JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

August 28, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Submitted electronically via regulations.gov.

Re: Request for Information for Access to Home Health Aide Services; Medicare Program 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies (RIN 0938–AV03)

Justice in Aging appreciates the opportunity to respond to the request for information on access to home health aide services and the other above-referenced provisions of the proposed Medicare home health rule. 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.

Request for Information (RFI) for Access to Home Health Aide Services

- *Why is utilization of home health aides continuing to decline as shown in Table B2 and Figure B4 if the need for these services remains strong?*

As a threshold matter, we believe the issue of declining home health aide hours provided should be framed as an access issue, rather than a utilization issue. This is because people with Medicare *need* home health aide services, as CMS recognizes, but do not have access. Access to these 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. The Center for Medicare Advocacy surveyed 217 HHAs across 20 states in 2021 that confirmed widespread misinformation among HHAs themselves about Medicare coverage of home health aide services and that HHAs are improperly limiting these services.[1] Nearly all HHAs (95%) reported they would only be able to provide 6 aide hours or less per week. Instead of 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.

[1] Center For Medicare Advocacy, Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved (Dec. 2021), https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf.

CMS policies play a role in disincentivizing agencies from providing aide services. For example, 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. It is not the *need* for aide services that is declining, but rather the access that is being inappropriately denied. Therefore, we strongly urge CMS to ensure that Medicare HHAs serve enrollees who require Medicare-covered home health aide services up to the statutorily defined limit of 28-35 hours a week.

- *To what extent are higher acuity individuals eligible for Medicare (for example, individuals with multiple comorbidities or impairments of multiple activities of daily living) having more difficulty accessing home health care services, specifically home health aide services?*

As discussed above, Medicare payment policy disincentivizes HHAs to take on people with higher needs and chronic conditions. Payment for aide services, which are particularly important for people who need help with multiple activities of daily living, is almost non-existent and declines overtime (after 30 days) under the PGDM.

- *What are notable barriers or obstacles that home health agencies experience relating to recruiting and retaining home health aides? What steps could home health agencies take to improve the recruitment and retention of home health aides?*

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. 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 CMS's attention to the direct care workforce look holistically at both Medicare and Medicaid and ensure that efforts are aimed at increasing and sustaining workers that can meet the

[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.

diverse long-term services and supports needs of older adults and individuals with disabilities. For example, CMS should support training and career development that covers the broad array of services individuals may need, cultural humility, and empowers home health aides and all direct services providers to maximize their skills and better serve their clients.

- *How effective is the coordination between Medicare and Medicaid to ensure adequate access to home health aide services? Please share insights on the level of utilization of Medicaid benefits by dually eligible beneficiaries for additional home health aide services that are not being provided by Medicare.*

Nearly half of the 12 million people dually eligible for Medicare and Medicaid need assistance with one or more activities of daily living,[3] 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 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 to 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.[4] As this is well within the Medicare limit, 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 too caps the hours/frequency of personal care an individual can receive, even if their needs are greater. If Medicare were covering most of these 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.[5] The other harm is that people are having to impoverish themselves to qualify for Medicaid to get any of their LTSS needs met. As stated above, Medicare can and should be meeting many older adults' needs for assistance with daily activities. 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. Even if they qualify for Medicaid, HCBS coverage often has capped enrollment and is not immediately accessible when the need

[3] KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (2023)
[4] https://www.cdss.ca.gov/inforesources/ihss/program-data
[5] *See, e.g.,* Justice in Aging, California's In-Home Supportive Services Program: An Equity Analysis (June 2023).

arises,[6] 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 application delays--especially important to supporting these marginalized communities to live at home.

- *Are physicians' plans of care less reliant on home health aide services in the past, or are HHAs less willing/able to provide these services? If so, what are the primary reasons for why such services are not provided?*

The primary issue is that HHAs are less willing to provide home health aide services, which results in physicians to stop prescribing health aide services or including them in plans of care. Physicians may believe the disinformation about Medicare coverage of aide services and HHA's ability to provide them or they may realize it is futile to include these services because they know the HHA won't follow through. Either way, the result and harm are the same.

- *What are the consequences of beneficiary difficulty in accessing home health aide services?*

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.

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 be providing an important stopgap for people who need assistance with daily activities while they wait for Medicaid coverage to start. This would help many low-income older adults avoid unnecessary institutionalization.

We urge CMS to address this issue through an equity lens and measure disparities in access to Medicare home health.[7] 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

[6] Justice in Aging, Medicaid's Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today - Justice in Aging (Sept. 2021).

[7] *See e.g.,* Bipartisan Policy Center, Optimizing the Medicare Home Health Benefit to Improve Outcomes and Reduce Disparities | Bipartisan Policy Center (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.")

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 CMS to work with HHAs to develop and implement training on issues of implicit bias, LGBTQ+ and other culturally appropriate care, 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 Medicare enrollee. 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 identify whether older adults with limited proficiency in English are able to actually access interpretation services when interacting with HHAs. Focus groups in partnership with trusted messengers could also identify other barriers and even discrimination, both implicit and explicit. For example, focus groups participants may reveal whether HHAs are declining to serve LGBTQ+ older adults because of bias or because they are less likely to have family caregivers to support them and therefore higher need. These mechanisms provide an avenue to assess outcomes from the consumer's perspective, rather than relying on formal quality measures and audits that may themselves be discriminatory against those already experiencing inequities in access to home health care.

Discharge Function Score Measure

Justice in Aging is concerned with this proposed measure and the impact it will have on individuals with disabilities and chronic conditions who have maintenance goals. We agree with CMS that understanding an individual's functional status is important and that home health care can improve function. However, not everyone should be discharged from home health and therefore applying this measure to all individuals and emphasizing functional "improvement" perpetuates misinformation about the home health benefit and further disincentivizes HHAs from serving individuals with maintenance goals. We urge CMS to ensure all home health quality measure do not discriminate against individuals with long-term needs and maintenance goals.

Documentation Requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Products Supplied as Refills to the Original Order

We appreciate CMS's attention to how to ensure documentation requirements for durable medical equipment (DME) do not burden Medicare enrollees. We hear from advocates that enrollees with disabilities and chronic conditions and their caregivers spend a lot of time refilling prescriptions and

procuring supplies, so it is important for CMS to work towards minimizing this burden. We support the proposal to not require the Medicare enrollee to provide specific quantities remaining when confirming the refill need. We recommend CMS require the supplier to offer multiple modalities for contacting enrollees about refills (including at a minimum phone call, text message, and email) and to allow enrollees to select their preferred method as well as an alternate method.

CMS also asks whether there are certain diagnosis/device combinations that should not require monthly enrollee refill confirmation. There are likely many enrollees with disabilities and chronic conditions who do not experience frequent fluctuations in DME needs and we recommend CMS conduct enrollee focused research on this topic to identify whether there are common situations that could be exempted from this policy. We also recommend considering the specific situations people dually eligible for Medicare and Medicaid may encounter to ensure Medicare's refill policies are not conflicting with Medicaid's or causing confusion or extra burden. In addition, we recommend CMS consider a person-centered approach to this question by implementing a process for suppliers to ask the enrollee whose needs do not fluctuate if they want to be contacted monthly to confirm their refills. Some individuals may prefer that contact as a reminder, whereas others may prefer less frequent contact.

Conclusion

We urge CMS to uphold Medicare's home health coverage law 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. 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, Director of Federal Health Advocacy, at nkean@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director of Health Advocacy