Center for Medicare Advocacy
MedicareAdvocacy.org

Response to July 2023 CMS Request for Information (RFI): Eight Questions Addressing Access to Home Health Aide Services

Introduction

The Center for Medicare Advocacy (CMA) is grateful to the Centers for Medicare & Medicaid Services (CMS) for the opportunity to respond to the RFI about access to necessary home health aide services. Home health services as authorized by Medicare law, regulation and policies[1] are increasingly unavailable in practice. For patients who meet qualifying criteria, Medicare law authorizes up to 28-35 hours a week of home health aide and nursing services combined, as well as therapies and medical social services.[2] While this coverage law has not changed, home health aides services, as a percentage of total home health visits, has declined from 48% of total services in 1997 to 5% in 2021.[3] According to federal regulations, home health aides must provide "hands on personal care services," such as bathing, dressing, grooming, feeding, toileting, transferring and numerous other services that are needed to help maintain the individual's health or to facilitate treatment.[4] Unfortunately, in practice, patients can rarely access even a fraction of these Medicare-covered aide services. Patients may contact every Medicare-certified home health agency (HHA) that serves their home zip code[5], seeking Medicare-covered services, only to find no HHAs willing to provide aide services. As reflected in a recent study of 217 HHAs by CMA, aide access problems are especially difficult for homebound beneficiaries with chronic, longer-term, and disabling conditions who need both skilled and aide services to effectively maintain or slow decline of their condition and stay safe and healthy at home.[6]

As will be discussed in this RFI response, barriers to aide services have decimated access to care. These barriers include the following:

1. CMS and HHA policies and practices have de-valued and dis-incentivized the provision of aide services in Medicare-covered home health care for decades, helping to lead to the current crisis.
2. There is competition for available aides in other care settings while the demand for aide services grows substantially (both Medicare-covered and non-covered).
3. HHAs contend that aides are not available, although many workforce issues are addressable and preventable.

The full extent of barriers to aide services cannot be fully discerned until CMS takes affirmative steps to remedy current discriminatory policies and practices that discourage the provision of aide services to individuals with chronic and longer-term conditions.

RFI Question 1 - 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?

1. **Aide utilization by HHAs is declining, but patient need for aides is not declining.** In the Federal Register, Calendar Year 2024 Home Health Proposed Rule *Table B2* and *Figure B4* show the downward trend of home health aide utilization for the most recent 5-year period, a reduction of more than 40%.[7] In reality, home health aide utilization has declined steadily over the past two decades by almost 94% - from a 30-day average of 6.7 visits in 1998[8] to less than half a visit a month in 2022[9], while Medicare coverage laws, rules, and sub-regulatory guidance on the use of aides has remained unchanged. The proposed rule states *"[a]necdotally, CMS has heard that beneficiaries have had difficulty receiving home health aide visits under the Medicare home health benefit"*[10]. One simply needs to look at the decline in actual number of visits in *Table B2* and *Figure B4* to know this "difficulty" is a fact, not just an anecdote. The decline in utilization does not reflect a decline in need. CMA hears heartbreaking stories regularly from people who qualify for home health aide services but cannot find a Medicare-certified agency to provide them. For beneficiaries, especially individuals living with chronic and longer-term conditions who qualify for Medicare-covered home health care, the ability to live safely at home with quality health and dignity has declined significantly due to the lack of covered aides to assist them.

2. **Despite the precipitous decline in aide services provided by HHAs, Medicare beneficiaries need, and qualify for, aide services.** There is no question as to "if" the need for aide services remains strong. Aide services can comprise a vital part of a beneficiary's health care. The proposed rule recognizes this and states, *"[a]s the population ages, the prevalence of chronic disease increases and the need for home-based dependent services is on the rise. For eligible beneficiaries, home health services can provide a necessary adjunct to medical care in managing medical conditions; assisting with ADLs [activities of daily living];…assisting with medication management and adherence;…taking vital signs…"*.[11] In the Home Health Notice of Proposed Rulemaking for 2022, CMS expressed similar concern about the drastic decline in delivery of necessary home health aide services by acknowledging, *"home health aides deliver a significant portion of direct home health care. Ensuring that aide services are meeting the patient's needs is a critical part in maintaining safe, quality care."*[12]

3. **The decline in the provision of Medicare-covered aide services has been exacerbated by a combination of factors that were initiated decades ago and steadily eroded HHA hiring and the availability of aide services over time.** Many of these factors resulted from HHAs assimilating and applying CMS policies to their decisions about the types of patients HHAs will serve. These decisions by HHAs, discussed in more detail below, include HHAs:

A. **Adapting to CMS audit and compliance systems,**
B. **Maximizing profitability outcomes from quality and value-based purchasing incentive measures,**
C. **Responding to CMS payment reforms,**
D. **Capitalizing on the most profitable patient mix,**
E. **Refusing to provide services to patients with conditions that require more resources,**
F. **Strategically keeping aide staff low in Medicare-certified agencies while increasing aide staff in related business affiliates,**
G. **Requiring family caregivers to perform aide tasks, in violation of Medicare policy and the Medicare Conditions of Participation,**
H. **Disrespecting the value and contributions of home health aides, in violation of the Medicare Conditions of Participation,**
I. **Having the advantage of an administrative appeals system that provides patients with no practical recourse for improperly denied services, and no repercussions to HHAs.**

Aide under-utilization practices by HHAs are also abetted by: The Medicare Payment Advisory Commission's (MedPAC's) disapproval of Medicare-covered unskilled services, inaccurate published materials from CMS and the Social Security Administration (SSA) that mis-state the amount and type of aide services covered by law, and the failure of CMS and Congress to address the growing crisis. See further information from MedPAC and SSA, cited below. Medicare-covered home health aide services are fading away and beneficiaries, especially individuals with longer-term and chronic, disabling conditions, are being unfairly denied desperately needed covered services.

A. **HHAs adapt to avoid triggers for CMS audit and compliance systems, especially cases with necessary aides for people living with chronic and longer-term conditions.** HHAs endeavor to avoid audit and review triggers by the Medicare Administrative Contractors (e.g. "probe and educate") and the Health and Human Services (HHS) Office of the Inspector General (OIG). Because HHAs can self-select which patients to serve, HHAs often strategically determine to choose "safe" cases to stay under the audit radar – beneficiaries who only have short-term, post-acute care needs, many of whom may need little to no aide services.[13] For example, this may include providing care to someone who had a hip replacement and needs short-term therapy for a few weeks to improve their mobility, but not to someone with a chronic condition such as Multiple Sclerosis who requires longer-term skilled services and relatively more extensive assistance with activities of daily living (ADLs) by an aide. In 2021, CMA conducted a survey of 2017 HHAs, many of whom commented that a higher-than-average use of aides by their agencies resulted in more audit scrutiny by the Medicare Administrative Contractors (MACs) and the HHS OIG.[14] HHAs

strategically choose to avoid assessing and serving patients that are likely to make them more vulnerable to be audited.

B. **HHAs maximize results from quality and Value-Based Purchasing (VBP) incentive measures by choosing cases that require limited aide services.** When HHAs perform better on quality measures, they garner more rating system quality "stars" allowing "stars marketing" to attract greater volume of beneficiaries to their agencies. Similarly, when HHAs do better or worse on VBP measures, there are potential additional payments agencies may earn or potential penalties they may incur. Measured quality and VBP criteria incentives are heavily based on patient improvement through HHA use of nurses and/or therapists, despite unfounded claims that "risk adjustment" of criteria eliminates incentives to discriminate against individuals with conditions that may not be expected to improve. According to the CMA survey, many HHAs only offer home health services to beneficiaries who have the ability to improve.[15] Declining to serve patients with longer-term and chronic conditions allows HHAs to attain higher quality measure scores but significantly reduces or eliminates services for patients who may be in the most significant need of aide services for longer periods of time, services that are necessary to keep patients living safely at home.

C. **Home Health Agencies react and respond to payment reforms.** Since CMS adopted a prospective payment system (PPS) for home health (with the exception of the low-utilization payment allowance, or LUPA) in the late 1990s, home health aides have been increasingly excluded from calculation in PPS models that replaced fee-for-service (FFS) for most home health reimbursement. Under these models, it does not matter if a HHA provides no aides, or the maximum coverage of 35 hours a week of aide services, reimbursement by case is barely affected; this, in turn, negatively impacts future payment calculations which are based on what has most recently been provided. In addition, HHAs recognize that the greater the number of aide visits provided in aggregate, the lower the overall "market-basket" of reimbursement will be in the future, since service mix data influences base payment and aides represent the lowest reimbursed service and a lower base-payment. Over the past two decades, HHAs have provided fewer aide visits each year resulting in current CMS data analysis – less than one half a visit of aide serves per 30-day period in the overall reimbursement calculation. For future calculations, the PDGM base calculation reflects the current usage. CMS will not pay for services that have not been provided to patients. Therefore, payment reform has allowed HHAs to ignore aides and to now more accurately inform patients that "CMS does not pay for aides" that the law says should be covered. HHA's utilization behavior is so strongly influenced by payment that in 2019, the year prior to the public health emergency, admissions from the community accounted for 74.3% of patients,[16] but in 2021, after PDGM went into effect, and case-mix reimbursement

highly-favored post-institutionalized patients, the percent of episodes for individuals "not discharged from facility in past 14 days" was reported to be only 35% of home health episodes.[17]

D. **HHAs capitalize on their most profitable patient mix, which is typically low in aide services.** HHAs self-select the Medicare patients they will serve (or not serve), and then HHAs determine the services they provide, based on their hiring choices and OASIS assessments. Allowed practitioners who order services are required to validate the assessment for care to begin by re-signing their original order. Over the years, HHAs have adapted to the profitability inherent in the Medicare system or model of payment in effect at any given time. Provided with significant opportunities for profitability, the past several decades have resulted in major high-value HHA ownership changes. In some years, home health agencies posted the highest trading multiples for mergers and acquisitions. For example, purchase of agencies increased 8% in 2015, and "deal value" increased 121%.[18] Home health care has become big business. HHAs focus more on profits for shareholders and less on critically needed services for patients. Beneficiaries who need aide services at the level allowed in Medicare law are typically higher resource need patients and less attractive to serve in HHAs' more profitable patient mix.

E. **HHAs reduce or refuse to provide services to patients who have high acuity needs and require more home health aides.** The RFI states: "*CMS wants to ensure that all Medicare beneficiaries receiving care under the home health benefit are afforded all covered services for which they qualify*."[19](emphasis added). However, beneficiaries frequently report that they cannot even find a HHA willing to provide them with an assessment for services when the HHA learns they have a chronic or longer-term condition. The lack of access to services is confirmed in the example provided earlier in the RFI response - Bayada declined 2/3 of new requests for home health care "due to shortage of available aides". In practice, the problem with aide utilization is as much about the reduced number of aides provided for beneficiaries "receiving care" as it is for beneficiaries who cannot access any services from a Medicare-certified HHA. Further, HHAs rarely provide services to beneficiaries who do not have access to their own caregivers. In 2021, only 2% of Medicare-covered home health episodes were provided by HHAs for beneficiaries who had no available caregiver.[20] CMS does not appear to require Medicare-certified HHAs to report the number of Medicare beneficiaries HHAs decline to even assess for services. Thus, the true unmet need for aide services is not reflected in figures reported by HHAs or CMS. This is a glaring omission in available data. CMS should require HHAs to report the services they decline to provide for beneficiaries they serve and for those they decline to admit for care.

F. **HHAs have transferred aide staff to affiliates through related party transactions for additional payment sources.** HHAs enrolled in Medicare are more often telling patients that they do not have aide staff available in their Medicare-certified agency, but aides can be available to the patient through an affiliated entity (often with the same company name) for private pay. Such strategy often allows the HHA to receive the full Medicare payment while the affiliate simultaneously bills for aide services. This practice reduces the amount of aide hours staffed and available through the Medicare-certified HHA and it provides an unacceptable alternative to Medicare-covered services for patients, who should be able to make *full use* of their covered Medicare home health benefit, including receiving the aide services they qualify for. Forcing beneficiaries to obtain aide services outside Medicare reimbursement is not financially possible for most people living with chronic and longer-term conditions.

G. **Increasingly, HHAs improperly force patients' family members to perform aide services.** Medicare-certified HHAs must follow Medicare Conditions of Participation (COP) regulations to receive Medicare reimbursement. The COPs require a patient's comprehensive assessment to include the willingness, ability, availability, and schedules for primary caregivers and other "available supports"[21]. Under Medicare policy, patients are entitled to have reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. The exception to that is where an "able and willing" family member or other person will be providing services that adequately meet the patient's needs."[22] Despite Medicare regulation and policy, in practice, many HHAs are only offering a few aide visits at the onset of care to "teach" family and other caregivers how to provide care, even if those caregivers are not willing and/or able to continue the care (and even if the patient objects to having a family member provide intimate care). Indeed, the Center for Medicare Advocacy has been informed by patients that some HHAs require the family caregiver(s) to be available as a condition of the HHA accepting the patient for any services. The Center for Medicare Advocacy has also seen examples of termination of aide services for beneficiaries who continue to require and qualify for them on the grounds that there is no family or other caregiver to provide the required personal services, such as when a beneficiary lives alone. This is also contrary to Medicare law. Finally, the 2024 physician fee schedule proposed rule raises potential payment for practitioners who provide unpaid Caregiver Training Services (CTS) to assist the patient or act as a proxy for the patient.[23] If CTS is finalized, CMS should confirm with HHAs that CTS will not be an appropriate substitution or replacement for a Medicare-covered home health aide under the law, but only as additional Medicare-coverage to increase a willing and able caregiver's knowledge.

H. **HHAs do not generally consider home health aides valuable members of the home health care team.** COPs require HHAs to provide services ordered by the allowed

practitioner in the plan of care as long as the HHA is permitted to perform the services under state law and the services are consistent with training received by the home health aide to perform the services[24]. The COPs also require home health aides to be members of the interdisciplinary team; report changes in a patient's condition; and complete appropriate records in compliance with home health agency policies and procedures[25]. Further, services provided by the home health aide must include: following the plan of care; maintaining open communication with the patient, representatives, caregivers, and family; demonstrating competency with assigned tasks; complying with infection prevention and control policies and procedures; reporting changes in the patient's condition; and, honoring patient rights.[26] The Center for Medicare Advocacy hears regularly from patients, caregivers, and other advocacy organizations, that aides are usually only allowed to shower a patient. HHAs are not properly assessing or meeting the needs for additional Medicare covered aide services that are critical to keep patients safe and healthy at home.

I. **Patient appeals of egregiously improper denials do not deter such denials even when coverage is eventually affirmed.** HHAs incur no practical consequences for improperly declining to provide services, reducing services, or discharging a patient who continues to qualify for Medicare aide services, or other home health services. Even when beneficiaries appeal discharges using the expedited appeal system and obtain fully favorable decisions, the HHAs that discharge those patients suffer no consequences and are not required to provide the necessary care. The patients have no recourse, no practical rights since Medicare Conditions of Participation are rarely followed by HHAs or enforced by CMS, and patients are at the mercy of HHAs that choose which patients they serve and to maximize their profit margins. The standard, after-the-fact appeal system is essentially unavailable to home health patients because they have to *receive* services in order to appeal for their coverage, and very few patients can afford to pay for services, nor will HHAs provide them pending uncertain payment by Medicare. The Center for Medicare Advocacy also hears from patients about the following: HHAs provide no required discharge notice when the HHAs unilaterally (and inappropriately) decides to end services; HHAs disregard recertifications when they no longer want to serve patients; HHAs commit unsafe and inappropriate discharges; and HHAs refuse to supply Quality Improvement Organizations (QIOs) with medical records and do nothing when QIOs find "in favor" of the patient.

4. **Additional Aide Utilization Concerns That May Impact HHAs, as Stated by HHAs to the Center for Medicare Advocacy[27]:**
   - Medicare dependent services, including aides and medical social services are "not required" services for HHAs to be enrolled in Medicare.
   - Medicare payment is only for "skilled" work.

- Original Plans of Care are revised to reduce or remove Medicare-covered aide hours when HHAs inform authorized providers that aide hours are not available.
- Messaging from "trusted sources" (MedPAC, SSA, MACs, OIG) is negative, or incorrect, and diminishes HHA aide utilization:
    - In its annual *March Report to Congress*, MedPAC consistently denigrates the use of home health aides, despite the fact that aides are coverable under the law for up to 35 hours a week when combined with nursing services, which may mean 34 hours of aides and 1 hour of nursing a week. In one such MedPAC report, for episodes where aide hours exceeded nurse hours, MedPAC remarked, *"[t]hese episodes raise questions about whether Medicare's broad standards for coverage are adequate to ensure that skilled care remains the focus of the home health benefit.*"[28] MedPAC offers no explanation for redefining Congressional intent, in law for decades,by stating that only skilled services should be the "focus" of the home health benefit. Congress wrote the law with specificity, authorizing aides when necessary for patient health and safety. To emphasis its disfavor of aides, MedPAC advises that beneficiaries fortunate enough to avoid hospitalization before qualifying for home health (significantly beneficiaries with chronic and longer-term conditions, many of whom need aides) should also be charged a copayment.[29]
    - In its' Program Operations Manual System (POMS), updated last October, Social Security inexplicably provides a grossly inaccurate explanation of Medicare-covered aide services (not contained in law, regulation, or policy), but presumably obtained from CMS HHA training information. "*Home health aide visits usually last 1-3 hours a day and generally are provided 2 or 3 times a week. For the very few ill patients who need extensive personal care services in addition to skilled services, Medicare will pay for part-time medically reasonable and necessary aide services 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where a patient's personal care needs extend beyond 3 weeks. For example…institutionalization cannot immediately be arranged.*"[30]

- Patient surveys, known as HHCAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems), are inadequate to evaluate a lack of services. First, HHCAHPS are only completed by individual patients who receive services, not individuals who meet Medicare criteria but who cannot obtain services. Further, the survey questions only ask about the quality of the services individuals receive, not critical under-service. Patients may be very happy with the one visit they received, or as one HHA said to a patient, "*be grateful, some care is better than nothing*", but there is no place in the HHCAHPS for a patient to report lack of service for unfilled care needs.

5. **There is increasing competition for a limited number of available aides in the job market.**[31] Currently in the United States, 5 million people rely on home health aides to keep them safe and healthy in their homes. The population is aging and becoming sicker. Within 10 years another million people will need aides, an increase of 25-34%, and the number of elderly in the U.S. is expected to double by 2050. In 2021, almost 3.4 million workers were employed in facilities and in homes holding similar positions as nursing assistants, home health aides and personal care assistants (for dually eligible-Medicare and Medicaid individuals). Aides are also employed to work for individuals with other insurance and they are further engaged for private payment. The Bureau of Labor Statistics (BLS) has cited home health aides as one of the fastest growing jobs, with a need for 750,000 new workers every year, while another 332,000 existing home health aides may retire or drop out of the occupation every year, and 287,000 may seek other types of work. Medicare-certified HHAs draw from the same competitive pool of available aides seeking work as other employers offering similar services. To illustrate the competition for aides, one large Medicare-certified HHA, Bayada, which provides services in 350 locations in 22 states, claimed that *it had to decline nearly two-thirds of new home health care requests due to the shortage of available aides*[32].

RFI Question 2 - 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?

1. **Individuals who require more care (higher acuity) have more difficulty accessing home health care in general, and aides in particular.** Higher acuity individuals generally require more home health agency resources than lower acuity individuals. When CMS largely abandoned the pay-per-service structure for HHAs in the late 1990's and adopted various new prospective payment systems (PPS) over the years, the intent (perhaps just hope) was for lower-cost patients and higher-cost patients to balance each other out under PPS – HHAs might lose money on the higher-cost patients but make up for it on lower-cost, higher-margin. Instead, HHAs found they could easily self-select and cherry-pick lower acuity patients and pocket the savings, leaving many higher acuity patients unserved, or at best underserved. CMS has not fulfilled its oversight duty to monitor, penalize, and prevent this discriminatory behavior. HHAs that strategically choose to serve only lower resource-need patients have even been lauded by MedPAC as "relatively efficient" providers, sporting large margins on traditional Medicare patients for years, highlighted by a recent 28.4% annual profit margin on traditional Medicare in 2021[33]. Unfortunately, MedPAC voices no concern that "relatively efficient" HHAs are making large profit margins because they are underserving even the lower-resource need

patients that they accept, not providing home health aides, and/or by not assessing higher acuity patients. Many HHAs have voiced to CMA that they must make larger profit margins on traditional Medicare patients to make up for Medicare Advantage (MA) plan contract losses (MA plans pay only 40-60% of the amount traditional Medicare pays[34], leaving the public Medicare program to subsidize MA patients), and other operating losses.

It is critical that CMS use its nondiscrimination oversight and enforcement authority to actively enforce the nondiscrimination conditions of participation for Medicare-certified HHAs with regard to disability. CMS should investigate the practices of HHAs that tend to exclude or underserve beneficiaries with disabilities and take enforcement action where necessary. A "Frequently Asked Questions" document on civil rights protections for people with disabilities, like the one that was issued for providers relating to the COVID-19 public health emergency,[35] would also be helpful and could express some of the same principles. For example, individuals with disabilities may not be denied an equal opportunity to participate in and benefit from Medicare-covered home health services, including aides; providers may not refuse to admit or serve patients with chronic, disabling conditions in a way that prevents them from having an equal opportunity to benefit from care as those without chronic disabilities.

2. **Lack of aide services impacts individuals with chronic and longer-term conditions more significantly than individuals with shorter-term and post-acute care needs.** Under the current iteration of PPS, the Patient Driven Groupings Model (PDGM), HHAs receive relatively higher levels of reimbursement for the early services episode, the first 30 days, which may lead HHAs to provide minimal aide services, and only for a brief period of time. For individuals with shorter-term needs, inability to obtain all necessary covered aide services may have less of an impact on their ability to remain in their home and to maintain the highest quality of life possible, given the relatively short duration of the lack of aide services. However, higher acuity individuals with chronic and longer-term care needs, such as individuals living with ALS, Alzheimer's, Multiple Sclerosis, Parkinson's, Paralysis, Post-Stroke, and other chronic and longer-term conditions, are even more significantly impacted after the initial 30-day episode, when reimbursement is greatly reduced under PDGM, and access to aides is further reduced thereafter, and often for long periods of time. Individuals with chronic and longer-term conditions typically need more services over time, not less, to keep their conditions stable, or to obtain more help as their conditions progress.

3. **As use of aides by HHAs has declined over time, payment for aides has been virtually eliminated from the base PGDM calculation.** Every iteration of PPS has disfavored payment to HHAs for aide coverage. The PDGM base calculation amount favors post-institutional care and the initial 30 days of services through higher case-mix adjustment for admission source and timing. In the case-mix adjustment formula for

PDGM, there is an extremely low percentage of additional reimbursement for beneficiaries with high functional impairments and multiple comorbidities, relative to beneficiaries with low functional impairments and no co-morbidities.[36] Further, HHAs have virtually eliminated providing aides and this significant reduction is reflected in the lower usage data that in turn causes CMS to adjust the base calculation regarding aides downward. Ironically, this helps allow HHAs to more confidently tell patients that "Medicare does not pay for aides". CMS has failed to take the needs of higher acuity patients into account in its PDGM calculation.

4. **HHAs face no repercussions when they fail to provide aide services.** Higher acuity individuals have little recourse to obtain necessary aide services through low utilization payments (short-term only) or outliers (statutory constraints and operational disfavor by HHAs). Patients also have little recourse through the appeals system which allows patients to appeal only if all their services have been terminated, not just aides (or other individual services). Even when all of the services are terminated, appeals are practically useless, as discussed previously in this RFI. HHAs can improperly terminate care of a Medicare beneficiary who meets coverage criteria and there is no effective process to hold the HHA accountable or to reinstate necessary care. For example, the Center for Medicare Advocacy recently appealed a home health termination, an administrative law judge issued a fully favorable decision in favor of the beneficiary who met all Medicare criteria for coverage, but the HHA was not required to take the patient back and suffered no consequences for the inappropriate discharge. This patient is currently receiving skilled services from a different HHA and paying privately for aide services.

5. **HHAs that provide fewer services, including aides, are lauded and less likely to be audited, while HHAs that serve higher acuity individuals are more likely to be penalized and audited.** HHAs that serve higher acuity individuals often find themselves criticized by MedPAC for not being as "efficient" as HHAs that chose to only serve lower acuity individuals. HHAs also find themselves in the cross hairs of auditors, such as MACs and the HHS OIG when they serve higher acuity individuals. The more resources a patient needs and receives, the more triggers are engaged for improper use of services. HHAs that are underserving patients are more likely to pocket larger traditional Medicare profits without audits or other consequences from oversight entities. CMS has failed to take the needs of higher acuity patients into account in its review and auditing practices.

RFI Question 3 – 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?

Home health aides engage with patients in very intimate ways, in very private settings - patient homes. Many patients express to CMA how valuable aides are to perform services that allow patients to stay in their homes. Many aides express to their patients that being an aide is meaningful work and they choose to serve patients because they are personally inspired by the patients they serve and fulfilled by the personal hands-on care and assistance they provide.

Aide work is demanding and requires physical, psychological, and emotional skills.[37] The following list of barriers, and recommendations to resolve them, are based on comments CMA has received from patients, and from aides who serve them.

Current barriers for recruiting and retaining home health aides[38]:

- Aides being provided to those who can pay privately or through Medicaid payment,
- Restrictive immigration policies that do not focus on the need for aide services (such as a 5% H-1B petition approval for health care occupations – while computer jobs garner 61% H-1B petition approval),
- Low compensation, relative to other available support jobs in the economy,
- Competition (demand high relative to supply) for aide-type labor in the national economy, while future need for aide services will increase substantially,
- Minimal opportunities for job and career/managerial growth (often only part-time or limited-time positions available),
- Potentially long travel times between clients,
- Rarely consulted or included in development of patient care plans,
- Physically, psychologically, and emotionally difficult and stressful work,
- Higher-than-average injury rates,
- Limited training,
- Unfulfilling work – home health aides are expected to perform an overly limited set of tasks for a Medicare-certified HHA (usually only employed to give showers, not to further engage with the patient), and to achieve the work at an unrealistically rapid pace.

Recommendations to improve recruitment and retention:

- Increase compensation and improve plans for sustained growth and job security at HHAs.
- Engage aides more fully in the plan of care; recognize aides as a highly-valued member of the care team, follow the required Medicare Conditions of Participation.
- Provide ongoing advanced training and job development.
- Creating a centralized training delivery system with options for customization by individual employers may help reduce costs in the future.[39]
- Support aide work and participation on the home health team more respectfully, providing adequate time to serve a patient and with a strong safety plan in place (for example, if a patient requires a 2-person transfer, there is a plan for a 2-person transfer).

- Grow the available work force through more supportive policies, including immigration, for example, by increasing approval of H-1B visas for healthcare occupations.
- Identify ways to take the pressure off competition for aides-type occupations by using available funding for related work in Medicaid home and community-based services (for example, $12.7 billion from the American Rescue Plan Act available until 2025).
- Encourage and train individuals who may not be currently working, or not performing work that is as meaningful as they would like, to be interested in work in which they can help others and find fulfillment.
- Decrease travel time by recruiting aides in geographical areas where patients are located and skilled services are provided.
- Allow aides to engage in all Medicare covered aide services needed by the patient and provided under regulation,[40] not just for showers (also, cease disrespectfully referring to the aide as a "shower girl", as numerous HHAs do).
- Review State Data Center on the Direct Care Workforce information provided by the Paraprofessional Healthcare Institute (PHI).[41]

RFI Question 4 – Are HHAs paying home health aides less than equivalent positions in other care settings (for example, are aides in the inpatient hospital setting or nursing home setting paid more than in home health)? What are the reasons for the disparity in hourly wages or total pay for equivalent services?

According to the U.S. Bureau of Labor Statistics Occupational Outlook Handbook, full-time home health aide equivalent positions in hospitals and skilled nursing facilities are sometimes called nursing assistants, nurse aides, or personal care assistants.[42] Nursing assistants provide similar services to patients as the personal hands-on care services provided by home health aides.[43] The median salary for a nursing assistant in a health care facility as of May 2021 was $30,310 per year.[44] The median salary for a home health aide as of May 2021 was $29,430.[45]

While services provided by nurse assistants, personal care assistants, and home health aides may be similar in nature, although not exactly the same, and salaries close in range, further analysis must be considered, including compensation and other factors to understand working conditions, job opportunities, and full-time versus part-time employment.

- In facilities, assistants/aides are typically employed to be physically present in the facility and do not have to physically travel from patient home to patient home - there is more consistent ability to provide patient care and less need to engage in transport and traffic.
- Work in the facility may be more personally rewarding for the assistant/aide because the aide is typically allowed to do more varied tasks than just provide a shower (which is typically all a home health aide is scheduled to provide for an HHA) and then leave to run to the next house to provide another shower, and so on, for their entire shift. This

practice violates the Medicare conditions of participation as established at 42 C.F.R. §484.80(g)(h).

- There is more personal security for an aide in a facility than in a home, as there is typically other staff present to call on if something goes wrong with the patient. In the home, a relatively isolated setting, there will be different security considerations for the aide and the patient.
- Similarly, there is greater personal support and safety for an aide in a facility as there may be other staff who can assist if the patient falls or the aide is in need of additional support to care for the patient.
- General working conditions in facilities may be more fully supported for aides to pursue additional career growth, receive stronger benefit packages, and be represented through unions.
- Aides may be able to have a more flexible schedule with a home health agency, but this usually occurs when the job is part-time and temporary.

RFI Question 5 – In what ways could HHAs ensure that home health aides are consistently paid wages that are commensurate with the impact they have on patient care that they provide to Medicare beneficiaries?

1. **Aides and the services they provide must be valued as an important component of the home health care for patients.** The home health aide has a vital role as a member of the home health team serving the patient and should be supported and valued for their unique and important contribution. CMS has been respectful in acknowledging Congressional intent in the need, and critical role, for home health aides in both 2024 and 2022 notices of proposed rulemaking. However, too many HHAs downplay the need for this role or eliminate aide services altogether. Further, policy advisors, such as MedPAC, must cease scorning the legally covered role of aides in Medicare home health care in their annual reports to Congress and auditors must not target cases that require aides. The attitude of many HHAs, that home health aide services do not have important value for keeping people safe and healthy at home must change and all necessary services must be properly included in plans of care, not just merely showers or other singular services. CMS must also devise an appropriate payment mechanism to compensate appropriately for delivering all necessary aide services.

2. **HHAs must have affirmative incentives to provide aides, PPS systems have not worked and CMS has not adopted an appropriate case-mix calculation within PPS to give HHAs a financial incentive to staff for/provide aide services.** Under PPS systems, aides have been re-based out of the payment formula. CMS should not be paying for services that HHAs don't provide, but years of neglect to address this issue have brought critically needed aide visits to practical non-existence for patients. This has

created a circular dysfunction - HHAs claim they are currently not paid to deliver aide services, and they are correct. On the other hand, HHA profit margins related to other disciplines provided are exceedingly high for traditional Medicare. PDGM was not the first PPS model to cause a decline in available aide services, but it has delivered a near-final blow to their existence. PDGM is not a system that is meant to accommodate patients with higher acuity needs, and therefore higher aide needs. The lack of aide availability, as mentioned earlier in this RFI response, is not solely attributable to PPS, nor to a shortage of workers in the economy. CMS's auditing and quality rating systems cause HHAs to decline to accept patients who they fear will trigger audits, or lower quality stars ratings, or lower HHVBP incentive payments – these are patients who most need services to address chronic and longer-term conditions. CMS has also failed to exert its oversight and monitoring duty to ensure that patients with long-term disabilities do not face discrimination in the provision of aide services.

3. **CMS should explore alternate ways to compensate agencies when they provide necessary aide services and CMS should require accountability to ensure compensated aide services are delivered.** Aides have effectively been eliminated from the base calculation of PDGM (as have medical social services). CMS should consider implementing a payment model specifically for dependent services (aides and medical social services), separate from payment consideration for skilled services for individuals who require and qualify for aide services. PDGM would need to be adjusted accordingly. Such a model may generate appropriate reimbursement incentives for HHAs to provide necessary dependent services and allow CMS to better track the effectiveness of those services for qualifying beneficiaries, including avoidance of hospitalizations and other health care costs. This may also allow HHAs to provide appropriate compliance with the requirements for aides in the Medicare Conditions of Participation.

RFI Question 6 – 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.

Medicare insures approximately 65 million beneficiaries[46]. About 18% of beneficiaries are dually eligible for Medicare and Medicaid[47], thus leaving 82% of Medicare beneficiaries non-Medicaid covered and largely with limited access to alternate Medicare-covered aide services.

Of beneficiaries who are dually eligible, coordination between Medicare and Medicaid for aide services appears to be non-existent for traditional Medicare and Medicare Advantage plans. CMA appeals hundreds of dually eligible home health care cases annually for Medicare

coverage. These are appeals on behalf of beneficiaries and a state Medicaid agency, ensuring that Medicare pays when it should prior to Medicaid coverage, as Medicaid is entitled to be the payer of last resort.[48] Attorneys and advocates at CMA who review dually eligible cases report that aide services are consistently more available for dually eligible individuals than for non-dually eligible individuals.

One reason dually eligible individuals may receive more aide/assistant services is that additional services (beyond Medicare-covered personal hands-on care) are covered by Medicaid, which allows Medicaid personal care assistants to perform services not limited to Medicare-covered services. For example, a Medicaid personal care assistant may also provide non-personal-hands-on care tasks such as transportation, shopping, and bill paying, tasks that are not Medicare-coverable. Because covered services overlap between Medicare home health aides and Medicaid personal care assistants, but are more expansive under Medicaid, it appears that some HHAs turn to Medicaid to cover all the costs of all aide/assistant hours, rather than allocating the personal hands-on care time to Medicare and the remaining non-personal care time to Medicaid. Thus, entire PDGM payments are retained by the HHA for the provision of skilled services, and the HHA also claims Medicaid coverage for aide/assistant time. Further, in some states, obtaining Medicaid payment for home health aide and other services is less complicated and time-consuming than Medicare.

Prior to the public health emergency, the OIG had announced that it would perform a study that would investigate the use of home health aides in Medicare and Medicaid. It does not appear that study was undertaken and/or concluded, however completing the investigation may provide significant value to address this question.

RFI Question 7 – Are physicians' plans of care less reliant on home health aide services than in the past, or are HHAs less willing/able to provide these services? If so, what are the primary reasons why such services are not provided?

The answer is that both of these problems are occurring.

First, physicians' (allowed practitioners') plans of care are less inclusive of home health aide services than in the past, but it is not because their patients have less need for those services. It is because HHAs have made it clear to allowed practitioners, by revising or refusing aide orders, that aide services are generally very limited or not available and it is futile to request them. In fact, as the Bayada example earlier in this RFI indicated, Bayada denied the majority of requests for home care when they included a request for aides.[49] Thus, in order to avoid having a request for all services rejected, many allowed practitioners have reduced or eliminated requests for aide services.

The Center for Medicare Advocacy had been suggesting that beneficiaries document personal-care logs and ask their allowed practitioners to specify in orders the exact aide services they need for hands-on, personal care, how often they need each of those services to be performed, and for how long each day, given their unique care needs. Increasingly however, beneficiaries told us their allowed practitioners typically do not want to make their initial orders highly specific as to necessary aide services because the allowed practitioner order will have to be revised after the HHA assesses the patient and the HHA communicates to the allowed practitioner that aide services are much more limited or not available. Some allowed practitioners are more frequently initially ordering very limited aide services, finding it a better ordering "strategy" in order to get any covered aide services. Further, several state enforcement agencies (usually Departments of Public Health) have informed CMA that CMS trains them that Medicare-covered home health orders do not drive the delivery of care. Instead, the final order, and the plan of care, created after the HHA OASIS assessment, is sent to the allowed practitioner for sign-off on the assessed services, as both the order and plan of care. In other words, the HHA determines the services the patient will receive, and the allowed practitioner then signs the order for those services (in a sequence contrary to Medicare law and policy). The HHA drives the transaction for services. Thus, plans of care are not appropriate indicators of the true need for covered home health aide services or what services the allowed practitioners would order if the full extent of services available by law were available.

Second, beneficiaries often tell the Center for Medicare Advocacy, that HHAs are less willing/able to provide aide services, often requiring family caregiving commitments prior to accepting a patient for HHA services. While HHAs regularly ignore Medicare policy that caregivers must be willing and able to provide aide services to patients, and some agencies refuse to initiate services unless the family agrees to be "taught" to perform aide services, many HHAs refuse to staff, or they under-staff, aides. The nursing director of one large HHA system in Virginia told CMA that a patient could not possibly get more than one bath a month, as the HHA only had one aide on staff for 600 clients.

The primary reasons aide services are not provided by HHAs have been discussed in more detail previously in this response to the RFI. In summary, these include:

- CMS failure to monitor and enforce Medicare Conditions of Participation and failure to monitor and prevent discriminatory patient selection, service, and discharge practices,
- CMS failure to take the needs of beneficiaries with chronic and longer-term conditions into account in its policies and practices with regard to aide services,
- Unfairly targeted and overly aggressive audits by MACs and HHS OIG that focus on "overuse" of services and rarely, if ever, on under delivery of services, thus audit-targeting cases of individuals who need more aide services and receive home health services for longer periods of time while rewarding minimal care as "efficient",
- CMS and CMMI Quality and Value Based Purchasing measures (previously discussed in this RFI response) that provide significant incentives for HHAs to serve shorter-term,

post-acute care patients and avoid serving patients who need more and longer aide services because they have conditions that may not improve,
- Creation and staffing of HHA business affiliates that sell aide and aide-type services for private payment while not hiring staff at a related Medicare-certified HHA,
- Requiring family caregivers to be trained to perform aide-type services, even for times when family members and patients are not willing and/or able to provide aide services, in violation of Medicare policy,
- Reliance on Medicaid, other insurance, and private payment to provide additional funding, when available, for critical and necessary aide services,
- Greater economy driven staffing shortages,
- Insufficient payment to HHAs required to be used for aides because aides were not provided and now payment is not included in the baseline PDGM nor in the PDGM component calculations (despite overly-large HHA profit margins in traditional Medicare for all home health services).

RFI Question 8 – What are the consequences of beneficiary difficulty in accessing home health aide services?

Almost every day, staff at CMA hear near-crisis stories from home health qualifying beneficiaries and family members who are frustrated – sometimes panicked – due to their inability to find Medicare-covered aide services. They cannot understand when we explain that Medicare law covers aides, but they typically aren't available from Medicare-certified HHAs.

Here are some of the personal and societal consequences for our clients:

- Unnecessary hospitalizations and nursing facility admissions,
- Inability to remain safely in the community,
- Further medical complications, including:
    - Infections, UTI, skin breakdown from lack of hygiene, care assessment, movement. Etc.,
    - Falls,
    - Lack of critical medication and exercise assistance,
    - Stress-related health concerns,
    - Hunger and malnutrition,
    - Depression, feeling like a burden on family and caregivers, other mental health problems,
- Forced institutionalizations due to lack of assistance in the home,
- Strained and broken family relationships, as family members need to work and cannot be forced into caregiving activities,
- Damage to children when household adults are unable to get necessary care.
- Loss of dignity and quality of life.
- Feeling unsupported by a Medicare program they depended on and that has failed them,

Conclusion

The lack of access to Medicare-covered home health aides is a crisis, particularly for people with chronic and longer-term conditions who need aide services to remain safe and healthy at home. CMS must oversee Medicare-covered home health care, including those policies that affect the provision of home health aides, in a way that takes individuals with chronic, longer-term, and disabling conditions into account. Once CMS addresses internal policies and procedures to allow beneficiaries access to necessary aide services, additional steps to ameliorate the aide crisis will become more evident. The true extent of any workforce shortages also cannot be discerned until CMS has taken affirmative steps to remedy the current discriminatory policies and practices that discourage the provision of aide services to higher acuity individuals. CMS must meet its obligations and affirmative duty to ensure that individuals are living in the most integrated setting appropriate to their needs. Aide services are critical to that duty. Over the past several years, CMA has written extensively about the shrinking home health aide benefit. These papers are on our website at Home Health Care - Center for Medicare Advocacy. There are also a number of studies available that speak to the value of assistance such as that provided by Medicare-covered home health aides.

Further, addressing the lack of Medicare-covered aides directly, over the years a number of journalists have highlighted Center client stories of Medicare beneficiaries who struggle without home health aides, including the following articles:

- https://www.washingtonpost.com/national/health-science/home-care-agencies-often-wrongly-deny-medicare-help-to-the-chronically-ill/2018/01/18/7be2e0fc-fc38-11e7-9b5d-bbf0da31214d_story.html
- https://www.bostonglobe.com/metro/2020/01/11/families-als-patients-struggle-find-home-care/CCUXk8C9H0n77Cvd45vgYM/story.html
- https://kffhealthnews.org/news/seniors-aging-in-place-turn-to-devices-and-helpers-but-unmet-needs-are-common/
- https://kffhealthnews.org/news/why-home-health-care-is-suddenly-harder-to-come-by-for-medicare-patients/
- https://kffhealthnews.org/news/what-to-do-if-your-home-health-care-agency-ditches-you/

Finally, in a survey conducted by the Center in 2021 with 217 HHAs in 20 geographically diverse states[50], only 4% of HHAs indicated they would consider providing 20 or more hours of aide services a week. 95% of HHAs would only be able to provide 6 hours or less. Comments relevant to home health aides recorded from the survey are instructive and include the following, identified by state of each HHA:

- "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)

Many agencies volunteered 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)

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)

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[1] 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) .
[2] 42 U.S.C. §1395x(m)(1)-(4). Receipt of skilled therapy can also trigger coverage for home health aides.
[3]MedPAC March 2023 Report to Congress, page 250 MedPAC March 2023 Report to the Congress: Medicare Payment Policy; MedPAC March 2021 Report to Congress, page 245 http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf; MedPAC March 2019 Report to Congress, page 234 mar19_medpac_entirereport_sec_rev.pdf
[4] 42 CFR §409.45(b)(1)(i)-(v). See also, Medicare Benefits Policy Manual, Chapter 7, §§50.1 and 50.2.
[5] Find Healthcare Providers: Compare Care Near You | Medicare
[6] https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf
[7] Federal Register 2023-14044.pdf (govinfo.gov), Table B2, page 43663; Figure B4, page 43671.
[8] MedPAC March 2021 Report to Congress, page 236 http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf
[9] Federal Register 2023-14044.pdf (govinfo.gov), pages 43663, 43671.
[10] Id. at 43671.
[11] Id.
[12] Federal Register 2021-13763.pdf (aapc.com), pages 35956, 35958.

[13] HHAs' right to pick and choose patients is not without limit. HHAs and HHS are subject to antidiscrimination law such as Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act. *See also Johnson v. Becerra*, No. 1:22-cv-03024 (TNM), 2023 WL 2784874 (D.D.C. Apr. 5, 2023), on appeal No. 23-5128 (D.C. Cir.) (plaintiffs represented by CMA challenge HHS policies and practices that restrict the availability, accessibility and coverage of home health aide services for individuals with chronic, disabling conditions in violation of Medicare and disability law).
[14] Home Health Survey and Access Summary - Final Draft (00517436.DOCX;3) (medicareadvocacy.org)
[15] Id.
[16] MedPAC March 2022 Report to Congress, page 282. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_v3_SEC.pdf
[17] HH QRP Discharge Function Score Measure – Technical Report (cms.gov), see Appendix A, page 22.
[18] Mullaney, T. Home Health Deals Commanded Impressive Evaluations in 2016. Home Health Care News, January 2017.
[19] Federal Register 2023-14044.pdf (govinfo.gov), page 43671.
[20] HH QRP Discharge Function Score Measure – Technical Report (cms.gov), see Appendix A, page 23.
[21] 42 C.F.R. §484.55(c)(6)
[22] Medicare Benefit Policy Manual, Chapter 7, Section 20.2 Medicare Benefit Policy Manual (cms.gov)
[23] https://public-inspection.federalregister.gov/2023-14624.pdf, pages 218-227.
[24] 42 C.F.R. §484.80(g)(2)
[25] 42 C.F.R.§484.80(g)(4)
[26] 42 C.F.R. §484.80(h)(4)
[27]Home Health Survey and Access Summary - Final Draft (00517436.DOCX;3) (medicareadvocacy.org)
[28] mar18_medpac_entirereport_sec_rev_0518.pdf, page 250.
[29] Id., page 249.
[30] SSA - POMS: HI 00601.440 - Part Time or Intermittent Services - 10/25/2022; SSA - POMS: HI 00601.400 - Services of a Home Health Aide - 10/25/2022
[31] Article: Immigrant Health-Care Workers in the Unit.. | migrationpolicy.org; Amid a Severe Shortage of Home Health Aides, Immigrants Help Care for Our Seniors (immigrationimpact.com); Immigrants Who Staff Home Health Care In the U.S. Worry About Deportation : Shots - Health News : NPR; Caring for Immigrant Caregivers - Public Health Post
[32] Amid a Severe Shortage of Home Health Aides, Immigrants Help Care for Our Seniors (immigrationimpact.com); Staffing Shortages Force Home Health Giant Bayada to Deny 64% of Referrals in Key Markets - Home Health Care News
[33] MedPAC March 2023 Report to Congress, page 250 MedPAC March 2023 Report to the Congress: Medicare Payment Policy
[34] LHC Group's Keith Myers: To Fix the Medicare Advantage Problem, Cut Out the Middle Man - Home Health Care News
[35] https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/disabilty-faqs/index.html
[36] Federal Register 2023-14044.pdf (govinfo.gov), pages 43681-43702.
[37] Caring for Immigrant Caregivers - Public Health Post
[38] Article: Immigrant Health-Care Workers in the Unit.. | migrationpolicy.org; Amid a Severe Shortage of Home Health Aides, Immigrants Help Care for Our Seniors (immigrationimpact.com); Immigrants Who Staff Home Health Care In the U.S. Worry About Deportation : Shots - Health News : NPR; Caring for Immigrant Caregivers - Public Health Post
[39] https://www.phinational.org/impact_story/workforce-initiative-increased-recruitment-retention-across-agencies/
[40] 42 C.F.R. §409.45(b)(1)-(4)
[41] https://eldercareworkforce.org/phi-launches-first-state-data-center-on-the-direct-care-workforce/
[42] Nursing Assistants and Orderlies : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov)
[43] Id.
[44] Id.
[45] Home Health and Personal Care Aides : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov)
[46] CMS Fast Facts

[47] Id.
[48] COB TPL Training and Handbook (medicaid.gov), page 20.
[49] Amid a Severe Shortage of Home Health Aides, Immigrants Help Care for Our Seniors (immigrationimpact.com)
[50] Home Health Survey and Access Summary - Final Draft (00517436.DOCX;3) (medicareadvocacy.org)