 2019), available at: <https://thehill.com/opinion/healthcare/470677-family-caregivers-need-support-medicare-should-cover-in-home-care-aides>.

²⁴ Centers for Medicare and Medicaid Services (CMS), Medicare-Medicaid Coordination Office, Fact Sheet: "People Dually Eligible for Medicare and Medicaid" (March 2023), available at: https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/mmco_factsheet.pdf.

²⁵ *Health Affairs*, "Financial Hardships of Medicare Beneficiaries With Serious Illness," by Kyle, Blendon, et al., Vol. 38, No. 11, pp. 1801–1806 (November 2019).

²⁶ See also, Johns Hopkins University Bloomberg School of Public Health study that also finds people with limitations in activities of daily living (ADLs) experience significant harm when they cannot access adequate help with ADLs at home. "Medicare Spending and the Adequacy of Support with Daily Activities in Community-Living Older Adults with Disability," by Jennifer L. Wolff, Lauren H. Nicholas, Amber Willink, John Mulcahy, Karen Davis, and Judith D. Kasper, Commonwealth Fund and National Institutes on Aging (May 2019), as reported by American Association for the Advancement of Science (AAAS) EurekAlert website at: https://www.eurekalert.org/pub_releases/2019-05/jhub-msh_1052819.php.

²⁷ See, Center for Medicare Advocacy "Home Health Practice Guide: Medicare Home Health Coverage and Care Is Jeopardized By the New Payment Model—The Center for Medicare Advocacy May Be Able to Help" (January 7, 2020), available at: <https://medicareadvocacy.org/home-health-practice-guide/>; also see, e.g., Center for Medicare Advocacy Weekly Alert "Medicare Coverage of Home Health Care Has Not Changed Under the New Payment System (PDGM)" (February 20, 2020), available at: <https://medicareadvocacy.org/medicare-coverage-of-home-health-care-has-not-changed-under-the-new-payment-system-pdgm/>.

²⁸ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM>.

PDGM's financial incentives include higher rates for the first 30 days of home care. Payments are also higher for beneficiaries who are admitted after an inpatient institutional stay (hospitals and skilled nursing facilities), and lower for those admitted from the community. (The "community" category includes hospital outpatients, including hospitalized patients in "observation status," as well as patients who start care from home, without a prior hospital or SNF stay.) The new payment model also reduced the billing period from 60 days to 30 days, encouraging shorter periods of care. Additionally, PDGM lowered the financial incentive to provide physical, occupational or speech language pathology therapy by removing therapy service utilization payment thresholds.

The current Medicare home health payment system and shift in financial incentives have reduced access to necessary care.²⁹ *Home Health Care News* reports that "[s]tories of widespread layoffs of PTs, OTs and SLPs persist—and now new reports of agencies incorrectly telling their patients that Medicare no longer covers therapy under the home health benefit. . . ."³⁰ Reductions in skilled therapy not only harm the individual who needs that care; they can also end access to home health aides, because aide coverage is dependent on the individual's also receiving skilled therapy or nursing.

In response to misinformation and service changes in light of PDGM, CMS released a special edition *Medicare Learning Network (MLN) Matters* article on February 10, 2020.³¹ The MLN made clear that, while the reimbursement system had changed, Medicare coverage law and rules had not:

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

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

CONCLUSION

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

²⁹ <https://www.cms.gov/medicare/quality/home-health/>;

The Medicare payment structure creates incentives for home health agencies to provide care for beneficiaries with shorter-term, post-acute care conditions. Further, CMS policies and practices create barriers to Medicare-covered home care for people with longer-term and chronic conditions. These barriers and incentives include:

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

³⁰ *Home Health Care News*, "CMS Watching Home Health Providers Closely Amid Shifting Therapy Strategies," by Robert Holly (February 12, 2020), available at: <https://homehealthcarenews.com/2020/02/cms-watching-home-health-providers-closely-amid-shifting-therapy-strategies/>.

³¹ CMS, MLN Matters article, "The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)", Number: SE20005 (February 10, 2020), available at: <https://www.cms.gov/files/document/se20005.pdf>. ". . . [E]ligibility criteria and coverage for Medicare home health services remain unchanged. . . . as long as the individual meets the criteria for home health services as described in the regulations at 42 CFR 409.42, the individual can receive Medicare home health services, including therapy services. . . . Citing to the *Jimmo v. Sebelius* Settlement Agreement, the MLN also states "there is no improvement standard under the Medicare home health benefit and therapy services can be provided for restorative or maintenance purposes." (Emphasis added.)

under the law. **Congress must insist the law that already exists is properly implemented and fully enforced.**

APPENDIX

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

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

- CMA Comments to CMS' 2024 Notice of Proposed Rule Making (NPRM) for Home Health Care (August 2023): <https://medicareadvocacy.org/wp-content/uploads/2023/08/Home-Health-Aides-2024-NPRM-RFI-Response.pdf>.
- CMA Comments to CMS CY 2023 Proposed Home Health Rule (August 2022): <https://medicareadvocacy.org/home-health-comments-2023/>.
- Bipartisan Policy Center (BPC) Paper "Optimizing the Medicare Home Health Benefit to Improve Outcomes and Reduce Disparities" (including Appendix authored by CMA) (April 2022): https://bipartisanpolicy.org/wp-content/uploads/2022/04/Optimizing-the-Medicare-Home-Health_R0_Web-Ready.pdf.
- Commonwealth Fund Blog, "The Medicare Home Health Benefit: An Unkept Promise," by Judith A. Stein and David A. Lipschutz, Center for Medicare Advocacy (April 28, 2022): <https://www.commonwealthfund.org/blog/2022/medicare-home-health-benefit-unkept-promise>.
- CMA Home Health Survey: "Medicare Beneficiaries Likely Misinformed and Underserved" (December 2021): <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>.
- CMA Comments on CY 2022 HH Prospective Payment System and More (August 5, 2021): <https://medicareadvocacy.org/cma-comments-on-cy-2022-hh-prospective-payment-system-more/>.
- CMA Alert: "79 Organizations Call on CMS and ACL to Ensure Access to Medicare-Covered Home Health Care" (June 2021): <https://medicareadvocacy.org/orgs-to-cms-enforce-home-health-coverage/>.
- CMA Issue Brief: "Medicare Home Health Coverage: Reality Conflicts with the Law" (April 2021): <https://medicareadvocacy.org/issue-brief-medicare-home-health-coverage-reality-conflicts-with-the-law/>.
- CMA Alert "Shrinking Medicare Home Health Coverage: It's Time to Act" (April 2021): <https://medicareadvocacy.org/shrinking-medicare-home-health-coverage-its-time-to-act/>.
- CMA Comments on Proposed Home Health Rules (August 27, 2020): <https://medicareadvocacy.org/center-comments-on-proposed-home-health-rules/>.
- CMA Issue Brief "Medicare and Family Caregivers" (June 2020) (Drafted for ACL's RAISE Family Caregiver Advisory Council): <https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf>.
- CMA Issue Brief: "Medicare Payment vs. Coverage for Home Health and Skilled Nursing Facility Care" (March 2020): <https://www.medicareadvocacy.org/wp-content/uploads/2020/03/Issue-Brief.-Medicare-Payment-vs.-Coverage.pdf>.
- CMA "Home Health Practice Guide" (January 2020): <https://medicareadvocacy.org/home-health-practice-guide/>.
- CMA Alert: "Potential Impacts of New Medicare Payment Models on Skilled Nursing Facility and Home Health Care" (October 31, 2019): <https://medicareadvocacy.org/potential-impacts-of-new-medicare-payment-models-on-skilled-nursing-facility-and-home-health-care/>.
- CMA Comments on 2019 Proposed Home Health Rule (September 12, 2019): <https://medicareadvocacy.org/center-comments-on-2019-proposed-home-health-rule/>.
- CMA Alert: "As Home Care Needs Increase, Access Issues Must Be Addressed" (September 5, 2019): <https://medicareadvocacy.org/as-home-care-needs-increase-access-issues-must-be-addressed/>.
- CMA Alert: "Inadequate Personal Care at Home Increases Overall Medicare Costs" (June 13, 2019): <https://medicareadvocacy.org/inadequate-personal-care-at-home-increases-overall-medicare-costs/>.

- CMA Alert: “Home Health Aide Coverage Continues to Shrink: Attention Must Be Paid” (February 21, 2019): <https://medicareadvocacy.org/home-health-aide-coverage-continues-to-shrink-attention-must-be-paid/>.
- CMA Alert: “Home Health Aide Coverage Continues to Shrink in Traditional Medicare While CMS Enhances it in Medicare Advantage” (November 15, 2018).
- CMA Alert: “Home Health Telephone Survey” (November 15, 2018): <https://medicareadvocacy.org/home-health-aide-coverage-continues-to-shrink-in-traditional-medicare-while-cms-enhances-it-in-medicare-advantage/> <https://medicareadvocacy.org/home-health-telephone-survey/>.
- CMA Issue Brief Series: “Medicare Home Health Crisis” (April 2017–October 2018): <https://www.medicareadvocacy.org/wp-content/uploads/2018/11/HH-Issue-Brief-Full.pdf>.
- CMA Comments on Proposed Medicare Home Health Rule (August 30, 2018): <https://medicareadvocacy.org/center-comments-on-proposed-medicare-home-health-rules/>.
- CMA Alert: “Medicare Home Health Rules Proposed by CMS to ‘Improve Access to Solutions’ Will Further Reduce Patient Access to Care” (July 5, 2018): <https://medicareadvocacy.org/medicare-home-health-rules-proposed-by-cms-to-improve-access-to-solutions-will-further-reduce-patient-access-to-care/>.
- CMA Alert: “Medicare Home Health Coverage is Not a Short Term Benefit—Congress Reiterated This in the Balanced Budget Act of 1997 (BBA ‘97)” (May 3, 2018): <https://medicareadvocacy.org/medicare-home-health-coverage-is-not-a-short-term-benefit-%e2%80%92congress-reiterated-this-in-the-balanced-budget-act-of-1997-bba-97/>.
- CMA Comments on Proposed Home Health Payment Rules (September 25, 2017): <https://medicareadvocacy.org/center-comments-on-proposed-home-health-payment-rules/>.
- CMA Issue Brief: “The Promise and Failure of Medicare Home Health Coverage” (December 15, 2016): <https://medicareadvocacy.org/the-promise-and-failure-of-medicare-home-health-coverage/>.
- CMA Comments on Proposed Home Health Payment Changes (August 26, 2016): <https://medicareadvocacy.org/center-comments-on-proposed-home-health-payment-changes/>.
- CMA Comments on Medicare Prior Authorization of Home Health Services Demonstration (April 6, 2016): <https://medicareadvocacy.org/center-comments-on-medicare-prior-authorization-of-home-health-services-demonstration/>.
- CMA Comments on Proposed Rules: CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements (September 1, 2015): <https://medicareadvocacy.org/comments-on-proposed-rules-cy-2016-home-health-prospective-payment-system-rate-update-home-health-value-based-purchasing-model-and-home-health-quality-reporting-requirements/>.
- Also, see, generally, CMA website at: <https://medicareadvocacy.org/medicare-info/home-health-care/>.

QUESTIONS SUBMITTED FOR THE RECORD TO JUDITH A. STEIN, J.D.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Over the past decade, home health aide visits per episode have declined significantly from 48 percent of all billed MHH hours in 1997 to only 5 percent in 2021.

What are the factors driving the turnover rates of home health aides?

Answer. There are a number of reasons for the significant decline in covered home health aide visits. As the Center for Medicare Advocacy noted in our response to CMS’s July 2023 Request for Information (see <https://medicareadvocacy.org/wp-content/uploads/2023/08/Home-Health-Aides-2024-NPRM-RFI-Response.pdf>), these include:

1. CMS and HHA policies and practices have devalued and disincentivized the provision of aide services in Medicare-covered home health care for decades, helping to lead to the current crisis.

2. There is competition for available aides in other care settings while the demand for aide services grows substantially (both Medicare-covered and non-covered).
3. HHAs contend that aides are not available, although many workforce issues are addressable and preventable.

Further, as noted in our RFI comments, home health aides are often available, but *not* through the Medicare-covered home health benefit. We are aware that **home health agencies (HHAs) have transferred aide staff to affiliates through related party transactions for additional payment sources.** HHAs enrolled in Medicare often tell patients that they do not have aide staff available in their Medicare-certified agency, but aides can be available to the patient through an affiliated entity (often with the same company name) for private pay. This strategy often allows the HHA to receive the full Medicare payment for other services, while the affiliate simultaneously bills for aide services. This practice reduces the amount of aide hours staffed and available through the Medicare-certified HHA and it provides an unacceptable alternative to Medicare-covered services for patients, who *should* be able to make *full use* of their covered Medicare home health benefit, including receiving the aide services they qualify for. Forcing beneficiaries to obtain aide services outside Medicare is not financially possible for most people living with chronic and longer-term conditions. It is also inappropriate since Medicare coverage for this care *is* available under the Medicare law.

At the same time, **there is increasing competition for the limited number of available aides in the job market.** Currently in the United States, 5 million people rely on home health aides to keep them safe and healthy in their homes. The population is aging and becoming sicker. Within 10 years another million people will need aides, an increase of 25–34 percent, and the number of elderly in the U.S. is expected to double by 2050. In 2021, almost 3.4 million workers were employed in facilities and in homes holding similar positions as nursing assistants, home health aides and personal care assistants (for dually eligible Medicare and Medicaid individuals). Aides are also employed to work for individuals with other insurance and they are further engaged for private payment. The Bureau of Labor Statistics (BLS) has cited home health aides as one of the fastest growing jobs, with a need for 750,000 new workers every year, while another 332,000 existing home health aides may retire or drop out of the occupation every year, and 287,000 may seek other types of work. Medicare-certified HHAs draw from the same competitive pool of available aides seeking work as other employers offering similar services.

For additional information, see our response to RFI Questions 3 to 5 in the above-cited response to CMS's July 2023 RFI.

Question. What additional data should be collected to better understand the key factors and how effective interventions can be designed and implemented?

Answer. As reflected in a 2021 survey of 217 home health agencies by our organization, aide access problems are especially difficult for homebound beneficiaries with chronic, longer-term, and disabling conditions who need both skilled and aide services to effectively maintain or slow decline of their condition and stay safe and healthy at home. (See Center for Medicare Advocacy report CMA Home Health Survey | Medicare Beneficiaries Likely Misinformed and Underserved December 15, 2021, <https://medicareadvocacy.org/cma-home-health-survey-medicare-beneficiaries-likely-misinformed-and-underserved/>.) In other words, individuals who require more care (higher acuity) have more difficulty accessing home health care in general, and aides in particular.

In order to ensure that the home health benefit is accessible to everyone, including individuals with chronic conditions, CMS should collect and report data concerning individuals' health conditions, and track such data over time, to determine whether certain individuals with certain conditions are encountering more difficulty accessing care. Among the data CMS should collect and report are:

- Patients who need maintenance care;
- Patients without caregiving assistance; and
- Episodes of care with plans of care that have improvement goals or maintenance goals.

CMS should confirm concerns about the increasing lack of access to services, for all the identified compounding reasons, also recognizing that the proposed Discharge Function Score Measure will further discriminate against individuals with chronic and longer-term conditions. In *Appendix A of the Discharge Function Score Measure*

Technical Report by Abt Associates, the number of 30-day episodes (and percentage of total home health cases), HHAs served individuals with several longer-term and chronic conditions in 2021 are identified as follows:

- Rheumatoid Arthritis and Inflammatory Connective Tissue Disease (HCC40) 131,039—3 percent.
- Dementia With Complications (HCC51) 80,818—2 percent.
- Dementia Without Complication (HCC52) 384,481—9 percent.
- Quadriplegia (HCC70) 8,789—0 percent.
- Paraplegia (HCC71) 14,137—0 percent.
- Spinal Cord Disorders/Injuries (HCC72) 18,906—0 percent.
- Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease (HCC73) 5,691—0 percent.
- Cerebral Palsy (HCC74) 15,123—0 percent.
- Muscular Dystrophy (HCC76) 3,499—0 percent.
- Multiple Sclerosis (HCC77) 36,244—1 percent.
- Parkinson’s and Huntington’s Diseases (HCC78) 137,681—3 percent.

CMS should examine the trend of the number of 30-day episodes (and equivalent days prior to PDGM) for these conditions over the past 25 years and identify CMS policies and practices that have contributed to an increasing lack of access to Medicare-covered care for individuals with these conditions.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What specific recommendations do you have on how we can use the ACO model and telehealth to expand home health, including changes with CMS regulations, CMMI models, and legislation, to lower costs and improve patient care?

Answer. As noted in my written and oral testimony, there are myriad problems with the administration of the Medicare home health benefit and access to Medicare-covered care. In our experience, it is inappropriately limited in traditional Medicare and access to Medicare-covered home care is even more restricted for Medicare Advantage (MA) enrollees.

With respect to using Accountable Care Organizations (ACOs) to improve patient care for those attributed to an ACO, it is critical to ensure that the incentives to stint on care inherent in capitated payment models do not migrate to ACOs. There are already incentives in home health payment and quality measures that lead home health agencies to seek out certain types of patients and avoid others. For example, the home health value-based purchasing (VBP) measures which, among other things, award home health agencies for meeting certain improvement standards, create disincentives to provide care for beneficiaries with longer-term and chronic conditions.

As discussed in our comments to CMS’s proposed 2023 home health rule (our comments are available here, <https://medicareadvocacy.org/home-health-comments-2023/>), current quality criteria inappropriately favors services for individuals with conditions that can improve. Further, existing quality criteria reward discharge from home health care, thereby discriminating against beneficiaries with life-time conditions who continue to need care and should not be discharged. Above all, additional quality outcome incentives and payments applicable in the ACO arena should not exacerbate these problems.

With respect to telehealth, there are certainly ways to increase access to services via telehealth when the patient has adequate equipment and sensory and cognitive capabilities. Ideally, these remotely provided services should ideally supplement, not supplant, in-person care. The human contact and depth of observation and experience that comes with in-person visits cannot be fully replaced by telehealth. In particular, Medicare-covered home health aide care, which has been all but disappearing, calls for in-person attendance. By definition, this care is made up of “hands-on personal” services that cannot be properly provided virtually.

COMMUNICATIONS

HILLCREST HOME CARE
1820 Hillcrest Drive
Bellevue NE 68005

September 19, 2023

Dear Subcommittee on Health Care members,

Thank you for the opportunity to provide a statement for inclusion in the hearing record for the above-named discussion.

I am currently the Administrator of a medium-sized home health agency serving the Omaha and Lincoln metro areas in Nebraska. I am also a licensed physical therapist, who has spent time during my career “in the field” serving a home health client caseload. Our agency is focused on providing care for the aging adult population, and we serve an estimated 400 persons daily under the skilled home health benefit. The vast majority of our clients are beneficiaries of Medicare and Medicare Advantage plans.

The PDGM payment model changes brought both positives and negatives to the operation of a home health agency in today’s world. Positives include: including a higher reimbursement for more complex clients and a shared challenge to deliver care in the most cost-efficient manner. Negatives include: home health agencies shouldering the financial burden for complex clients whose needs were not adequately captured by the PDGM grouping system, and reimbursement models not adequately covering the environment of cost of living increases.

The pandemic and the resulting several years of wage and cost of living inflation have added significantly to the overhead costs of home health-care delivery. We have incurred significant increases in the following areas: medical supply costs, gas/mileage reimbursement costs, necessary wages to remain competitive for a shrinking labor supply. Home health clinicians (nurses, physical therapists, occupational therapists, certified nurse assistants) are considered advanced practice clinicians in their field—this work requires a high level of independence and critical thinking, as providers are often one-on-one with clients. The skills required to provide the proper care in this setting are above entry-level, and our industry is competing for talent with hospitals offering \$10,000 sign-on bonuses and inflated wages. Skilled clinical labor is the key to provision of timely and quality complex medical care, and the reimbursement cuts undermine the ability to serve our clients. Adequate reimbursement goes right to our most valuable asset to preserve our ability to provide services—wages.

As mentioned during the hearing, our agency is also experiencing more referrals than we can manage. More clients are needing home health services than can be matched with accepting providers. Hillcrest Home Care is #1 in market share for Medicare home health episodes in our service area, however we currently decline approximately 40% of all referrals received due to capacity. We are currently one of the only home health providers in our metro area still accepting referrals for Medicare Advantage beneficiaries, due to the poor reimbursement (lower than the cost of providing services). Many providers “cherry-pick” referrals before accepting, making the difficult decision to evaluate the financial viability of accepting a patient with high care needs under the current reimbursement model. The statement that home health agencies “have a 25% profit margin” is categorically false. The expenses to provide home-based services are outpacing Medicare reimbursement, and the proposed cuts will absolutely threaten our ability to serve out our mission to deliver home health care in our community.

We have experienced contraction in our local market, with several local home health agencies in our service area closing in the past several years. This has resulted in a scarcity of home health providers able to accept new patients, which has a downstream effect of increasing more costly hospital and Skilled Nursing Facility stays as a result.

Our agency is a high-quality provider, earning a 4.5 star CMS quality rating and superior Value Based Purchasing percentile ranking. Our quality rating indicates our success in timely initiation of care and prevention of rehospitalization. We are a critical piece of our community's health-care system, allowing for timely throughput of persons discharging from hospital to home and freeing up valuable bed space for incoming hospital patients. Health care is pushing more complex care out of institutions and into the home, requiring increased skill and service at a time when reimbursement is going down. Today, we are treating patients in the home who never would have left the hospital five years ago. The decreasing reimbursement trend for home-based care delivery to sicker and sicker patients is not sustainable.

The proposed additional Medicare reimbursement cuts will have a negative impact on service delivery to the Medicare beneficiaries in our community. Please consider support of the following to preserve and sustain the possibility of high quality care provision in the home:

- Support of the Preserving Access to Home Health Act S. 2137/H.R. 5159
- Consideration of reimbursement for telemedicine visits in the home health setting

Sincerely,

Lauren Wright
Administrator

INTERNATIONAL CAREGIVERS ASSOCIATION

P.O. Box 193
Mapleton, ME 04757

September 18, 2023

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510-6200

To Whom It May Concern,

The Care Provider Partnership Agreement Program (CPPAP), an innovative approach to dementia care designed to provide more compassionate, person-centered services through new staffing models and specialized training is now available for home care, home health, assisted living, and long-term care.

CPPAP was created by ICA's founding president, Dr. Ethelle Lord, to address gaps in the current healthcare system and improve the quality of life for both dementia patients and their caregivers. Industry research shows that nurses are facing historically high burn-out rates.

"After caring for my late husband through his difficult journey with dementia, I recognized the urgent need for change in long-term care facilities and standards," said Dr. Lord. "CPPAP introduces a fresh perspective centered on partnership, dignity, and preserving person hood. It is my life's work to transform perceptions, improve training, and implement this holistic model focused on relationship and humanity."

The CPPAP program provides customized dementia care plans tailored to each individual. It is built on facilitating a partnership between caregivers, care recipients, and specialized coaching teams. It also puts forward a dynamic new framework for dementia care operations.

New staffing protocols reduce fatigue and burnout by allowing caregivers to work 6-hour shifts at 8-hour pay. Facilities are also required to provide 24/7 access to both a registered nurse and a dedicated dementia coach. The coach offers ongoing education and support to equip staff with the skills needed to provide attentive, knowledgeable care.

CPPAP further sets itself apart by empowering family members to become actively involved as Care Partners in facilities like nursing homes and assisted living. For at-home care, CPPAP enables agencies to offer 24/7 care for family respite. To

achieve CPPAP certification, hospitals must hold a Magnet or Pathway designation, which signifies excellence in nursing practices and healthy work environments. This ensures best practices are observed at all times.

About Dr. Ethelle Lord

Dr. Ethelle Lord is the pioneering founder and president of the International Caregivers Association, established over 20 years ago. She earned a doctorate in organizational leadership and devoted her career to advancing dementia education and services. Dr. Lord gained firsthand experience when she cared for her late husband through his journey with dementia. These insights inspired her to create the Care Provider Partnership Agreement Program as an innovative solution to transform long-term care and improve quality of life and work. Dr. Lord is a respected voice in the dementia field, working to shift perceptions, boost training, and implement holistic models centered on compassionate care.

In addition to being a sought-after speaker, Dr. Lord is an accomplished author. In her book “Alzheimer’s Coaching: Taking A Systems Approach in Creating an Alzheimer’s Friendly Healthcare Workforce,” she shares insights from caring for her husband Major Larry S. Potter, USAF Retired, who had Vascular Dementia (VaD). She also authored “How in the World . . . and Now What Do I Do?”—an Alzheimer’s primer in several languages (English, French, Spanish, Arabic) outlining 12 major points for coping better with dementia.

About ICA

The International Caregivers Association (ICA) is a leading organization Dr. Ethelle Lord founded over 20 years ago to advance dementia education and services. ICA provides coaching, training, and consulting to improve care in facilities worldwide. ICA has offices in Maine and California, USA and serves a global clientele. For more information, please visit the www.InternationalCaregiversAssociation.com.

More About CPPAP

The CPPAP establishes a new gold standard through rigorous specialized training, family involvement as Care Partners, and 24/7 access to dedicated nurses and coaches. This innovative model aims to revolutionize dementia care by maintaining relationships and dignity at the heart of person-centered services. Three major differences set CPPAP facilities apart: the dedicated dementia coach position, dramatically lower staff turnover and burnout, and high levels of family involvement. The program aims to revolutionize dementia care through new staffing models, training and a relationship-based approach focused on humanity. For more information, please see www.DementiaCarePartnership.com.

Sincerely yours,

Ethelle Lord

Introducing a New Standard in Dementia Care: The Care Provider Partnership Agreement Program

Prepared by Dr. Ethelle Lord

Dementia care is due for a revolution. After 21 years of caring for my husband with dementia, I recognized the urgent need for change in long-term care. This inspired me to create the Care Provider Partnership Agreement Program (CPPAP) to set a higher standard in dementia care and services through a total culture change.

The CPPAP institutes three primary changes for facilities like nursing homes, assisted living, and home health agencies:

- Caregivers work 6-hour shifts at 8-hour pay, reducing fatigue and burnout.
- A registered nurse is available 24/7 to oversee care.
- A dementia coach is accessible 24/7 to educate and support staff.

For home care services, the CPPAP requires:

- Rigorous dementia education for all caregivers.
- Access to a dementia coach 24/7 for ongoing training.
- Ability to provide 24/7 care for family respite.

To achieve CPPAP certification, an organization must hold a Magnet or Pathway designation, which recognizes excellence in nursing practices and healthy work environments.

- The Magnet Recognition Program designates organizations worldwide where nursing leaders align goals to improve patient outcomes. It provides a roadmap to nursing excellence benefiting the whole organization.
- The Pathway to Excellence Program recognizes healthcare organizations for positive practice environments where nurses excel. Any healthcare setting with nurses caring for patients may apply.

The CPPAP introduces two pivotal new roles. The dementia coach possesses specialized expertise to educate all staff. Their role is to assess the engagement of those with dementia and support personalized care.

The CPPAP also empowers family members to become actively involved Care Partners. This leads to reduced stress and greater satisfaction. Three major differences set CPPAP facilities apart:

- The dedicated dementia coach position.
- Dramatically lower staff turnover and burnout.
- High levels of family involvement.

Most importantly, the CPPAP's individualized approach leads to improved quality of life. It also boosts workplace satisfaction by supporting staff.

The CPPAP offers a blueprint for the future of empathetic, knowledgeable dementia care through culture change. I aim to pay forward lessons learned from past caregivers. The CPPAP can transform your organization to lead the way.

Visit www.DementiaCarePartnership.com to find out more and contact us for a free consultation on how we can customize the CPPAP program to fit your dementia care and coaching needs.

JUSTICE IN AGING
1444 I Street, NW, Suite 1100
Washington, DC 20005
202-289-6976
<https://justiceinaging.org>

October 2, 2023

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510

Justice in Aging submits this statement for the above-referenced hearing record. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We focus our efforts primarily on those who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency. Justice in Aging has decades of experience with Medicare and Medicaid and improving both programs and integration for people dually eligible.

We appreciate the subcommittee holding this important and timely hearing on Medicare's role in helping older adults age in place. Our comments focus on how declining access to home health aide services, denials for people with higher needs, and premature termination of home health care impact people dually eligible for Medicaid.

Robust Oversight and Enforcement of Medicare Law Is Necessary to Secure Access to Home Health Aide Services

Access to home health aide services is declining due to a combination of discriminatory policies, home health agency (HHA) business decisions, and poor oversight. Advocates report that home health agencies often refuse to take on Medicare enrollees who are more in need of "non-skilled" aide services and tell enrollees that aide services are not available at all or do not cover anything beyond bathing.¹ Instead of

¹Center for Medicare Advocacy, Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved (December 2021), <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>.

providing home health aides, agencies refer patients to their non-Medicare, private pay “affiliates” for related services, cost-shift home health aides for patients dually enrolled in Medicare and Medicaid to Medicaid, or force individuals to rely on family caregivers.

Denying access to Medicare-covered home health aides for help with activities of daily living as critical as bathing, toileting, grooming, skin care, walking, transferring, and assistance with medications, puts enrollees at risk of being hospitalized or entering a nursing facility because they do not get the support they need to stay safely at home. These practices are detrimental to the enrollee’s health and well-being and costlier for Medicare. It also pushes costs onto Medicaid, straining limited HCBS dollars and contributing to unmet need.

The Centers for Medicare and Medicaid Services’ (CMS) policies play a role in disincentivizing HHAs from providing aide services. For example, as the Center for Medicare Advocacy shared during the hearing, providing aide services and serving Medicare enrollees with greater needs increases the likelihood that an agency will be audited. On the flip side, there is no accountability for *not* providing aide services. HHAs are able to understaff aides in their Medicare lines of business, decline people who need these services, and maximize their profits by providing aides to those who can afford to pay out of pocket. The Office of Inspector General (OIG) and Medicare contractors do not audit to protect either the program or enrollees by investigating agencies that *underserve* patients, even when practices such as refusing to accept or prematurely discharging patients with chronic conditions may constitute discrimination on the basis of disability. Instead, audits apply incorrect standards and only focus on agencies “overserving” patients. HHA profit margins bear this out: MedPAC reported in 2021 that home health agencies post approximately 16% profits every year (23.4% for “efficient” providers).² This represents millions of dollars in profit that should be going to home health aide care.

Additionally, CMS’s payment policy focuses on “skilled” services and does not incentivize agencies to provide aides nor the full 28–35 hours of services Medicare authorizes. Under the current payment rules, “profitable” Medicare enrollees are people who need short-term care following inpatient institutional stays. This incentivizes HHAs to deny access altogether to people who are not transitioning out of an institutional stay and people who need more aide services.

Robust oversight is necessary to ensure that HHAs actually provide necessary care in accordance with Medicare law. It is not the *need* for aide services that is declining, but rather the access that is being inappropriately denied.

We urge Congress to address this issue through an equity lens and to measure disparities in access to Medicare home health.³ Not only are there underlying health disparities that affect the makeup of the people with the greatest needs for and least access to services, but the same social determinants of health that cause those disparities also make the home health system harder to navigate. For example, a person with limited income and resources who is returning home from a hospital stay and is told by an HHA that Medicare doesn’t cover the personal care services they need has fewer financial resources, time, and energy to investigate or appeal the HHA’s decision not to provide services. An individual with limited English proficiency or who has experienced discrimination in the past may not feel empowered to ask for services in the first place or dispute what the HHA tells them.

Many low-income older adults have experienced trauma from racism, discrimination and poverty, as well as events such as war and corrupt government regimes. Therefore, interactions with government—even for services and benefits—are potentially stressful and triggering. Adding to the stress in the home health context, interactions with HHA staff are often first occurring at a particularly difficult time following an illness, rapid decline in function, or loss of support from family. Home health services are also very intimate, occurring inside an individual’s own home, so ensuring HHAs are not discriminating in how or to whom they provide care is of particular importance. We encourage Congress to support training on issues of implicit bias, LGBTQ+ and other culturally appropriate care, and to combat dis-

²MedPAC, Report to Congress (March 2021), *supra*, p. 257–258, available at www.medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0.

³See e.g., Bipartisan Policy Center, Optimizing the Medicare Home Health Benefit to Improve Outcomes and Reduce Disparities (recommending CMS “Require MACs to report coverage denials by condition, service type, race, age, functional status, cognitive deficit, and episode trigger to identify access disparities.”)

criminatorial notions like the pervasive myth that people of color over-report pain, leading them to be evaluated for less care.

Improving Access to Medicare Home Health Aide Services Will Benefit People Dually Eligible for Medicaid and the Medicaid Program

Nearly half of the 12 million people dually eligible for Medicare and Medicaid need assistance with one or more activities of daily living,⁴ which are the “non-skilled” services Medicare home health covers. This means that Medicare home health aides have a significant role to play for this population. However, in Justice in Aging’s experience with advocates and our observations, coordination between Medicare and Medicaid for home health aide services is non-existent. There are many benefits that both Medicare and Medicaid cover with varying degrees of complexity to navigate. However, home health aide services are not a service we hear about navigation issues with because HHAs are not providing these services through Medicare. Rather, **Medicaid is paying for all the personal care services for people dually eligible as HCBS enrollees.**

The consequence of the pervasive disinformation about Medicare home health aide coverage (and longevity of coverage) has led to people dually eligible and their advocates not knowing about or pursuing Medicare coverage of personal care services. While the Medicare benefit is not as expansive as Medicaid HCBS and is unlikely to fully meet the LTSS needs of many people dually eligible, it *should* be meeting more of their personal care needs and Medicaid should be wrapping around to provide additional hours and services such as transportation and other supports to facilitate community integration that Medicare does not cover. For example, participants in California’s In-Home Supportive Services (IHSS) program are authorized to receive an average of about 25 hours of personal care per week.⁵ As this is well within the Medicare limit of 28–35 hours, Medicare could and *should* be fulfilling many of these hours.

There are multiple harmful consequences of not employing Medicare’s home health aide benefit and over-relying on Medicaid. One is that dually eligible individuals are likely not getting all their needs met, as Medicaid programs cap the hours/frequency of personal care an individual can receive, even if their needs are greater. While we strongly urge Congress to pass legislation like the HCBS Access Act⁶ to end waiting lists and enrollment caps, the Medicare home health benefit is and will remain key to ensuring everyone who needs personal care support at home can access it. *If Medicare were covering most of these personal care hours, limited Medicaid HCBS dollars could go further to fill in more hours and serve more people.* This could help mitigate racial inequities in hour allocations among Medicaid HCBS participants.⁷

Another harm of people not being able to access the full Medicare home health benefits they are entitled to is that they have to impoverish themselves to qualify for Medicaid to get any of their LTSS needs met. As discussed above, Medicaid HCBS coverage is not available immediately. Individuals must apply and wait for approval, which often takes 2 to 3 months, before services can begin. If there is a waiting list, they may have to wait years. Medicare home health aide services could and should be providing an important stopgap for people who need assistance with daily activities while they wait for Medicaid coverage to start.

The greatest harm is that people dually eligible, who are low-income and not able to afford to fill in the gaps in care, are having to enter nursing facilities when they could be supported at home by Medicare home health. Even if they qualify for Medicaid, HCBS coverage often has capped enrollment and is not immediately accessible when the need arises,⁸ in contrast to nursing facility coverage *and* Medicare coverage of home health aides. Moreover, people of color, people with limited English proficiency, women, LGBTQ+ individuals and others face additional barriers to navigating and accessing HCBS, making proper provision of Medicare home health aide services—a universal benefit with no waiting lists or

⁴ KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (2023).

⁵ CA Dept. Social Svcs, IHSS Program Data (last updated August 2023).

⁶ Justice in Aging, Fact Sheet: The HCBS Access Act (June 2023).

⁷ See, e.g., Justice in Aging, California’s In-Home Supportive Services Program: An Equity Analysis (June 2023).

⁸ Justice in Aging, Medicaid’s Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today—Justice in Aging (September 2021).

application delays—especially important to supporting these marginalized communities to live at home.

Invest in the Direct Care Workforce

Medicare home health is not immune from the direct care workforce crisis that is impacting Medicaid long-term services and supports. The work of home health aides is critically important yet undervalued. Many people who are passionate about doing this work—often women of color—can find higher paying, less demanding jobs in retail or service industries. The fact that most home care jobs do not pay competitive wages worsens the shortage of direct care workers, as many people are forced to choose jobs in order to make a living in industries that do not have such urgent need. Medicare, as the primary payer, can and should seek to rectify this issue through its payment policies and HHA oversight. If payment policies value and incentivize aide services and HHAs are held accountable for providing those services, HHAs will have to make sure they are recruiting and retaining an adequate workforce to provide those services.

We also recommend that Congress address the direct care workforce holistically both in Medicare and Medicaid and ensure that efforts are aimed at increasing and sustaining workers that can meet the diverse long-term services and supports needs of older adults and individuals with disabilities. For example, **Congress should pass legislation to increase Medicaid HCBS funding so that states can sustain the investments in the direct care workforce they made using American Rescue Plan Act funds.**⁹ This funding is necessary to recruit and retain an adequate workforce to meet the growing LTSS needs and ensure that there are no disparities in access based on coverage. Funding should also support training and career development that covers the broad array of services individuals may need, centers culturally appropriate care, and empowers home health aides and all direct services providers to maximize their skills and better serve their clients.

Conclusion

Thank you for your attention to this important issue. We urge Congress to ensure Medicare’s home health coverage law is being upheld so that Medicare-covered home health care, including home health aide services, are available to everyone who qualifies, especially those with longer-term, more complex conditions who may not be expected to improve.

If any questions arise concerning this submission, please contact Natalie Kean, Director of Federal Health Advocacy, at nkean@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director of Health Advocacy

NATIONAL ACADEMY OF ELDER LAW ATTORNEYS
1577 Spring Hill Road, Suite 310
Vienna, VA 22182
703-942-5711
www.NAELA.org

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

The National Academy of Elder Law Attorneys (NAELA) submits this statement for the record for the hearing, “Aging in Place: The Vital Role of Home Health in Access to Care.”

NAELA is a nonprofit professional association of over 4,000 elder and special needs law attorneys that conditions membership on a commitment to the *Aspirational Standards for the Practice of Elder and Special Needs Law Attorneys*,¹ recognizing

⁹Advancing States, ARPA HCBS Spending Plan Analysis (March 2023).

¹https://www.naela.org/Web/Web/About_Tab/History_and_Standards/History_and_Standards_Sub_landing/Aspirational_Standards.aspx.

the need for holistic, person-centered legal services to meet the needs of older adults, people with disabilities, and their caregivers. Supporting the dignity and independence of these vulnerable populations is at the center of what we do, and we write in agreement with the spirit of this hearing that most Americans seek to age in place and public policy should support that aim.

The hearing held September 19, 2023, reflected a united, bipartisan commitment by committee members and witnesses to recognize the desire of most Americans to age in their homes and communities,² and reflected thoughtful consideration of the myriad complicating issues and factors to be resolved in achieving this goal through public policy. NAELA shares that commitment, and our members, representing tens of thousands of Americans in all 50 states, the District of Columbia, and territories, are eager to engage and support thoughtful policymaking on federal and state levels to ensure all Americans can age where they choose, where they are safest, and where they can receive the support they need to sustain maximum independence and autonomy.

We would like to draw your attention to several critical policy areas that require congressional action. These areas need thoughtful consideration and action to ensure that older Americans have the necessary support and resources to age in place:

1. **Medicaid HCBS Policy and Funding Reforms:** We urge the committee to explore opportunities for strengthening Medicaid policies that improve access to home and community-based services (HCBS) for Medicaid eligible beneficiaries. Expanding Medicaid coverage and accessibility for HCBS can enable seniors and individuals with disabilities to receive essential care at home, preserving their independence and quality of life. Congress should also examine and standardize planning rules to ensure beneficiaries who qualify for HCBS can access benefits.

In addition, Congress should mitigate Medicaid's institutional bias through a number of specific actions. For example, for HCBS provided pursuant to a state waiver under Section 1915(c) of the Social Security Act, coverage is prospective-only from the date on which the state Medicaid program (or its agent) approves an HCBS service plan because federal financial participation (FFP) may not be claimed for Section 1915(c) waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. Given that most states' HCBS programs are authorized under Section 1915(c), Congress could reduce the institutional bias in Medicaid by allowing states to receive FFP for services provided prior to the development of the service plan in certain circumstances, such as for populations that are highly likely to be eligible for an HCBS service plan. We also echo the suggestion made by witness David C. Grabowski, PhD, to extend the increase in the federal match rate for Medicaid HCBS as Congress has done in the past under the American Rescue Plan Act and the Affordable Care Act's Balancing Incentive Program.³

2. **Medicare Coverage:** It is essential to enhance Medicare coverage for home health services, including skilled nursing care and physical therapy. Ensuring seniors have access to these services at home can contribute significantly to their ability to age in place. We wish to reiterate the testimony from Judith Stein, JD, President of the Center for Medicare Advocacy, who points out that the Medicare home health benefit could greatly improve quality care for beneficiaries and should be better understood and enforced.⁴
3. **Telehealth Expansion:** Telehealth has proven invaluable, especially in rural areas with limited access to healthcare facilities. We encourage the committee to support policies that expand telehealth access and reimbursement for seniors, allowing them to receive medical care remotely.
4. **Caregiver Support:** The Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act of 2018 a vital piece of legislation, but more can be done to support family caregivers as was made clear in the National Strategy to Support Family Caregivers. One clear legislative action would be to make Medicaid spousal impoverishment protections permanent. Supporting

² Binette, Joanne, and Fanni Farago. 2021 Home and Community Preference Survey: A National Survey of Adults Age 18-Plus. Washington, DC: AARP Research, November 2021, <https://doi.org/10.26419/res.00479.001>.

³ https://www.finance.senate.gov/imo/media/doc/09192023_grabowski.pdf.

⁴ https://www.finance.senate.gov/imo/media/doc/09192023_stein_testimony.pdf.

and expanding caregiver support policies can ease the burden on families caring for aging loved ones.

5. Older Americans Act and Adult Protective Services (APS) Funding: The Older Americans Act-authorized programs provide a crucial lifeline for addressing social isolation, safety, and essential support to seniors, especially those in rural communities. Yet states and local service providers cannot meet the demand, particularly as more Americans are living longer with chronic conditions and wish to avoid institutionalization. Ensuring adequate, stable funding for social service programs—including meal delivery, legal services, and transportation services, as well as critical services for seniors at risk of fraud, neglect, or abuse—is crucial for building the infrastructure needed to allow Americans to age in place. To protect seniors from abuse and neglect, support linkages to legal services and medical-legal partnerships, and support post-acute and long-term care worker recruitment and retention, Congress should pass the Elder Justice Reauthorization and Modernization Act.

These policy areas have a profound impact on the lives of older Americans. Your leadership and advocacy can empower seniors to age in place, maintain their dignity, and receive the care they require in the safety and comfort of their homes and communities.

If you have questions, contact Mike Knaapen (mknaapen@naela.org), Director of Public Policy and Alliance Development at NAELA.

Sincerely,

Bridget O'Brien Swartz
President

PRIVATE CARE ASSOCIATION, INC.
P.O. Box 0911
Southern Pines, NC 28388-0911
<https://www.privatecare.org/>

U.S. Senate
Subcommittee on Health Care
Committee on Finance

September 19, 2023

The Private Care Association (“PCA”)¹ appreciates the opportunity to submit this Statement for the Record concerning the above-referenced hearing.

Several hearing witnesses discussed the inadequate access to home care, which was attributed to, among other things, the reimbursement rates under government programs and the difficulty in meeting the home-care needs of rural populations.

This Statement is limited to only one dimension of the home-care access problem. But it is a dimension which witnesses did not address, namely, the effect of the U.S. Department of Labor (“DOL”) issuing regulations in 2013 (which became effective in 2015) that significantly narrowed the scope of the companionship-services exemption² to the Fair Labor Standards Act of 1938 (“FLSA”). Importantly, this exemption applies only to nonmedical home care. Accordingly, this Statement pertains only to home-care access issues that involve nonmedical home care.

By way of background, Congress enacted the companionship-services exemption (the “CSE”) during 1974, when it expanded the FLSA to cover domestic workers. The CSE exempts from the FLSA’s overtime and minimum-wage requirements individuals employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves. The exemption applies generally to individuals who provide nonmedical care in an individual’s home.

¹ PCA is a national association representing caregiver registries.

² 29 U.S.C. § 213(a)(15).

In the year following the CSE's enactment, DOL issued regulations³ to implement the CSE and make clear that the exemption applied to covered services—regardless of whether the caregiver provides the care pursuant to an agreement with the care recipient or through a “third party employer.”

The CSE reflects a trade-off Congress struck at the time that balanced the interests of expanding FLSA coverage to domestic workers against the interests of ensuring that working families could continue to afford home care for an elderly or disabled family member.⁴ The balance struck consisted of exempting families from having to pay FLSA wages when caregivers provide care for their elderly or disabled family members.

Nearly 40 years later, DOL issued regulations⁵ during 2013 that significantly limited the scope of the CSE and completely eliminated its application to a “third party employer.” This action represented a stunning policy reversal of the promise Congress made to working families when it enacted the CSE.

Prior to the CSE regulations going into effect in 2015, an in-home caregiver could work exclusively for one family for as many hours as the caregiver chose to work. The CSE regulations changed this, by subjecting nonmedical home care not meeting the narrowed terms of the CSE (or provided through a “third-party employer”) to the FLSA's complex overtime and minimum-wage requirements. Many seniors who pay for home care with their private funds cannot afford to pay overtime rates. And long-term care insurance policies and government-funded programs generally pay fixed amounts for home care. Consequently, the 2013 CSE regulations have resulted in many in-home caregivers being restricted to working no more than 40 hours per week per family (or agency)—to avoid the unaffordable overtime rates.

Subjecting nonmedical home care to the FLSA's overtime requirements also reduces continuity of care to seniors—which can be especially problematic for those who suffer from Alzheimer's or dementia. And it disrupts the lives of many in-home caregivers by not being able to work exclusively for one family as many hours as they choose. Instead, such caregivers generally need to find other families who happen to need home care during the specific hours they are not working for their primary family.

PCA respectfully urges the Subcommittee to consider examining the effect of the 2013 CSE regulations on the availability of nonmedical home care. Specifically, PCA submits that consideration be given to examining:

- The number of nonmedical in-home caregivers whose work hours per week have been restricted to no more than 40 per week, to avoid the FLSA's overtime requirement;
 - The number of hours these caregivers are able to provide nonmedical in-home care for other clients, who happen to need care during the hours they are not working for their primary client;
 - The number of hours of nonmedical home care being “lost” on account of these caregivers not being able to find other clients who need care during the hours they are not working for their primary client; and
- The number of nonmedical in-home caregivers who actually earn overtime as a result of the 2013 CSE regulations.

³*Application of the Fair Labor Standards Act to Domestic Service*, 40 Fed. Reg. 7404 (February 20, 1975) (amending 29 CFR Part 552).

⁴DOL explained the compromise Congress struck when enacting the companionship-services exemption in Wage and Hour Advisory Memorandum No. 2005-1 (December 1, 2005), titled *Application of Section 13(a)(15) to Third Party Employers*:

Soon after the [1975] regulations were promulgated, the Department explained that *Congress was mindful of the special problems of working fathers and mothers who need a person to care for an elderly invalid in their home*. Opinion Letter from Wage and Hour Div., Department of Labor, WH-368, 1975 WL 40991 (November 25, 1975). In particular, *legislators were concerned that working people could not afford to pay for companionship services if they had to pay FLSA wages*. See 119 Cong. Rec. 24,797 (statement of Senator Dominick, discussing letter from Hilda R. Poppell); *id.* at 24,798 (statement of Senator Johnston); *id.* at 24,801 (statement of Senator Burdick). That cost concern applies whether the working person obtains the companionship services by directly hiring an employee or by obtaining the services through a third party. . . . As explained above, *Congress created the exemption to ensure that working families in need of companionship services would be able to obtain them*. . . . (Emphasis added).

⁵*Application of the Fair Labor Standards Act to Domestic Service*, 78 Fed. Reg. 60,453 (October 1, 2013) (amending 29 CFR Part 552).

PCA surmises, based purely on anecdotal evidence, that the 2013 CSE regulations adversely affected all parties affected. Seniors who cannot afford to pay overtime rates have lost access to continuity of care; many caregivers are restricted to working no more than 40 hours per week per client and are unable to find other clients needing home care during the hours they are available; few caregivers are earning overtime; and the total number of hours of nonmedical home care being provided has been artificially reduced, thereby exacerbating the lack of availability of non-medical home care.

PCA respectfully submits that a thorough examination of the effect of the 2013 CSE regulations *could* reveal an opportunity to expand access to nonmedical home care while also enabling seniors, once again, to enjoy continuity of care and empowering in-home caregivers to work as many hours as they choose for one family. And this would be an especially attractive opportunity *if* the findings reveal that the vast majority of in-home caregivers who work more than 40 hours per week are not earning overtime but instead are having to move from client-to-client (or agency-to-agency) to work the same hours they worked before the 2013 CSE regulations. Now that the CSE regulations have been in effect for more than seven years, sufficient data should be available to conduct a meaningful analysis of this issue.

PCA would appreciate the opportunity to work with the Subcommittee in ascertaining the effect of the 2013 CSE regulations on access to nonmedical home care. Thank you very much for your consideration.

Respectfully,

Russell A. Hollrah
 Washington Counsel to Private Care Association, Inc.
 Hollrah LLC
 1025 Connecticut Avenue, NW, Suite 1000
 Washington, DC 20036
 (202) 659-0878
 rhollrah@hollrahllc.com

TEXAS ASSOCIATION FOR HOME CARE AND HOSPICE
 9390 Research Blvd., Bldg. 1, Suite 300
 Austin, TX 78759
 (512) 338-9293
 f (512) 338-9496
<https://tahc.org/>

U.S. Senate
 Committee on Finance
 Subcommittee on Health

The Texas Association for Home Care and Hospice (TAHC&H) thanks the Committee for the opportunity to comment on the role of home health in access to care. On behalf of our concerned members, TAHC&H would like to reinforce concerns from the hearing about the serious and patient-limiting access issues caused by the Centers for Medicare and Medicaid Services' (CMS) CY 2024 proposed rule that will slash payment rates for Medicare home health services. TAHC&H is concerned about the long-term impact of CMS' proposed payment cuts to the home health benefit which will place an undue burden on providers and make it harder for our most at risk seniors to receive medically necessary care in the most cost effective and preferred setting, their homes. Additionally, Texas home health providers that offer essential home and community-based services (HCBS) to Medicaid beneficiaries with complex needs, have grave concerns with CMS' Medicaid Access Rule proposal that requires 80 percent of Medicaid HCBS payments are spent on direct care wages. While TAHC&H members desire to offer competitive rates for recruitment and retention of a quality workforce, it is not clear how Texas providers will be able to implement this requirement without exacerbating access issues in areas where providers are already in short supply.

The Texas Association for Home Care and Hospice represents over 1,200 licensed Home and Community Support Services Agencies (HCSSAs) across the state of Texas. TAHC&H remains committed to working with the Committee and CMS to improve access to these services by ensuring providers can offer home health care to Texas beneficiaries.

CY 24 Home Health Prospective Payment System (PPS) Proposed Rule

In 2018, Congress directed CMS to change the Medicare home health payment system beginning in 2020. In doing so, Congress required the new payment system, the Patient Driven Groupings Model (PDGM), to be budget neutral compared to the old system, intending that post-2020 payments should be as if the new system had not been enacted. To achieve budget neutrality, CMS was authorized to make certain payment adjustments on both permanent and temporary basis that allowed for a reconciliation of assumed behavior changes and actual behavior changes.

We are extremely concerned and disappointed at CMS' decision to implement a 5.653% reduction to home health agencies (HHAs) in 2024. CMS finalized a 3.925% cut last year despite strong opposition from patients, providers, and lawmakers. CMS has inaccurately presented the payment update for CY 24 as a nominal 2.2% reduction, when the agency has proposed to continue a permanent payment adjustment that reflects an over 9% cut to HHAs in just two years. Despite Congressional intent that CMS implement the new home health payment model, PDGM, in a budget neutral manner, CMS maintains its position that it has the authority to make determinations based on the impact of the previous payment model. We urge the Committee to implore CMS to halt its proposed massive cut to Medicare home health services. Another year of significant cuts will place most Texas home health agencies at risk of closing, forcing the at-risk seniors we serve into higher cost nursing facilities. Notably, the referral rejection rate has increased significantly (from 49% in 2020 to 71% in 2022) indicating that hospital lengths of stay are increasing, and patients are not able to move easily from hospital to home.

The cumulative impact of these proposed cuts is billions of dollars carved out of the Medicare home health program which is only a small percentage of the overall Medicare budget, further adding to the challenges Medicare providers face in serving their patients—the majority (94%) of which say they would prefer to receive necessary health care in their own home. Home health is estimated to save the Medicare Trust Fund an estimated \$1.38 billion over 6 years due to avoided hospitalizations and decreased transfers to more expensive post-acute care settings, yet CMS continues to ignore data and recommendations from home health providers that another massive cut will compound these access problems leading to costlier care and worse outcomes for patients. Diminished access to the home health benefit will impact our entire health-care system—driving up costs due to increased hospital lengths of stay and forcing patients into costlier sites of care. The CMS proposal will be detrimental to Medicare beneficiaries in Texas that desire medically necessary care in their homes, particularly in rural areas, where home health providers are often the only source of health care. Further, chronically low payment rates have created ongoing disparities in care perpetuating the continued struggles of home care agencies to maintain their financial stability and a stable workforce. It is estimated that 51.9% of Texas home health agencies will have margins below zero and be forced to forgo \$81.5 million in reimbursement if the 2024 cuts are implemented.

Medicaid Program: Ensuring Access to Medicaid Services Rule

In the proposed Medicaid Access rule, CMS is proposing to require that at least 80 percent of all Medicaid payments, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers that provide homemaker services, home health aide services, and personal care services.

TAHC&H has significant concerns that the 80% payment requirement could have consequential damaging impacts for Medicaid Home and Community Based Services (HCBS) program providers. Of particular concern is the lack of data used to produce the calculation for an 80% payment threshold. While we agree that direct care worker pay rates is an issue that needs to be addressed, presently there simply is not enough data available related to State Medicaid HCBS services to substantiate an industry requirement of this magnitude. Due to insufficient data and absent a full understanding of the state-by-state payment rate structures and regulatory requirements for these programs, it would be reckless of CMS to apply this mandate to states universally.

TAHC&H does not believe that mandating 80% of payment reimbursements to direct care workers will ensure higher wages for workers, instead we have serious concerns that this will force providers to make cuts to other essential programs, such as direct care worker support systems, day to day operations and processes, or alternatively, shut down entirely. We believe that small providers with low caseloads, rural providers with low caseloads and high mileage reimbursements, providers that serve certain ethnic groups, and minority owned providers will be crip-

pled by this mandate. We also believe that this will negatively impact direct care workers who desire additional training and education for career development, and who rely on provider support systems that could be potentially cut due to lack of funds. Additionally, this proposed policy this will further exacerbate the staff turnover and retention efforts specific to home care providers because they will have to cut costs related to direct care worker support systems and support staff, as well as certain training and education opportunities for direct care workers due to reduced funds available to support these costs, which will in turn cause direct care workers to go elsewhere to access these benefits.

TAHC&H recommends that CMS withdraw the 80% payment requirement from this proposed rule and instead focus on collecting ample data to create viable payment and wage options to ensure payment rates to direct care workers are sufficient for services and quality of care. We believe that using Electronic Visit Verification (EVV) data would be a possible route for collecting ample data, as well as requiring states to do independent analysis of costs of care to set minimum standards for states and determine overall future changes to direct care worker compensation. We also recommend that CMS engage stakeholders in a workgroup type setting to ensure a better understanding of the differences in payment rate structures and regulatory differences of the Medicaid programs state by state. We believe that by taking this route, CMS and stakeholders will be able to find a workable solution at the most fundamental level as opposed to implementing a blanket mandate that will not work due to the differences in the structure of Medicaid programs at the state level. We further recommend that CMS publicly disclose all data and analytical methodologies regarding any future payment thresholds to ensure transparency.

Texas home care agencies want to continue to deliver cost-effective care, but it is critical that CMS recognize the need for sustainable support for an industry that services our most vulnerable. It is important that investments are made to retain, recruit, and strengthen the home care workforce and reverse consequential access to care issues due to payment cuts. Providers have been sounding the alarm on the inadequacy of rates for over a decade.

We appreciate your interest in ensuring seniors have the freedom to age in place and that low-income, disabled individuals have access to care in their home and community. We implore the Committee to protect and ensure the delivery of high-quality, cost-effective home-based care and services to those that need it.

Respectfully Submitted,

Jessica Boston
Director of Government Affairs

