JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

October 2, 2023

To: Senate Committee on Finance
Attn. Editorial and Document Section
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From: Justice in Aging
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Submitted via email: Statementsfortherecord@finance.senate.gov

Re: September 19, 2023, Subcommittee on Health Care Hearing on "Aging in Place: The Vital Role of Home Health in Access to Care"

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 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

[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.

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

[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.

[3] *See 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.")

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 discriminatory 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 Act[6] 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]

[4] KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (2023)
[5] CA Dept. Social Svcs, IHSS Program Data (last updated Aug. 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).

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 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.

[8] Justice in Aging, Medicaid's Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today - Justice in Aging (Sept. 2021).
[9] ADvancing States, ARPA HCBS Spending Plan Analysis (Mar. 2023).

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