

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 27, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1747-P
Baltimore, MD 21244-8013

Submitted electronically via [regulations.gov](https://www.regulations.gov)

Re: File Code CMS-1747-P; Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Service Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements – Proposed Rule

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice of Proposed Rulemaking (NPRM) and the accompanying Request for Information on Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs.

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 health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency.

Our comments focus on the need to improve access to home health, especially among enrollees with long-term chronic conditions who need services to maintain current functioning and prevent decline.

Home Health Proposal

1. CMS should address widespread access barriers preventing enrollees from obtaining critical Medicare-coverable home health care

Despite qualifying under the law and despite the reported availability of services from Medicare Home Health Agencies,¹ many Medicare enrollees cannot access necessary home care. In practice, agencies deny access to many enrollees who qualify for home health care, especially those with longer-term,

¹ MedPAC's recent analysis of "adequate access" reported that "Over 99 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated in 2019, and 86 percent lived in a ZIP code with five or more HHAs." MedPAC, Report to Congress (March 2021), p. 232, available at http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.

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chronic conditions, because home health agencies lack operational incentives to serve them. Home health agencies pick and choose more profitable patients, without any apparent oversight from CMS as to whether the agencies' admission practices discriminate against or exclude eligible enrollees with chronic conditions. Further, despite Conditions of Participation rules to the contrary, advocates report many agencies discharge patients at-will, while agencies are often able to keep an entire bundled payment for ordered services that are not actually delivered. We urge CMS to develop policies and practices that encourage home health agencies to provide care for *all individuals* who qualify under the law, for *all services* covered under the law.

2. CMS should ensure home health agencies deliver the required amount and scope of Medicare-covered home health aide services

We share CMS's stated concerns about the drastic decline in delivery of necessary home health aide services. As noted in the proposed rule, between 1998 and 2017 home health aide visits declined 88% (FR 35958), despite no change in Medicare coverage law. We also strongly agree with CMS that aides *should* deliver a significant portion of direct home health care and are a critical part of maintaining safe, quality care for Medicare enrollees.

Over the past twenty years, Medicare home health coverage has changed from the Congressionally intended benefit, as is still written in law, to a narrowly construed, short-term, post-acute skilled service benefit lacking many of the critical covered services that should be provided by home health aides. This reduction in home health aide services has been driven by administrative rules, policies, and guidance through the Prospective Payment System (PPS), the Patient Driven Groupings Model (PDGM), Home Health Value Based Purchasing (HHVBP), Quality Reporting Measures (QRM), Medicare Administrative Contractor (MAC) decisions, and Office of Inspector General (OIG) audits. Enrollees who ask for home health aide services are constantly told by agencies that "Medicare doesn't pay for home health aides."

Based on shortcomings in the PPS system, agencies appear to find little-to-no payment incentives to provide aide services. Although the law allows for up to 28-35 hours a week of necessary home health aide services, for a robust list of personal care related-services, most enrollees who would qualify for that level of service count themselves "lucky" to receive a bath every week or two. Advocates report that agencies are increasingly not staffing for home health aides (current COVID-related circumstances aside). Instead of providing home health aides, agencies refer patients to their non-Medicare, private pay "affiliates" for related services, or cost-shift home health aides for patients dually enrolled in Medicare and Medicaid to Medicaid. In the case of Medicare Advantage, many plans simply do not allow home health aide services to be delivered. 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 self-administered medications, puts enrollees at risk of being hospitalized or entering a nursing home because they do not get the support they need to stay safely at home. These practices are more costly for Medicare and detrimental to the enrollee's health and well-being.

As annual payment "re-basing" occurs, service delivery data show increasingly less home health aide services have been provided. This reduction in services is then reflected in payment rates, creating a cycle of reduced payment and reduced care. However, PPS was designed to be an aggregate bundled payment system. It is intended to provide adequate payment to meet the needs of all qualified patients, not for agencies to maximize profits on each enrollee.

We urge CMS to ensure that Medicare home health agencies serve enrollees who require Medicare-covered home health aide services up to the statutorily defined limit of 28-35 hours a week. Robust oversight is necessary to ensure that agencies actually provide necessary care.

3. CMS should suspend, not expand, Home Health Value Based Purchasing (HHVBP)

a. The HHVBP model denies coverage to people who are not expected to improve

We disagree with CMS's determination that the criteria for expanding the HHVBP model under Section 1115A(c) have been met. CMS states "that expansion of the HHVBP Model would not deny or limit the coverage or provision of Medicare benefits for Medicare beneficiaries" (FR 35917). In fact, access is, and will continue to be, impacted. The HHVBP model has devastated delivery of home care to people who are not expected to improve and expansion of HHVBP will exponentially worsen the problem. HHVBP criteria focus almost exclusively on improvement in patient function and promote agency competition that results in potential rewards or penalties for providers, up to +/- 5% (FR 35920). Since HHVBP was first proposed in 2015, the criteria used to measure HHVBP clearly discriminate against Medicare enrollees with longer-term, chronic conditions who require skilled care but are not expected to improve – patients covered by the *Jimmo* class action settlement ("*Jimmo*"). CMS has failed to secure meaningful measures in HHVBP for individuals who do not improve, but who need services to maintain function or to slow decline. Instead, HHVBP measures penalize home health agencies when patient improvement is not achieved.

As CMS notes in the proposed rule, "the distribution of payment adjustments would be based on quality performance as measured by both achievement and improvement, across a proposed set of quality measures conducted to minimize burden as much as possible and improve care" (FR 35917). However, minimizing burden to providers, in the context of HHVBP, means having them meet quality standards exclusively for people whose conditions are expected to improve. This comes at the expense of access for enrollees who require Medicare-covered services to maintain their condition or slow decline, access that is mandated by the *Jimmo* settlement. In short, expanding HHVBP as proposed will continue and exacerbate the devastating loss of access to necessary home health care that enrollees covered by *Jimmo* have experienced.

b. CMS's proposed self-care and mobility measures are not appropriate or adequate for enrollees who are not able to improve

As previously noted, HHVBP measures clearly discriminate against Medicare enrollees with longer-term, chronic conditions who require skilled care but are not expected to improve. CMS's proposed self-care and mobility measures would not change this. We agree that enrollees who are capable of improving in self-care and mobility should maximize that opportunity. But CMS should not prioritize these patients, through HHVBP or other means, at the expense of care for patients who will not be able to perform self-care or become mobile.

In the proposed rule, CMS describes self-care and mobility HHVBP measures in a way that attempts to include *Jimmo* beneficiaries. However, examining the proposed measures shows that these measures will also discriminate against enrollees who cannot be expected to improve. This will worsen access to home health services for those with long-term, chronic conditions.

Therefore, we urge CMS to suspend HHVBP and not expand it unless and until measure sets account for all patients equally. If CMS does expand HHVBP, enrollees with maintenance goals should not be included in HHVBP until all measures, incentives, and disincentives equally reflect their needs and qualifications for Medicare home health coverage as for those who can improve. While this will not

make *Jimmo* enrollees any more desirable to home health agencies, it would at least mitigate some harm to enrollees by not imposing affirmative punitive HHVBP measures on agencies for serving patients with longer-term, chronic conditions.

4. CMS should review and redesign the Patient Driven Groupings Model (PDGM), which has created significant access obstacles, to advance access for all enrollees who need and qualify for services under the law.

Prospective payment systems (PPS) fail complex and chronic patients who try to access care at home. Unlike hospitals, home health providers can largely pick and choose which patients to serve. Regrettably, many home health agencies have taken advantage of their broad discretion combined with lack of CMS oversight to select patients who are most profitable under PPS. This practice disadvantages and excludes enrollees with longer-term, chronic conditions.

CMS describes the PDGM's purpose: "To better align payment with patient care needs and to better ensure that clinically complex and ill beneficiaries have adequate access to home health care" (FR 35879). However, this description does not reflect reality. The current systems fail clinically complex and ill enrollees.

PDGM heavily weights post-institutional and the first (early) 30-day period to the significant detriment of people with longer-term, chronic conditions. Results from the first year of Medicare's home health payment system, PDGM, reveal that Medicare home health payments for the first 30 days of care are, on average, more than 34% higher than for subsequent 30-day periods of care, regardless of the amount of home health services a patient needs, or for how long. Data from the first full year of PDGM illustrated the sharp payment decline to agencies after 30 days of home health care. After the first 60 days of home health care, payments decline even further.

Observed negative impacts on enrollees caused by PDGM since implementation, include:

- Medicare enrollees who were not recent inpatients and/or need more than 30 days of home health care experienced greater problems accessing care. Enrollees with longer-term and chronic conditions who are unlikely to improve experienced a decline in the availability of Medicare home care services.
- Enrollees with hospital observation, outpatient, or emergency stays experienced a decline in access to home health care, since PDGM treats them as admissions from "the community" and attaches lower reimbursement rates.
- Enrollees who need and qualify for Medicare-covered therapy received less therapy.
- Enrollees with severe functional impairments and comorbidities have even greater problems accessing care, as agencies determine they do not receive a sufficient payment boost through PDGM case-mix adjustments to provide care.
- Access to home health aide care continues its precipitous decline and home health aide services for enrollees who were not recent inpatients also declined. This is due in part to home health agencies increasingly hiring only sufficient staff to serve "profitable" Medicare enrollees, i.e., people who have had prior inpatient institutional care and people who need short-term care.
- For dually eligible Medicare and Medicaid individuals, many of whom have longer-term chronic conditions, more necessary home health care is being shifted to Medicaid.

- More Medicare Advantage plans are employing artificial intelligence and prior-authorization methods to limit the services they will allow home health agencies to deliver.

The oversight responsibilities of CMS include ensuring beneficiary access to services to which they qualify, ensuring quality services, and ensuring that payments to providers are appropriate. Regrettably PDGM fails on all counts. It limits access to individuals with long-term or chronic conditions, it disincentivizes provision of appropriate health aide services, and it rewards waste and abuse in the Medicare program by paying home health agencies prospectively, allowing agencies to reduce delivery of services and to inappropriately discharge patients with few repercussions for compliance infractions.

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, applying incorrect standards, they only focus on agencies “overserving” patients. Agency profit margins bear this out year after year. As MedPAC reports, home health agencies post approximately 16% profits every year (23.4% for “efficient” providers).² This represents millions of dollars in profit that could be going to patient care.

PDGM is a significant factor in reducing, and often eliminating, access to ongoing home health care for Medicare enrollees with complex or longer-term, chronic conditions. CMS should review this payment system and develop payments, policies, and practices that support home health care for all individuals who qualify for Medicare coverage under the law.

Request for Information: Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

1. Standardized Patient Assessment Data Elements that could be used to assess health equity in the care of HHA patients, for use in the HH QRP

We appreciate the expansion of required data reporting to include categories reflecting social determinants of health. It is particularly important to gather more data on preferred language and interpreter services for the Medicare population. Additional data elements we would recommend include sex, gender identity, sexual orientation, and disability status. These elements should be reported in such a way to allow for intersectional analysis with race, ethnicity, language and other data. Older adults and people with disabilities face the impacts of ageism, ableism and compounded discrimination on the basis of other identities. Data may not always show broad disparities by race, age, or sex alone, but looking at the experience of older women of color, for example, may reveal disparities that are masked when looking at those data separately.

2. Recommendations for how CMS can promote health equity in outcomes among HHA patients

Data collection and reporting serve many important purposes. We encourage CMS to share data with HHAs about their own patient base as well as the Medicare population in the areas they serve. As CMS suggests, HHAs can use this information to identify gaps and improve their quality of care. We also urge CMS to use this information to work with HHAs to better serve all eligible Medicare enrollees in their service area, not only their existing patient base. In the home health context, some Medicare enrollees

² MedPAC, Report to Congress (March 2021), supra, p. 257-258, available at www.medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0.

likely are not being served at all by any HHA. We believe it is CMS's role to identify these gaps and barriers to access and to work with HHAs to close them.

As our comments on the Home Health Proposal make clear, people with disabilities and complex, longer-term conditions experience the most barriers to accessing Medicare home health. We urge CMS to address this issue through an equity lens. Not only are there underlying health disparities that affect the makeup of this population, 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 a home health agency that Medicare doesn't cover the personal care services they need is less likely to invest time, energy or money in investigating or appealing 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.

Because many low-income older adults have faced a lifetime of discrimination, the impact of such trauma cannot be overlooked. Many older adults have experienced war and poverty, and some have faced corrupt government regimes and other sources of trauma, making interactions with government—even for services and benefits – 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. We encourage CMS to work with HHAs to develop and implement training on issues of implicit bias, and to combat discriminatory notions like the pervasive myth that people of color over-report pain, leading them to be evaluated for less care.

Finally, we recommend that CMS engage in robust oversight of the home health program, and do so through the lens of the consumer. We often hear that agencies administering programs do not hear complaints about discrimination based on race or language. However, we know that looking only at formal complaints is too high of a bar, especially when considering that an older adult who has been discriminated against may have very valid reasons for not wanting to complain. We recommend using "secret shoppers," for example, to help agencies identify whether older adults with limited proficiency in English are able to *actually* access interpretation services when interacting with HHAs. Secret shoppers and focus groups in partnership with trusted messengers could also identify other barriers and even discrimination, both implicit and explicit. Finally, focus groups provide an avenue to assess outcomes from the consumer's perspective, rather than relying on formal measures of quality that may themselves be discriminatory against those already experiencing inequities in access to home health care.

Conclusion

We urge CMS to uphold Medicare's home health coverage law so that Medicare-covered home health care is available to everyone who qualifies, especially those with longer-term, more complex conditions who may not be expected to improve. We also encourage CMS to take steps to both better identify and address health disparities and inequities in the home health benefit. If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,



Amber Christ
Directing Attorney