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Approaches to Improving Medicare's Home Health Benefit: Lessons from Medicaid

▲ Nurse Eric Thibodeau of UMass Memorial Health checks Leonice Quinlan's temperature at her home in Shrewsbury, Mass., on Dec. 9, 2021. The Medicare home health benefit is designed to enable beneficiaries to receive care in their homes after hospitalizations or other acute events or for ongoing needs. Photo: Craig F. Walker/Boston Globe via Getty Images

TOPLINES

Medicare's home health benefit falls short of its potential: many beneficiaries aren't aware of the benefit, many providers don't order this care, and home health agencies often don't provide the full range of services

Insights and lessons from state Medicaid programs could guide policymakers in improving access to the full potential of Medicare's home health benefit, especially regarding in-home aide services

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Medicare's home health benefit is crucial to the welfare of beneficiaries, but its application in providing personal care leaves much room for improvement in terms of service availability and equity.

Drawing on insights from Medicaid programs' experiences in providing personal care services, we found that: 1) a systematic approach to the referral and provision of personal care services is necessary to support equitable access; 2) separating the assessment and care plan development from the service provider helps to eliminate conflict in payment incentives; and 3) a fairly compensated direct-care workforce is required. While Medicaid programs help to fill gaps in Medicare's coverage, restrictive and varying eligibility requirements limit its role.

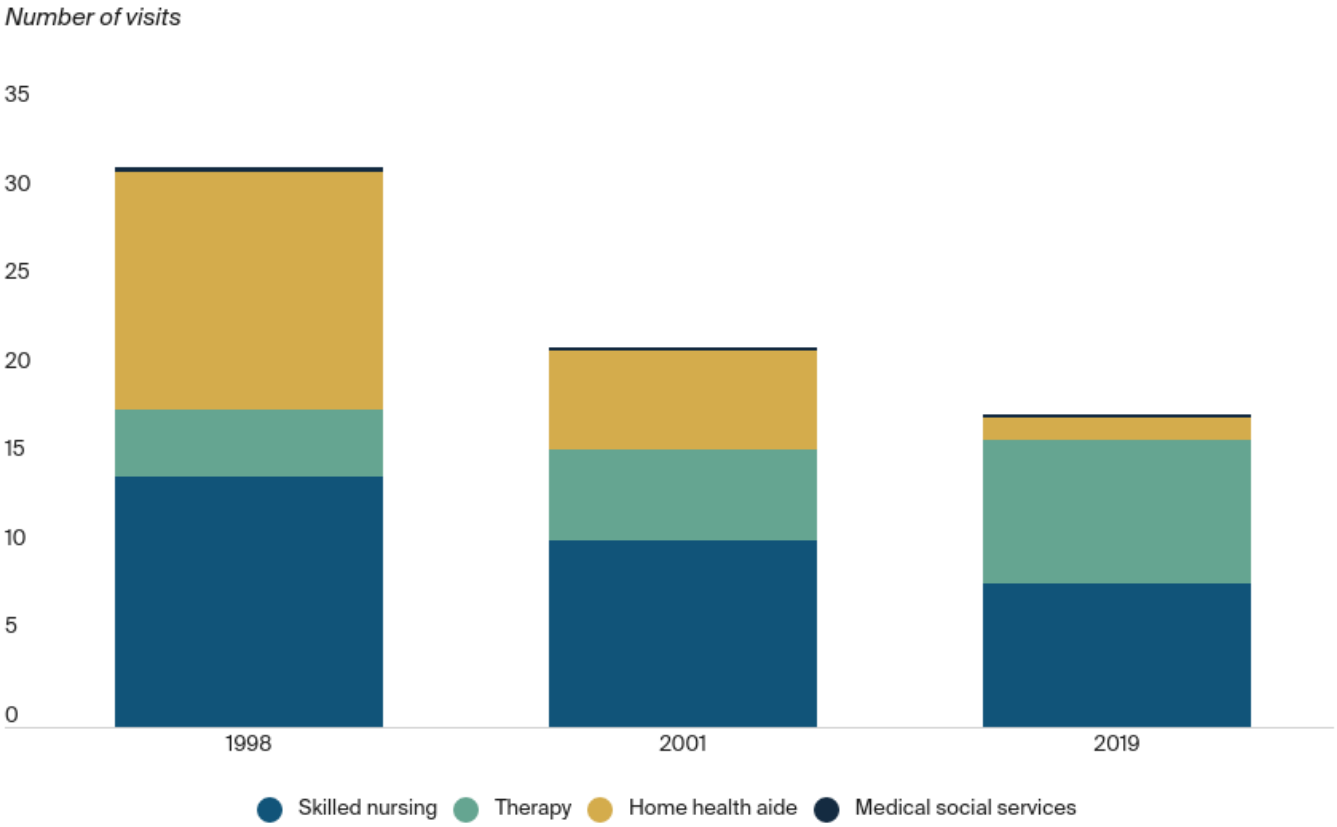
Introduction

The Medicare home health benefit is designed to enable beneficiaries to receive care in their homes after hospitalizations or other acute events or for ongoing needs. It covers skilled services such as nursing and physical therapy, as well as home health aide services, including help with personal care activities like bathing, dressing, grooming, feeding, and getting around.

In practice, however, the home health benefit is falling short of its potential. Many beneficiaries are not aware of the benefit at all, many providers do not order these services for their patients, and home health agencies often do not provide the full range of services. Medicare home health visits have declined steeply over the past 20 years, and payment incentives affect who is served and how (Exhibit 1). Moreover, racial and ethnic disparities in access to these services have been documented for patients with postacute needs. When Medicare does not cover home health services, the burden of finding and paying for them is borne by individuals and their family members — often to the detriment of their health and finances.

EXHIBIT 1

Medicare Home Health Visits per Episode



Data: Medicare Payment Advisory Commission, "Chapter 8: Home Health Care Services," in *Report to the Congress: Medicare and the Health Care Delivery System* (MedPAC, June 2021), 275–94.

Source: Barbara Lyons, Molly O'Malley Watts, and Diane Rowland, *Approaches to Improving Medicare's Home Health Benefit: Lessons from Medicaid* (Commonwealth Fund, July 2022). https://doi.org/10.26099/8a6d-4a98

For several decades now, state Medicaid programs have prioritized expanding access to home and community-based services (HCBS), including personal care services (PCS). Insights and lessons from Medicaid's experience could provide guidance to policymakers in their efforts to improve access to the full potential of Medicare's home health benefit, especially in-home aide services that have been highly underutilized. Although Medicaid's coverage of PCS and HCBS is broad in terms of services included, it is available only to beneficiaries who meet strict functional and financial eligibility requirements that vary by state. In contrast, Medicare's home health benefit is not means-tested, although it is available only to people who are homebound (people who

need help leaving home or for whom leaving home is not medically advised) and who need skilled care (see the Appendix).

We conducted structured interviews with 17 state officials, aging and disability experts, case managers, health care service providers, and advocates to assess the successes and challenges in the delivery of personal care services in Medicaid. The interviews, which took place between January and March 2022, probed program outreach and awareness, access and eligibility, needs assessment and care plan development, delivery of services, and quality and oversight.

Insights from Medicaid

Our interviewees made the following points about ways to make home health services accessible to all.

It is important that providers routinely offer home health services, including personal care, to all who qualify.

- State Medicaid leadership, departments, and district offices should work with hospital and nursing facility discharge planners, home health agencies, and home care agencies to put systems in place to promote appropriate referrals.
- Along with Medicaid, state, county, and local agencies facilitate referrals and intake of new patients. Community-based organizations such as Aging and Disability Resource Centers and Area Agencies on Aging are key entry points. Because these organizations are well known, trusted, and embedded in the community, they are integral to supporting "no wrong door" policies that ensure beneficiaries can access help, regardless of which agency they approach.
- Language-appropriate information that is informative, welcoming, and provided through trusted messengers is essential to overcome cultural barriers and misinformation. It can help to have home health and home care agencies that are owned and staffed by people who share cultural and linguistic backgrounds with patients served. In particular, interviewees stressed the importance of having clearly written information materials in a variety of languages to help providers comply with program rules, recruit and train workers, and conduct outreach.

A holistic approach is crucial when assessing beneficiaries' needs and developing care plans.

"Assessments should look at functional needs rather than 'pigeonholing' clients into a program based on diagnosis."

State official

- In Medicaid programs, a comprehensive needs assessment is usually conducted using tools adapted for specific programs or populations.[1] Areas of assessment typically include functional impairment, clinical conditions, mental/behavioral issues, caregiver support, safety, and home situation. Interviewees noted that a broad assessment of the needs of beneficiaries and their families can help to identify areas where additional services are necessary to prevent destabilization.
- Assessment tools should consider the needs of particular populations as well as individual beneficiaries' circumstances. For example, several states assess the need for supervision for patients with dementia and other cognitive impairments, resulting in a higher number of covered service hours. Assessments also should take into account caregivers' level of stress, their other family or work obligations, and temporary supports that may be needed until services are approved.
- Care models should be flexible enough to respond to changes in beneficiaries' circumstances and preferences. Self-directed services, whereby a beneficiary selects, manages, and pays their direct-care workers rather than relying on agencies to do so, are preferred by some beneficiaries.
- Separating the assessment of need and care plan development from the service provider can avoid conflicts in payment incentives and promote appropriate use of service. In Medicaid, states rely on trained assessors employed through state planning units, local health departments, aging and disability agencies, or contracted vendors to conduct assessments, develop service plans, and provide case management. State-approved services are then provided and paid for through home care agencies or through self-direction, whereby the beneficiary selects, manages, and pays their in-home aide. Interviewees stated that Medicaid managed care plans also may have their own assessment and approval process, but these additional steps can add complexity and redundancy, delay service delivery, and limit transparency.

Stronger systems are needed to assess the quality of personal care services and to surface problems.

- In Medicaid, PCS and other HCBS services are regulated by the states, and data for assessing service quality are not standardized across programs within and across states. Although process-oriented measures are commonly used, some states have added measures of beneficiaries' experiences and quality of life.[2] State officials reported that having better data would enable the tracking of disparities by race, ethnicity, service area (such as rural vs. urban), gender, age, health status, and health condition.

- It is helpful for beneficiaries to have formal advocates to turn to when they experience problems or need adjustments to their care plans. Legal and community-based advocates, as well as long-term-care ombudsmen, can help beneficiaries navigate the hearing and appeals processes.

A trained, culturally responsive, and fairly compensated direct-care workforce is needed to deliver personal care services.

"Home health providers can't find staff who can come regularly and have transportation. Rates are not adequate."

State-based advocate

- Direct-care workers are underpaid and undervalued and there are high turnover rates among these staff. According to one interviewee, hourly wages can be as low as $8.11. In addition, many direct-care workers do not have paid time off or health insurance benefits and must cover the costs of their transportation and childcare. The pandemic exacerbated workforce retention and recruitment challenges. States reported utilizing federal financial assistance under the American Rescue Plan Act to increase wages, provide retention bonuses, and other strategies. While states reported some success, they noted that additional steps are necessary to stabilize the workforce.

- Several efforts are underway to better support and grow the direct-care workforce. Interviewees reported the formation of multiple, cross-agency workgroups at the state and county levels to develop recruitment strategies, including better compensation, creation of career pipelines, and greater recognition of workers' role and value within the health system. Prompted by governors, several state legislatures are working to adopt more permanent changes, particularly regarding higher wages. Home care agencies are trying to recruit more direct-care workers — including family members of beneficiaries — by providing a wide range of benefits,

including same-day pay, cell phones, and referral bonuses. State officials noted that having linguistically and culturally appropriate recruitment materials also could help.

Medicaid helps to fill gaps in Medicare's home health benefit coverage, but variations among state and restrictive income eligibility limit its role.

- Where you live determines which personal care and home and community-based services are available. Some states offer PCS in the state plan benefit package; others offer these services only through waiver programs that enable states to offer home-based rather than institutional services to particular populations.[3] States are allowed to cap enrollment in HCBS waivers. As a result, waiting lists are often long and prioritize individuals in nursing facilities and hospitals — leaving individuals in the community without support for years. Medicare beneficiaries who do not qualify for Medicaid are often referred to nonprofit organizations that help pay for home care, but interviewees reported that such funding does not come close to meeting the demand.

"In Medicaid, the income and resources are really limited, and you can't serve the real demand."

State official

- Many low-income individuals are not eligible for Medicaid. This includes many Medicare beneficiaries with limited income and assets who need PCS but are not poor enough to qualify for Medicaid.[4]

Lessons for Medicare

Based on experiences in Medicaid, there are several short- and longer-term strategies that could expand access to Medicare's home health benefit.

Ensure that home health services, including personal care assistance, are routinely offered to Medicare beneficiaries.

- The Centers for Medicare and Medicaid Services (CMS) should ensure referral systems and service provision work effectively and equitably. Our stakeholder interviews revealed widespread and substantial misunderstandings of the scope and duration of Medicare's home health benefit. It would be helpful for CMS to

issue additional guidance to ensure providers offer home health benefits consistently in compliance with Medicare policies and regulations. To support this effort, CMS could conduct webinars and other educational strategies to help providers understand and abide by regulations.

- It also will be important to educate beneficiaries about the home health benefit through customized outreach strategies, including one for social media. For example, short videos portraying how an in-home aide has helped beneficiaries of different races and ethnicities manage at home can be informative and help to overcome cultural barriers. These strategies need to be linguistically and culturally relevant to diverse populations. Developing strategies that are informed by the lived experiences of beneficiaries is essential to accomplishing this objective.[5] In-home help with activities such as bathing and dressing is personal and often intimate. Beneficiaries and their families do not ask for help easily.[6] Developing channels for beneficiary input into communication strategies and program operation is essential to improving awareness of and access to home health services.

Close federal oversight of Medicare's home health benefit is necessary to identify disparities in access, service utilization, and quality of care and develop strategies to remedy them.

- Federal audits of provider referral patterns and home health agency practices are needed, particularly as new payment models are implemented, with recognition that underutilization of benefits is a significant problem. Additionally, Medicare Advantage (MA) plans require close monitoring to ensure that beneficiaries receive timely and sufficient home health and personal care benefits. To identify disparities, increased federal effort would help support the collection and analysis of utilization, spending, and beneficiary satisfaction data by factors such as race, ethnicity, language, disability, and service area. Additional federal investment also may be needed for the development of quality-of-life measures for beneficiaries receiving home health benefits.

- Examination of beneficiary complaints related to home health also would provide insight into how beneficiaries are affected by service limitations. Additional support may be necessary to help beneficiaries understand and navigate the appeal process.

Addressing the shortage of direct-care workers is a national imperative.

"We need to value the role of the home health aide in the health care continuum."

Area Agency on Aging leader

- Creating a robust, valued, and fairly compensated direct-care workforce will necessitate action in both the public and private sectors. Significant wage increases, family-supporting benefits, and innovative recruitment, pipeline, and career advancement strategies are necessary.
- The federal government can intentionally design and invest in support for Medicare's family caregivers, such as financial assistance and respite care benefits.[7] The federal government also can develop strategies to integrate family caregivers into the care planning and delivery decision process, provide necessary training and resources to family caregivers, and fund research on the impact of caregiving and on best practices.[8]

As currently configured, the home health benefit may not be sufficient to allow Medicare beneficiaries with postacute and chronic care needs to live at home and avoid adverse health outcomes.

"There is a gap in Medicare between acute skilled need and hospice care. We need more options for chronic care management."

State official

- Recent changes by CMS have provided Medicare Advantage plans with new flexibility to provide "nonskilled" supplemental benefits to help people with activities of daily living and instrumental activities of daily living. For example, an MA plan can, for a patient with diabetes, offer fresh produce and other food, nonmedical transportation, and home modifications.[9] These services can help beneficiaries better manage medical conditions at home. Examination of how MA plans administer these benefits and how they affect beneficiaries could provide valuable guidance for future changes to MA plans and traditional Medicare.[10]
- Policymakers also could consider whether current restrictions on access to Medicare's home health benefit are warranted in the traditional Medicare program,

given advances in technology and new models of care delivery.

Conclusion

Medicare's universal federal benefit offers the opportunity to provide enrollees with streamlined access to home health services and advance federal officials' prioritization of health equity and person-centered care.[11]

To build a better, more equitable system of home health services, it is necessary to clarify federal policy, conduct community outreach and provider education, prioritize person-centered care, and incorporate beneficiary input into program design and operation. As policymakers and program staff look to the future, deeper understanding of Medicaid's experience and closer collaboration with Medicaid counterparts could promote efficiencies in the Medicare program and provide more equitable care for beneficiaries.

APPENDIX. Home Health and Personal Care Services Under Medicare and Medicaid

Medicare	Medicaid
Eligibility	
Age 65 and older, or under 65 with a disability	Any age
Universal benefit, no income requirement	Means-tested benefit, with income and asset test requirements that vary by state and by program
Homebound requirement (including individuals who need postacute skilled care after hospitalization and individuals with longer-term, skilled-care needs)	Functional needs requirement for LTSS (including need for assistance with activities of daily living and/or instrumental activities of daily living)
Assessment	
National Tool: OASIS	State-specific tools that vary by program
Home care services	
Mandatory: Home health services, including skilled services and personal care aide services	Mandatory: Home health services State Option: Personal care and home and community-based (HCBS) waivers
Financing and administration	
Federally funded and administered	Jointly funded by the states and federal government; administered by the states
Quality	
Home Health Quality Reporting Program, drawing on OASIS and claims data	No national standards, state reporting requirements vary by program/service

Source: Barbara Lyons, Molly O'Malley Watts, and Diane Rowland, *Approaches to Improving Medicare's Home Health Benefit: Lessons from Medicaid* (Commonwealth Fund, July 2022). https://doi.org/10.26099/8a6d-4a98

NOTES

1 MaryBeth Musumeci, Molly O'Malley Watts, and Priya Chidambaram, *Key State Policy Choices About Medicaid Home and Community-Based Services* (Henry J. Kaiser Family Foundation, Feb. 2020).

2 The National Core Indicators (NCI) survey has helped states take a more person-centered approach to quality, but not all states participate (24 in 2022).

3 Waivers generally require a nursing facility level of care that excludes Medicare beneficiaries who require a lower level of personal care services. See: Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic* (Henry J. Kaiser Family Foundation, Mar. 2022).

4 MaryBeth Musumeci, Priya Chidambaram, and Molly O'Malley Watts, *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, June 2019); and Watts, Musumeci, and Ammula, "State Policy Choices," 2022.

5 For example, the proposed 2023 Medicare Advantage regulations will require Dual Eligible Special Needs Plans to convene an advisory group of plan members to provide input on design and implementation.

6 Barbara Lyons and Diane Rowland, "Improving Help at Home: Medicare Beneficiaries' and Caregivers' Experiences," *To the Point* (blog), Commonwealth Fund, July 11, 2022.

7 Anne Tumlinson, "What I Learned from My Family's Home Health Experience," *Health Affairs Forefront* (blog), Feb. 15, 2022.

8 Administration for Community Living, *RAISE Family Caregivers Act Initial Report to Congress* (ACL, Sept. 2021).

9 Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment* (Commonwealth Fund, Feb. 2021).

10 Molly Knowles et al., *Comparing New Flexibilities in Medicare Advantage with Medicaid Long-Term Services and Supports: Final Report* (Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Jan. 2022); Anne Tumlinson Innovations and Long-Term Quality Alliance, *A Turning Point in Medicare Policy: Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill* (July 2019); and Courtney Harold Van Houtven and Walter D. Dawson, *Medicare and Home Health: Taking Stock in the COVID-19 Era* (Commonwealth Fund, Oct. 2020).

11 Meena Seeshamani, Elizabeth Fowler, and Chiquita Brooks-LaSure, "Building on the CMS Strategic Vision: Working Together for a Stronger Medicare," *Health Affairs Forefront* (blog), Jan. 11, 2022.

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