

Center For Medicare Advocacy Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved ¹

Home health services as authorized by Medicare law, regulations, and policies² are too often unavailable in practice. For example, for patients who meet qualifying criteria, Medicare law authorizes up to 28 to 35 hours a week of home health aide personal hands-on care and nursing services combined, as well as therapies and medical social services.³ “Personal hands-on care” as defined by law includes many services. While bathing is included, it also includes dressing, grooming, feeding, toileting, transferring and other key services that help an individual remain healthy and safe at home.⁴ Unfortunately, patients can rarely access this level of Medicare-covered care. As reflected in a recent study by the Center for Medicare Advocacy, access problems are especially true for beneficiaries with chronic and longer-term conditions who need services to maintain or slow decline.⁵

From April 28, 2021-November 19, 2021, the Center for Medicare Advocacy (the Center/CMA) conducted a survey of 217 Medicare-certified home health agencies (HHA) in 20 states to learn what beneficiaries may experience when seeking home care.⁶ The agencies were identified through the Care Compare search tool at www.medicare.gov. The Center inquired about home health services available from each agency for a hypothetical patient with an authorized practitioner’s order certifying one hour of physical therapy per week, one hour of skilled nursing per week, and 20 hours of home health aide services per week.

All agencies indicated that they would be able to provide one hour of physical therapy per week, and 99% said they could provide one hour of skilled nursing care per week. Responses about home health aide services, however, were very different. 15% of agencies did not provide a clear answer regarding available home health aide services. Those that did provide an answer demonstrated overwhelmingly that home health aide services are not available in an amount even approaching the benefit as defined by Medicare law. This trend was present in rural and urban areas across all 20 surveyed states.⁷

Further, in order to see if accurate information about the Medicare home health benefit is available from the Centers for Medicare & Medicaid (CMS) – the federal Medicare agency – the Center made 10 calls to the official CMS Medicare help line, 1-800-MEDICARE. Center staff asked the same questions regarding services available for the same hypothetical patient as they asked home health agencies in the survey. Unfortunately, the information provided by 1-800-MEDICARE was inconsistent and often inaccurate.

I. 217 Agency Survey Results: Home Health Agencies Won't Provide 20 Hours of Home Health Aide Services, although the law authorizes 28 or more hours/week for beneficiaries that meet Medicare criteria.

<i>Would you be able to provide 20 hours of home health aide services?</i>		
Total Clear Answers *	Yes	No
185	4% (8 agencies)**	96% (177 agencies)

* Note: 32 agencies did not offer a specific yes/no answer.

**While 8 agencies reported yes, they would provide 20 Hrs. per week of aide services, when asked to specify a weekly maximum of aide hours, only 4 agencies said they would provide at least 20 hours per week.

<i>How many hours of aide services can you provide a week?</i>		
Total Clear Answers*	20 Hrs. or more	6 Hrs. or less⁸
164	2% (4 agencies)	95% (155 agencies)

* Note: 53 agencies did not offer a specific yes/no answer

**While 8 agencies reported yes, they would provide 20 Hrs. per week of aide services, when asked to specify a weekly maximum of aide hours, only 4 agencies said they would provide at least 20 hours per week.

II. Survey Respondents Reveal Widespread Misunderstanding of Medicare Coverage Law

A. Home Health Aides: Agencies Improperly Limit Medicare-Covered Home Health Aide Services

The Center's survey callers read the list of home health aide services authorized in the Medicare regulations⁹ and asked each agency respondent if they could provide a qualifying patient with 20 hours of aide services, in conjunction with weekly skilled nursing or physical therapy. In answering the question, 20% of agencies from 17 states volunteered unsolicited, incorrect information about Medicare coverage to explain why they would not provide this quantity or type of home health aide services.

Examples

- "Home health aides don't do anything directly. Work is usually sprung on an occupational therapist." (MA)
- "Medicare covers aides only twice a week, for about 1-2 hours, mainly for personal care." (CA)
- "Our home health aides don't help with all that stuff. The aide services have to meet Medicare coverage criteria." (CA)
- "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." (MI)
- "Skilled services are usually covered, but (Medicare) can't cover all those aide hours." (CT)
- "20 hours per week would be a homemaker." (IL)
- "Medicare doesn't cover home health aides." (KS)
- "Medicare allows us up to 3 (aide) visits per pay period" (MI)

- “A home health aide is a maximum of an hour visit twice a week. That’s what Medicare allows.” (MD)
- “It’s not common practice to have home health aides with Medicare.” (MN)
- “Medicare doesn’t cover 20 hours of home health aides.” (OH)
- “What we’re explaining is in-home care. The state Medicaid program will pay for in-home care (but Medicare will not).” (OR)
- The agency provides “only two or three home health aide visits per week, because insurance won’t cover more than that.” (TX)
- “The most aide services that could be provided is an initial 2 visits a week. That would be reduced over 30-60 days of services.” (MI)
- The agency can provide one hour of an aide per week. “This is all Medicare covers.” (UT)
- “Medicare does not cover the cost of home health aide services like this.” (WV)
- “These sorts of services would not be covered by Medicare.” (WV)
- “Home health aide isn’t a Medicare-covered service.” (WY)

B. Home Health Aides: Agencies Often Limit Aide Services to Bathing and Grooming

Continuing a trend identified by the Center in a 2016 survey of home health agencies, over 20% of agencies in 15 states volunteered the misinformation that bathing and grooming are the only services provided by home health aides. Indeed, across the country many agency respondents referred to home health aides as “bath aides.” Some agencies identified bathing as a skilled aide service, as opposed to other, “unskilled caretaking” aide services.

Examples

- “Home health aides can only bathe and then leave.” (GA)
- “Aides are for bathing and dressing. They don’t stay.” (MI)
- “Aides are only for showering.” (AZ)
- Home health aides are “just shower people.” (CA)
- “A home health aide assists with bathing and dressing, and that’s it.” (FL)
- “Home health aides typically help with bathing and light cleaning.” (IL)
- “Home health aides are only available for up to two times a week for showers.” (LA)
- “Home health aides are just there to assist with bathing and dressing safely.” (MD)
- “Aides only do showers.” (MN)
- Home health aides only do a skilled visit of bathing, dressing, or grooming. The agency considers other services “unskilled caretaking,” which the agency does not provide. (OH)
- “A home health aide is a bath aide.” (OR)
- Home health aides are “just basically for helping with showers.” (PA)
- “It’s usually about 1 time a week to help with bathing” (MI)
- Home health aides are “only available for one hour and only to bath and dress the patient.” (TX)
- “Medicare will only cover a bath or two per week.” (UT)
- Home health aides “go in once or twice (per week) to bathe.” (WV)
- “Medicare only covers bathing and showering.” (WY)

C. Home Health Aides: Agencies Improperly Apply Medicare Qualifying Criteria

Agencies across the country showed confusion about the meaning of home health care services, benefits, and definitions. They frequently commented that the aide services listed in the survey

(taken verbatim from the Medicare regulations) are not tasks that an aide performs. Some representatives criticized the hypothetical patient or ordering physician because the services were “not appropriate,” or were “too much.” There was also notable confusion about the definition of “personal care” (which is defined in federal regulations), with several agencies stating that the list of aide services did not constitute personal care, or confusing Medicare-covered personal care services with private duty care or personal assistance. These agencies often suggested hiring a private-pay aide, seeking services through Medicaid, or moving the patient to institutional care.

Examples

- “If a patient can’t toilet themselves, they shouldn’t have a home health aide.” (MA)
- “If a patient is not able to do these sorts of things, someone would need to help them get into a facility.” (OR)
- “Medicare tightened up in the 80’s. They used to provide 15 hours a week (of aide services), but then they caught on.” (CA)
- “It doesn’t sound intermittent with that amount of aide hours.” (IL)
- “Once it turns to custodial care, we would refer the patient to a different agency.” (MD)
- “Home health aide is private-duty. 20 hours is PCA (Personal Care Attendant) services.” (MN)
- This (aide services) is a private duty service. (WV)
- “Home health aide hours would be provided through a personal care agency that is not Medicare certified.” (UT)
- “Personal care services are covered by Medicaid” (and not by Medicare). (MD)
- “20 hours of home health aides is not appropriate.” (OR)
- “Just because a physician orders it, doesn’t mean it’s appropriate.” (NY)
- “20 hours (of aide services) is too much.” (OH), (MD), (UT), (WY)

D. Improvement Standard: Agencies Often Apply An Illegal Improvement Standard to Limit Medicare-Covered Services

Responses from the home health agencies also make it clear that, despite the settlement and federal court decisions in *Jimmo v. Sebelius*¹⁰, agencies regularly and incorrectly state that improvement is required for Medicare home health coverage. For example, 33% of agencies answered “no” to the question, “Does your agency offer Medicare-covered services to maintain a person’s condition or prevent their decline?”

Examples:

- “They can’t cover a chronic condition under Medicare. We can only do this with Medicaid services or a different insurance provider.” (MA)
- “Medicare provides temporary intermittent care. The goal is to teach caregivers how to care for the patient, then discharge.” (GA)
- “We don’t take maintenance patients, *per se*. We may see them for a few weeks to teach or train their family members to care for them.” (MI)
- “We try not to keep them on, because home health is supposed to be short-term.” (GA)
- “Once they’re better, we discharge.” (TX)
- “We won’t keep someone on just to maintain.” (TX)
- “Will they stay more than 60 days? Only if there is a non-healing wound. Then we can get the doctor to allow them to stay longer.” (MI)

- “Medicare does not pay for us to maintain. They have to be able to meet goals.” The respondent said that this question went directly against Medicare policy, and that the Center should obviously know this. (WY)
- “Medicare-covered services are there to help someone recover from an acute condition ... or to help them get back to a previous state. So it's a goal, and they want to reach that goal.” (MN)
- “This is not Medicare-covered. They must improve.” (LA)
- “Chronic care is not covered by Medicare.” (MD)
- “We’re not a long-term program.” (NY)
- “We do acute care, not chronic care.” (NY)
- “We don’t do maintenance services under skilled care.” (OH)
- “Once they hit baseline, home health is no longer necessary.” (OR)
- “Typically Medicare doesn’t cover those services.” (PA)
- “It's hard to keep longer term patients qualified and we get audited a lot.” (MI)
- “They have to show improvement.” (WV)
- “According to Medicare guidelines, we can’t provide Medicare services if a patient plateaus.” (FL)

III. Calls to 1-800-MEDICARE Yield Inconsistencies and Misinformation

In 2016, the Center made six calls to 1-800-MEDICARE, the official Medicare agency helpline, asking about home health services. At that time, the Medicare representatives read from a script that provided consistent and accurate information. In 2021, 15 similar calls were made to 1-800-MEDICARE, inquiring about home health services available to the survey project’s hypothetical patient. This time, responses were varied and often highly inaccurate. Seven of the calls yielded at least one incorrect statement about Medicare coverage.

A. 1-800-MEDICARE Information on Home Health Aides

All fifteen 1-800-Medicare representatives indicated that physical therapy, occupational therapy, and home health aides would be covered, but there was significant confusion about the duration of home health aide coverage. One Medicare representative stated there is a 30-day limit to aide services, four gave vague or unclear answers, and five said that an aide would be covered for up to three weeks, up to 28 hours a week. Although four Medicare representatives mentioned that the duration of services could be extended with recertification, this information was only provided after they were asked a specific follow-up question. There was also a wide range of information given about the services home health aides could provide. On the one hand, two Medicare representatives said that aides could assist with household activities such as retrieving mail. Two others, however, explicitly stated that “custodial care/home-making services” would “never” be covered by Medicare.

B. 1-800-MEDICARE Information About Improvement

Responses to inquiries about maintenance therapy were varied and unclear. Only five calls resulted in an unambiguous yes as to whether a patient could receive care if their condition was not expected to improve. Two CMS representatives provided vague responses which did not answer the question, even with follow-up questions; two indicated that improvement was an area of “fine print” which would usually be denied; and one CMS representative stated outright that maintenance services would never be covered.

C. 1-800-MEDICARE Information About Medicare Advantage Plans

Even more inconsistent were responses to questions about Medicare Advantage plans. Four CMS representatives indicated that traditional Medicare would set the baseline which Medicare Advantage plans could only exceed, four claimed that traditional Medicare guidelines have no bearing on Medicare Advantage coverage, and two indicated that Medicare Advantage plans generally cover less than traditional Medicare. One CMS representative claimed that Medicare Advantage *should* provide more than traditional Medicare, but does *not* in practice.

Examples

- “The longest I’ve ever seen it (home health services) last is 100 days.”
- Medicare covers aides only for “bathing, showering, or grooming.”
- “If the patient is not improving, it becomes an area of fine print.”
- Skilled nursing and home health aide services will probably be short term, but “we’ll cross that bridge when we get there. If 6 months goes by and she’s not getting better, we might want to revisit – why are we paying for these services if she’s not getting better?”
- The patient’s condition “must be expected to improve within a reasonable time.”
- “Some things in the original Medicare plan wouldn’t necessarily be covered” by Medicare Advantage.
- Home health “services are provided over a three-week period. That’s the maximum.”
- If the patient “is under an Advantage plan, none of this information applies in that case.”
- “This (home health care) is not long-term care. There must be recovery to be covered.”
- Medicare covers aides for “bathing and light housekeeping.”
- Medicare Advantage plans “should be the same, but are different in practice.”
- “Once you get to a certain dollar amount, the therapist would have to submit something to Medicare for reverification.”

IV. In Practice, Medicare Advantage Plans Provide Less Than Traditional Medicare

The Medicare Act mandates that Medicare Advantage plans cover, at least, all the medically necessary services that traditional (also known as “original”) Medicare covers.¹¹ However, when surveyed home health agencies were asked if there were differences in the services they could provide to clients enrolled in Medicare Advantage plans versus clients with traditional Medicare coverage, their comments describe a very different reality. Agencies from 16 different states volunteered that in their experience, Medicare Advantage plans provide less to patients and require more of agencies.

Major themes among agency comments were that Medicare Advantage plans deny more services, allow fewer visits per care modality, delay onset of care, lead to more changes to provider-approved plans of care, are significantly harder for agencies to work with, and require greater out-of-pocket costs. Many agencies also mentioned discrepancies in care caused by the pre-authorization process.

Examples

- “Abso-freakin-lutely! Medicare Advantage plans in our area are rotten.” (KS)
- “Very much so, there’s a difference. Medicare Advantage plans don’t approve as much services.” (LA)

- Medicare Advantage patients are reimbursed for less, and do not have therapy covered. Typically they only provide nursing services.” (OH)
- “The payment model is different so we can’t take as many Medicare Advantage beneficiaries. Traditional Medicare is better.” (WV)
- “Medicare Advantage plans typically offer less coverage.” (IL)
- Medicare Advantage plans will cut services prematurely, and there are no plans in the area that will cover home health aides. “When we submit the bill, it’s denied.” (KS)
- Coverage for OT services is “difficult with Medicare Advantage plans.” (KS)
- “We can have some restrictions on the care we offer for Medicare Advantage plan holders.” (FL)
- Medicare Advantage “might determine the length of time” the agency can provide services. (MN)
- “Medicare Advantage plans typically allow for between 7 to 12 visits. Sometimes more visits are requested and they are denied by the plan.” (MI)
- Aetna Medicare Advantage does “not provide home health aides for Aetna beneficiaries.” (NY)
- “Some Medicare Advantage plans will not reimburse for Medical Social Services.” (CT)
- “Humana will only approve a limited number of visits. People's Health provides a specific number of allowed visits. Up to 4 nurse, 6 PT, 0 OT, 4 aides, ST 6. They don't approve any maintenance. You must make progress toward improvement.” (LA)
- Some Medicare Advantage plans will never authorize aide services – like Anthem BCBS. They use an authorization company called MyNexus and won’t allow aide services.” (CT)
- “Medicare Advantage plans can be very limiting. Anthem and Humana are terrible, and very often do not cover services that patients need.” (OH)
- “Medicare Advantage plans often fight tooth and nail on the number of visits they will allow. Anthem is the worst. They use MyNexus, a company for prior authorization work, and allow very few visits.” (CT)
- “MA authorizations are limited. We [the agency] fight and appeal for more services. United Healthcare and Aetna provide particular coverage challenges.” (CT)
- “Managed Medicare seems to be a lot stingier with what they authorize than traditional Medicare. (OH)
- “Everything that is Medicare Advantage needs to be pre-approved, which may result in a delay in services.” (NY)
- “There is typically a delay in getting to the Medicare Advantage patients, since we have to wait for authorization before we can schedule assessments.” (CT)
- “Prior authorization is a hurdle.” (PA)
- Authorization “can delay services and have different guidelines. It’s just a little tighter when it’s an Advantage plan.” (OH)
- “Medicare Advantage requires authorization, which might change the plan of care.” (GA)
- “Some Medicare Advantage plans have conditions which can complicate things.” (The agency can still provide services, but exactly what those services entail may vary.) (UT)
- “Medicare Advantage complicates things.” (AZ)
- “What we might see as a medical necessity, a Medicare Advantage plan might not.” (OH)

V. CMS’s “Star Rating” Criteria Reward Agencies for Avoiding Patients Whose Condition Will Not Improve

There are two types of agency ratings listed in the Care Compare tool on Medicare.gov. First, “Quality Ratings” (Quality of Patient Care Star Ratings, “QoPC”) show “how a home health

agency compares to others on measurements of their performance.”¹² The QoPC are based on agency patient assessments and Medicare claim data on seven individual quality measures. Five of these seven measures explicitly score for patient improvement.¹³

The second agency ratings system listed on Care Compare is the patient satisfaction survey entitled Home Health Consumer Assessment of Healthcare Providers and Systems, or HHCAHPS.¹⁴ In contrast to the outcome-based QoPC ratings, the HHCAHPS’ 34 questions ask about health care providers, administrative staff, or the patients themselves.

In the Center for Medicare Advocacy’s survey, there was a correlation between agencies’ Quality Ratings and whether they were part of a large national chain¹⁵. Large chains had an average QoPC of 4.04 stars, while other agencies had an average of 3.37 stars. No relationship was found between Quality Ratings and any other element of the survey.

Over 70% of a home health agency’s QoPC is based on improvement. There is no measure that reflects an agency’s success at helping patients to maintain their level of function or slow their decline. In order to earn a higher Quality Rating, an agency is incentivized to serve more clients with acute conditions or short-term needs, because patients with chronic or long-term conditions are less likely to improve. The significantly higher Quality Ratings earned by agencies affiliated with large chains suggest that those agencies serve fewer clients with chronic or long-term conditions, as care focused on maintaining a patient’s condition or slowing their decline will result in a lower score on the CMS Quality Rating scale.

Patient Satisfaction Ratings were not found to have a significant correlation with any other element of the Center’s survey; notably, no significant relationship was found between Quality Ratings and Patient Satisfaction Ratings. This lack of correlation reflects the differences in the measurements’ standards. While the QoPC centers on patient improvement, the HHCAHPS tool does not address improvement at all. Instead, it focuses on process-based and qualitative measures related to a patient’s interactions with an agency’s employees.

Neither ratings system correlated to any substantive item in the Center’s survey, including whether an agency communicates accurate information about Medicare-covered services to patients, serves patients with chronic or long-term conditions, or actually provides all Medicare-covered services as ordered in a practitioner’s plan of care. As such, the ratings available on Care Compare are at best unhelpful to beneficiaries, and at worst misleading.

VI. Summary: Medicare Beneficiaries in Need of Home Care Underserved and Misinformed

In 2016, the Center for Medicare Advocacy conducted a similar survey in which 74 responses were obtained from agencies in four states. At that time, 8% of surveyed agencies said they would offer home health aide services for 20 hours per week, and 53% of respondents would offer only 3 hours or less per week of aide services. **In the 2021 survey**, only 2% of agencies said they would offer 20 hours of aide services, and 85% would offer 3 hours or less. While the 2016 results were sobering, it is clear from the 2021 survey that the availability of home health aide services has declined even further.

There is widespread misunderstanding among home health agencies about the meaning of personal care (the legally authorized role of home health aides), the amount of home health aide hours covered by Medicare, and the legality of providing maintenance services. Agencies regularly

provide misleading or actually incorrect information about Medicare benefits, home health aides services, Medicare coverage of care to maintain or slow decline, care for longer-term or chronic conditions, and even the appropriateness of seeking home health care at all.

The Center's 2016 and 2021 surveys demonstrate that Medicare-certified agencies are regularly providing beneficiaries with inaccurate information and inappropriately limited care. The surveys demonstrate that, according to the agencies themselves, it is nearly impossible for beneficiaries to receive anything approaching 20 hours per week of Medicare-covered home health aide services under a certified plan of care although the law authorizes 28 hours – 35 hours per week if needed. According to many comments volunteered by agency respondents and 1-800-MEDICARE representatives, patients with Medicare Advantage plans often receive even more limited services than those available to patients with traditional Medicare coverage.

Misinformation is found not just at the home health provider level, but also from the Medicare agency, CMS itself. Calls to 1-800-MEDICARE yielded inaccurate and inconsistent information about Medicare's home health benefit, aide services, the improvement standard, and Medicare Advantage plans. Additionally, an examination of the two home health agency rating systems used in CMS' Care Compare reveals that the ratings do not reflect an agency's likelihood to provide patient services in accordance with the Medicare home health benefit. Rather, Quality Ratings measure patient improvement, and Patient Satisfaction Ratings reflect experience with individual health care providers and agency staff. Whether an individual contacts CMS online or by telephone, they cannot count on receiving accurate information or sound guidance.

Across the country, from their first online search at Medicare.gov, to their call to 1-800-MEDICARE or a home health agency, to their discharge from care, beneficiaries seeking Medicare-covered home health services are regularly misinformed and woefully underserved.

VII. Recommendations¹⁶

A. Properly Administer Current Medicare Home Health Coverage Laws

1. Provide Accurate, Ongoing Education About Medicare Home Health Coverage

- a. Provide ongoing education for all participants in the Medicare home health process**, including, but not limited to: CMS, Medicare contractors and adjudicators, staff at 1-800-Medicare, state licensing and enforcement agencies, home health agencies, doctors and other authorized practitioners, HHS Office of the Inspector General, General Accounting Office and Medicare beneficiaries.
- b. Review all CMS, provider, contractor, and adjudicator print and on-line materials** for consistent, accurate descriptions of Medicare-covered home health services in general, and home health aide services in particular.

2. Ensure Fair and Appropriate, Non-Discriminatory Implementation of Medicare-Covered Home Health Services, as Authorized by Law, in All CMS Practices and Policies

- a. Develop a payment system that fairly compensates providers for all patients served.**

CMS policies permit providers to choose the patients they serve, but the Payment Driven Groupings Model (PDGM) unfairly favors, and sometimes over-pays for, services to short-term, post-acute care patients while disadvantaging patients with longer-term and chronic conditions. CMS should implement proper payment alternatives that provide equal incentives to serve all patients.

b. Develop quality measurement programs, including value-based purchasing, that measure quality services for all patients who are eligible for Medicare-covered home health care under the law.

All patients deserve high-quality health care services. Quality measurement programs should properly consider every type of patient served. Current programs strongly emphasize improvement goals, and disincentivize providers from serving patients whose conditions may not improve.

c. Develop meaningful and inclusive audit and appeal systems that mirror and enforce Medicare home health coverage as authorized by law.

Currently, Medicare contractors and the Office of the Inspector General (OIG) focus on penalizing “overutilization/provision” of Medicare-covered home health services as inappropriate activity. Contractors and the OIG examine claims for patients who necessarily need more resources, for a longer amount of time, than the majority of patients, referring to agencies that care for these patients as “outliers.” and targeting them for audits. This makes agencies hesitant to serve patients with chronic and longer term needs who qualify for Medicare-covered home health care. Further, audit reports often misstate the case facts and/or misapply the facts to the law. Audits and appeals should equally, and accurately, review and reverse agencies’ decisions that inappropriately limit access to care.

d. CMS should review how the entire impact of home health practices and policies, as well as its own payments, quality measures, and audits, work together to undermine and deny home health care to specific types of patients – particularly those with chronic and longer-term conditions.

Careful oversight and enforcement of laws, regulations, and policies that authorize Medicare-covered services are minimal and need to be strengthened to protect patients. The collective impact of current payment systems, quality measures, appeal decisions, and audits is dismantling access to care for patients, especially those with longer-term and chronic conditions. CMS should develop and implement a comprehensive plan to improve practices and policies in order to advance access to care for patients who qualify under Medicare law but are inappropriately left out of Medicare-covered home health care.

The Center for Medicare Advocacy, established in 1986, is a national nonprofit, nonpartisan law organization that provides education, advocacy and legal assistance to help older people and people with disabilities obtain access to comprehensive Medicare, health equity, and quality health care. The Center is headquartered in Connecticut and Washington, DC with additional attorneys throughout the country.

Endnotes:

¹ Contributors to the survey, analysis, and writing of this report include Center for Medicare Advocacy staff: Kate Stonebraker, Nurse Consultant, Matt Shepard, Communications Director, attorneys Kathleen Holt, Eric Krupa, Rachel Oest, and Judith Stein, and Sean Pergola, Health Policy Intern, Yale College.

² Medicare Act Home Health provisions are available at 42 USC §1361(m); implementing federal regulations are at 42 CFR 409 et seq; CMS home health benefit policy is available at [Medicare Benefit Policy Manual \(cms.gov\)](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings).

³ 42 U.S.C. §1395x(m)(1)-(4). Receipt of skilled therapy can also trigger coverage for home health aides.

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

⁵ <https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf>

⁶ From 4/28/21-7/26/21, calls were made to agencies in the following 19 states: AZ, CA, CT, FL, GA, IL, KS, LA, MD, MA, MN, NY, OH, OR, PA, TX, UT, WV, WY. To confirm that findings are persistent and widespread, on 11/19/21 additional calls were made to agencies in MI.

⁷ Results are based on information communicated directly by agency representatives. The actual provision of services as stated by agencies has not been independently verified. While we originally planned to produce a directory of care available from surveyed home health agencies, the results of the survey demonstrated that available care is so limited, a directory does not seem useful.

⁸ Of 185 clear responses to the question, “How many hours of aide services can you offer a week, directly or by arrangement with another agency?” 140 agencies, or 85% of respondents to the question, stated a weekly maximum of 0-3 hours. Another 15 agencies stated a maximum of 3.5-6 hours per week. In total, 155 agencies, representing 95% of all clear responses to the question, said they could provide a maximum of 0-6 hours of aide services per week.

Frequently, agencies responded to this question with a range of hours, such as “1-3 hours per week.” The upper limit of that range was used in the Center’s data analysis. Therefore, the amount of aide services stated in this report represents the most generous interpretation of the data collected from responding agencies.

⁹42 CFR §409.45(b)(1)-(4)

¹⁰ *Jimmo v. Sebelius*, No. 5:11-CV-17 (D.VT. 2013, 2018)

¹¹ 42 USC sec. 1395w-22(a); 42 CFR sec. 422.101

¹² medicare.gov; Care Compare

¹³ cms.gov, Home Health Star Ratings, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings> (“The 7 measures that are part of the Quality of Patient Star Rating are: Timely Initiation of Care (process measure); Improvement in Ambulation (outcome measure); Improvement in Bed Transferring (outcome measure); Improvement in Bathing (outcome measure); Improvement in Shortness of Breath (outcome measure); Improvement in Management of Oral Medications (outcome measure); Acute Care Hospitalization (claims-based) (outcome measure)”).

See also data.cms.gov, “About the data, Patient care star ratings,” <https://data.cms.gov/provider-data/topics/home-health-services/about-the-data> (“The quality of patient care star rating is a summary measure of agency performance based on how well a home health agency performs on 7 of the individual quality measures reported on Medicare Care Compare. These 7 measures include: **Process of care measures** – how often the agency: Initiated patient care in a timely manner. **Outcome of care measures** – how often the patient: Got better at taking their drugs correctly by mouth; Got better at walking or moving around; Got better at getting in and out of bed; Got better at bathing themselves; Experienced less shortness of breath; Required acute care hospitalization.”)

¹⁴ https://homehealthcahps.org/Portals/0/SurveyMaterials/HHCAHPS_Questionnaire_English.pdf

¹⁵ Agencies were considered part of a large national chain if they identified themselves as affiliated with one of the following: AccentCare Inc., Amedysis, Bayada Home Health Care, Brookdale Senior Living Solutions, Compassus, Elara Caring, Encompass Home Health & Hospice, Interim HealthCare Inc., Kindred Healthcare, LHS Group Inc., or Trinity Health at Home.

¹⁶ These recommendations focus on action that can be accomplished by the Administration, without Congressional action. Legislation should also be pursued. For example, Congress should pass a stand-alone home health aide benefit in traditional Medicare, to provide coverage for hands-on personal care without a homebound or skilled care requirement. A similar, albeit limited and discretionary benefit, was recently allowed in Medicare Advantage plans. See <https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf>