

# Medicare and Home Health: Taking Stock in the COVID-19 Era

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### ABSTRACT

**ISSUE:** The impact of the COVID-19 pandemic on Medicare home health has received little attention.

**GOALS:** Understand the effects of COVID-19 on Medicare home health beneficiaries, providers, and policies, and examine changes to improve home health care during and after the pandemic.

**METHODS:** An analysis of the current Medicare home health sector, including interviews with home health agencies, and a review of recent policy changes.

**KEY FINDINGS:** Data on COVID-19's impact on home health are lacking. COVID-19 infection rates among Medicare beneficiaries and the workforce have not been systematically reported during the pandemic. Federal policy changes made in response to COVID-19 have provided financial support to home health agencies, expanded provider licensures to certify use of home health, facilitated wider use of telehealth, and increased flexibility in Medicare Advantage plans.

**CONCLUSION:** Home health care is well positioned to provide services to Medicare beneficiaries. However, the current design of the Medicare home health benefit is not sufficient to meet the needs of postacute beneficiaries. Policy changes could potentially increase the value of the Medicare home health benefit in the COVID-19 era. Questions also remain about the relative quality of services, particularly among home health agencies working with Medicare Advantage plans.

### TOPLINES

- ▶ Data on COVID-19 infection rates in home health are not systematically reported.
- ▶ Home health could be an important care option for Medicare beneficiaries during the pandemic.



## INTRODUCTION

The COVID-19 pandemic has upended the entire health care delivery system in the United States, including home health. Older adults and individuals with underlying chronic health conditions are at greater risk for complications and death from COVID-19, the very population served by Medicare’s home health benefit.<sup>1</sup> Yet the full impact of COVID-19 on Medicare beneficiaries and the home health workforce remains unknown.

To better understand these effects, we analyzed peer-reviewed and grey literature on Medicare home health, interviewed home health providers about their experience during the pandemic, and examined recent federal policy changes made in response to COVID-19. The findings suggest that the current design of the Medicare home health benefit is not sufficient to meet the needs of postacute beneficiaries. Changes to the benefit could allow more Medicare beneficiaries to receive services in their own homes, rather than institutional settings, so they may reduce their exposure to COVID-19.

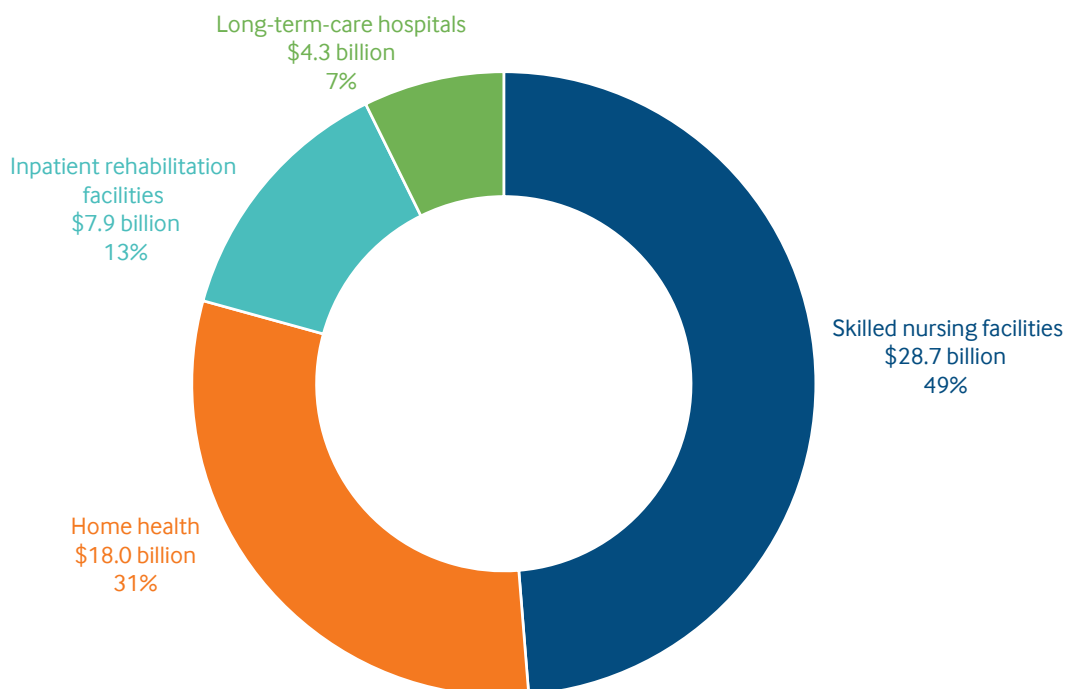
## WHAT DOES MEDICARE CURRENTLY COVER FOR HOME HEALTH?

### What It Covers

Eligibility for home health services through Medicare hinges on an individual’s homebound status. The two primary groups eligible for home health services are 1) individuals who need postacute, skilled care after a hospitalization, and 2) individuals with longer-term, skilled care needs that do not typically follow a hospitalization.

Until 2013, a narrow interpretation of eligibility for those in this second group who require continuous skilled care had been a barrier to home health care for many beneficiaries. However, the *Jimmo v. Sebelius* settlement agreement clarified that Medicare coverage of services, including home health, is based on individuals’ need for skilled care and not their potential for improvement. This reaffirms that Medicare must cover the cost of home health care for beneficiaries with long-term skilled care needs.<sup>2</sup>

Exhibit 1. Medicare Fee-for-Service Spending on Postacute Care, Fiscal Year 2017



Data: Medicare Payment Advisory Commission, 2019.

Medicare beneficiaries who need postacute care can choose among home health, skilled nursing facilities (SNFs), or long-term-care hospitals, and beneficiaries with different preferences may select different options (Exhibit 1).

Home health includes skilled nursing care, such as physical and occupational therapy, speech language therapy, and medical social services delivered in an individual's home. Location may drive an individual's choice of setting, as home health is not available in some rural areas; the vast majority of providers (84%) are located in urban areas.<sup>3</sup> Perceived quality also could drive setting choice, as postacute care quality in an SNF has been shown to be higher than in home health.<sup>4</sup> Finally, availability of a caregiver at home may drive setting choice because many basic services needed posthospitalization, such as meal preparation, are not covered by Medicare.

### What It Doesn't Cover

Medicare's home health benefit is not a long-term services and supports (LTSS) program, and it does not provide unlimited coverage. It is restricted to skilled care (rather than support of instrumental activities of daily living, which is covered by Medicaid) and covers fewer than eight hours per day and less than 28 hours per week.<sup>5</sup>

These limitations mean that Medicare beneficiaries who require skilled care and help with activities of daily living need to secure and coordinate two providers under two payment systems: Medicare and either Medicaid or private pay. These beneficiaries may be at risk for poor outcomes because of lack of coordination between providers. Home health aide shift changes alone, for example, are associated with increased likelihood of hospital readmission within 30 days of initial discharge.<sup>6</sup> Thus, better care coordination within and across agencies likely could improve home health beneficiary outcomes.

## FINANCING HOME HEALTH

### Sources of Public Funding

Medicare is the single largest payer of home health services, accounting for \$40 billion in fiscal year 2018, followed by Medicaid (\$35 billion in fiscal year 2018).<sup>7</sup> This \$40 billion accounts for 5.3 percent of the \$750 billion in total Medicare spending and more than 31 percent of total Medicare spending on postacute care (Exhibit 1).

Medicare payment for these services remains a contentious policy issue. Medicare margins are viewed as high, leading the Medicare Payment Advisory Commission (MedPAC) to recommend a reimbursement cut for future years.<sup>8</sup> The large amount of federal funding directed to this benefit underscores the importance of efforts to ensure Medicare home health is both sustainable and cost-effective for the long term.

### Medicare Payment

In recent years, the Centers for Medicare and Medicaid Services (CMS) has changed how it pays for home health services in an attempt to reduce costs while improving quality and outcomes. In 2020, CMS implemented a new prospective payment system with a new case-mix classification model, the Patient-Driven Groupings Model. The new system shifts reimbursement toward bundled payments based on patients' clinical characteristics rather than fee-for-service payments based on the volume of therapy visits. Providers receive two separate payments: one when care is initiated and the second when the episode of care is complete, with the episode of care reduced from 60 days to 30 days.

The new prospective payment system should produce a 3.4 percent payment increase for rural providers in 2020, on top of existing differences in home health payments between urban and rural areas because of rural add-on payments.<sup>9</sup> Yet there is limited evidence that rural add-on payments increase access for rural residents. Rural add-on payments also may not improve quality, as current evidence indicates that quality of care is better in urban areas compared with rural areas.<sup>10</sup>

Other efforts to reduce home health costs while improving quality and outcomes include the Value-Based Purchasing Model, implemented in nine states since 2016.<sup>11</sup> Value-based programs support CMS's mission to provide better individual care and achieve better population health at lower cost by using incentive payments to health care providers.<sup>12</sup>

## DEMOGRAPHICS: WHO USES HOME HEALTH?

### Number of Beneficiaries and Providers

Approximately 4.5 million people used some form of home health in 2016 (Exhibit 2).<sup>13</sup> Most home health users (78%, or approximately 3.5 million) were Medicare beneficiaries.

More than 12,000 home health agencies are registered in the United States, and the vast majority (81%) are for-profit entities.<sup>14</sup>

### Differences in Use by Race/Ethnicity

Racial and ethnic minority groups who use home health are more likely than white beneficiaries to have poor health outcomes, including more emergency department visits and rehospitalizations.<sup>15</sup> Emerging evidence also shows these same populations are disproportionately impacted by COVID-19, compared with other populations requiring home health.<sup>16</sup>

Despite evidence of poorer outcomes, delayed access to Medicare home health services does not seem to be a factor. Overall, there is little evidence of access barriers by race or ethnicity, with nonwhite beneficiaries more likely to receive services compared with white beneficiaries.<sup>17</sup> Understanding whether there is differential access to high-quality agencies by race and ethnicity and uncovering other driving factors will be critical to understanding why certain groups using home health have poorer health outcomes.

Exhibit 2. Demographics, Characteristics, and Chronic Conditions of Users of Postacute Care

	Home health	Skilled nursing facilities
<b>Age</b>		
Under 65	18.1%	16.5%
65 and older	81.9%	83.5%
<b>Sex</b>		
Male	39.1%	35.4%
Female	60.9%	64.6%
<b>Race/Ethnicity</b>		
Hispanic	7.4%	5.4%
Non-Hispanic White	76.1%	75.1%
Non-Hispanic Black	12.9%	14.3%
Other	3.7%	5.1%
<b>Chronic conditions</b>		
Alzheimer's and other dementias	32.3%	47.8%
Arthritis	59.6%	26.2%
Diabetes	45.1%	32.0%
Heart disease	55.0%	38.1%
Hypertension	88.9%	71.5%

Note: Definition of heart disease varies slightly by setting.

Data: Adapted from Lauren Harris-Kojetin et al., *Long-Term Care Providers and Services Users in the United States, 2015–2016*, series 3, no. 43 (National Center for Health Statistics, Feb. 2019).

## HOME HEALTH WORKFORCE: WHO ARE THE PROVIDERS?

Approximately 2 million people work as personal care aides, and another 800,000 work as home health aides serving Medicare, Medicaid, and private-pay patients with diverse needs.<sup>18</sup> There is some overlap in the work of personal care aides and home health aides despite differences in the training and certifications that are required. Home health aides are primarily female (88%), with a median age of 45 and no formal education beyond high school (50%). More than half of home care workers are nonwhite, and one-quarter were born outside the United States.

Median wages among home health aides vary by region but tend to be low; in 2017, the average hourly wage of home health and personal care aides in the U.S. was \$11.12.<sup>19</sup> Wages have been stagnant during the past 10 years with a mere 10 cents per hour gain in real terms. One-third of home care workers live below 138 percent of the federal poverty level, and 18 percent are uninsured. Paid sick leave and other employment benefits are uncommon.

Little formal training is required of the home health workforce, although for providers certified by Medicare and Medicaid, home health aides must have 75 hours of training and pass a competency exam.

Providers of skilled rehabilitation services in home health, such as occupational or physical therapy, receive much higher wages, reflecting their formal training and licensure.

## HOME HEALTH DURING COVID-19

### Initial Reductions in Demand and Access to Patients

Medicare home health beneficiaries are particularly vulnerable to COVID-19 because of advanced age, prevalence of chronic conditions, and recovery posthospitalization. Two COVID-19 phenomena have significantly reduced use of home health care: substantial decreases in elective surgeries and reluctance of Medicare beneficiaries to allow providers into their home out of fear of infection.<sup>20</sup>

In a recent survey, 92 percent of home health agencies reported lower revenues since the pandemic began, with nearly two-thirds reporting a revenue decline of at least 20 percent; smaller, stand-alone agencies likely experienced greater financial challenges than larger agencies.<sup>21</sup> COVID-19 infection rates among Medicare home health beneficiaries or agencies have not been reported during the pandemic, and any in-person services are provided without a clear understanding of whether workers or beneficiaries are infected. In contrast, data on nursing facility cases, including workers and beneficiaries, have been collected and released.<sup>22</sup>

### Lack of Personal Protective Equipment and Respiratory Services

Like many health care providers, home health agencies often struggle to maintain an adequate supply of personal protective equipment (PPE), which is essential to protect both providers and consumers from the spread of infection. These challenges have received far less national attention than the shortages experienced in other settings, such as SNFs and hospitals.

Rural agencies also lack skilled respiratory services compared with urban agencies.<sup>23</sup> This could be a significant problem during COVID-19 because these providers facilitate patient lung function recovery.

## COVID-19 POLICY AND REGULATORY CHANGES

### CARES Act

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, the \$3 trillion COVID-19 stimulus plan passed by Congress on March 23, 2020, allocated \$100 billion to health care providers. Of this, \$50 billion has been distributed to hospitals and LTSS providers, including home health agencies that bill Medicare, but there is little reporting on the proportion allocated to these agencies.<sup>24</sup>

The CARES Act allows nurse practitioners, clinical nurse specialists, and physician assistants to certify and recertify a Medicare beneficiary's eligibility for home health

services.<sup>25</sup> Prior to the CARES Act, only physicians were allowed to make this determination. This temporary policy change may be particularly helpful in areas with limited provider availability, including many rural communities. However, the change also may increase the risk of overutilization and open the door for potential fraud.

### Telehealth

Effective March 1, 2020, Medicare beneficiaries were provided sweeping expanded access to telehealth services. However, the ability for home health agencies to bill Medicare for telehealth remains limited, as only in-person visits can be reported on the claim.<sup>26</sup>

Limiting the ability to bill for telehealth may reduce the potential for fraud and overbilling of Medicare. However, strengthening telehealth access could enable critical monitoring of patient status at a time when beneficiaries are not eager to have providers visit their homes. Overall, expanded telehealth billing authority could reduce unmet needs for home health users.

### Medicare Advantage

CMS gave Medicare Advantage (MA) plans more regulatory flexibility so they could avoid disruptions in care and offer more nonmedical benefits.<sup>27</sup> This builds on CMS' changes in 2019 allowing MA plans to provide non-health-related benefits and cover in-home care services, caregiver supports, and palliative care.<sup>28</sup> Such supplemental benefits may be particularly useful for beneficiaries who require home health care and could complement the care Medicare fee-for-service covers, including meal delivery, nonmedical transportation, home modifications to support home living, and other social supports.

## POLICY IMPLICATIONS

Several policy changes could potentially increase the value of the Medicare home health benefit in the COVID-19 era.

### Expand Opportunities to Provide Care at Home

- **Better integrate home health, health care, and social care.** Including social care programs and nonmedical benefits in traditional Medicare is important for addressing all of an individual's needs and could help integrate LTSS (including home health) into the health care system and particularly benefit individuals recovering from COVID-19.<sup>29</sup>
- **Create a more robust benefit for postacute care at home.** As structured, Medicare's coverage of postacute care at home is inadequate to meet the needs of many patients returning home from the hospital. If Medicare were to cover more than one home health visit per day, it could help close the quality gap between SNF and home health care, avoid unnecessary institutional postacute care, and reduce costs.<sup>30</sup> Expanding the coverage conditions for telehealth home health visits also could help address the postacute care needs of patients recovering from COVID-19.
- **Pay family caregivers supporting COVID-19 patients' recovery.** Training and paying family caregivers to care for patients during the postacute period could accelerate patients' recovery from COVID-19 and prevent costly, negative outcomes for both beneficiaries and caregivers.<sup>31</sup> Medicare also could help support family caregivers by providing PPE to protect them from infection while they care for family members recovering from COVID-19 at home.

### Bolster the Home Health Workforce

- **Increase pay of home health aides to improve the quality of care.** Although home health agency reimbursement is already tied to regional wages, CMS could add a wage and benefit increase to payments for home health aides. Such a wage premium could help address the extra hazards involved in providing

direct care during a pandemic. Increased benefits such as paid sick leave also could promote safety during the pandemic and beyond by reducing the need for aides to work and earn when they are sick. These changes also could help address worker shortages (already a problem before COVID-19), increase retention, and lead to higher quality of care in the long term.<sup>52</sup>

- **Expand scope of practice.** As previously discussed, the CARES Act allows nurse practitioners, clinical nurse specialists, and physician assistants to certify a person's need for home health. Yet their scope of practice beyond this remains limited. Making these expansions permanent and evaluating other expansions in scope of practice could help support and enhance the quality of the home health workforce.

### Enhance Quality and Oversight

- **Expand regulatory oversight of home health agencies to motivate adoption of best practices.** Increasing oversight, which is currently limited, and allowing public access to agencies' emergency preparedness plans could improve their responses in future pandemics.
- **Reduce knowledge gaps.** Data on use of home health by Medicare Advantage enrollees are limited, and the data that do exist appear to show that home health agencies included in MA plans are of poorer quality compared with those in traditional Medicare.<sup>53</sup> Expanding MA plans to cover non-health-related benefits, such as palliative care or in-home support services, could change the quality of home health care overall for MA enrollees. Evaluating home health quality and outcomes by MA status could determine the relative benefit of these added services, especially during the COVID-19 pandemic.

- **Report COVID-19 data.** Given the lack of publicly available information about COVID-19 infections among Medicare home health beneficiaries and the workforce, the government could require that agencies report these data, as nursing homes are required to do. Ideally, these reports would be distinct from general population case reporting and could establish greater parity of COVID-19 data between home health agencies and skilled nursing facilities.

### CONCLUSION

The impact of COVID-19 on Medicare home health services is not fully understood. More research is needed on how COVID-19 affects home health use, particularly for populations experiencing disparities in accessing care.

Home health is well positioned to offer services to individuals in their own homes, which is an increasingly important care option during the pandemic. However, the current design of the Medicare home health benefit is not sufficient to meet the needs of postacute beneficiaries.

Policy options for addressing this problem include increasing pay for home health aides; bolstering allowable visits (including telehealth) for rehabilitation and monitoring; providing enhanced regulatory oversight; and expanding providers' scope of practice beyond the changes in the CARES Act. Careful evaluation of rule and policy changes could help identify any unintended consequences and elucidate whether the benefits of such initiatives exceed the costs.

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## ACKNOWLEDGMENTS

The authors would like to thank Bob Thomas and Mary Kofstad for providing background and experience during the COVID-19 pandemic. In addition, recent collaborations with Dr. Nathan Boucher and Dr. Rachel Werner have informed our writing.

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*Editorial support was provided by Laura Hegwer.*

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