Access to Rural Home Health Services: Views from the Field

KEY FINDINGS
Access to home health care can be challenging for rural Medicare clients. Key informants for this study from across the U.S. described many of these challenges, including:

- Medicare’s home health program regulation and reimbursement policies, such as the “face-to-face” provider visit and the definition of “homebound” required for eligibility;
- Aspects of the home health prospective payment model that are not well suited to small volume organizations -- often the only home health resource in rural communities;
- Limited reimbursement for telehealth and telemedicine – tools that could be useful in overcoming geographic barriers to accessing home health care in rural areas;
- Procurement requirements, such as competitive purchasing for durable medical equipment, that are not designed for rural markets;
- Difficulty recruiting, retaining and reimbursing the health workforce needed to provide home health care in rural areas; and
- Social and economic pressures on rural populations and community resources that affect home health care, such as high levels of poverty, out-migration, and hospital closures.

While not all of these challenges can be easily overcome, key informants identified solutions that merit consideration. Rural communities, especially those served by small and non-profit home health agencies, will likely benefit from payment reforms that reward quality services while providing incentives to innovate and use best practices in home health care.

BACKGROUND
Access to home health services for rural populations of the U.S. is a growing topic of attention and concern. The average age of the nation’s rural population is rising, increasing demand for a wide range of health care services. Changes in health care payment policies, many associated with implementation of the Affordable Care Act, include incentives to prevent avoidable hospitalizations and emergency department use. At the same time, hospital stays are shorter than in the past and more patients are being discharged with ongoing care needs. These changes should encourage hospitals, including those in rural communities, and hospital-associated...
health care systems to add or strengthen their ties with home health care services in order to improve patient outcomes after discharge.

Many characteristics of rural America, however, create obstacles that can hinder patients’ access to health care services, including home health care. Per capita income and educational attainment are lower for rural compared with urban residents, and while unemployment rates are similar between rural and urban populations, rural jobs are less often highly skilled. The elderly are a higher proportion of the rural than the urban population, and compared with their urban counterparts, the rural elderly are less likely to have private insurance and therefore are more dependent on Medicare and Medicaid. Nearly half of rural communities in the U.S. have had more people move out than move in during every decade since 1950. Another key characteristic of rural communities is their geographic isolation and as a result, long drive times between residents and needed services. These rural characteristics can threaten the economic viability of home health care businesses and reduce access to home health care for patients in hard-to-reach locations.

Home health agencies are most commonly freestanding (independent or part of a large chain organization), or hospital/facility-based (connected with an acute care hospital, skilled nursing facility or inpatient rehabilitation facility). Higher percentages of rural hospitals provide home health services than urban hospitals: in 2012-13, 31% of rural compared with 19% of urban hospitals offered home health services. Hospital-based rural home health services frequently struggle to be profitable, however, and often are maintained because of community commitment rather than as a sound business line. Not all rural home health services are delivered by rural-based agencies: one quarter of rural residents receiving home health services in 1997 were served by urban-based home health agencies.

Home Health - Medicare and Medicaid:
Both Medicare and Medicaid included reimbursement for home health services when established by Congress in 1965. For the following several decades, the number and types of services covered by these programs expanded, contributing to the formation of initiatives to control federal spending, including health care costs under Medicare. Incentives to control home health agency spending were part of the Balanced Budget Act of 1997 and led to a home health prospective payment system (PPS) that replaced the more traditional cost-based system. Home health PPS reimbursement, fully implemented in 2000, applied predetermined, case-mix adjusted, per-episode reimbursement limits. Also part of the post-acute care PPS are inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Since 2000, various changes to home health reimbursement have been implemented, including several iterations of temporary rural “add-on” payments to supplement reimbursement for patients in rural areas. These add-ons have ranged from 10% to 3%, and the most recent iteration expires at the end of 2017. The Centers for Medicare and Medicaid Services (CMS) in 2016 implemented a value-based purchasing model in nine randomly selected states (MA, MD, NC, FL, WA, AZ, IA, NE and TN) for all qualifying home health agencies. The model measures the quality performance of Medicare-certified home health agencies and applies an annual payment reduction or increase, beginning at 3% and increasing to 8% in later years of the initiative. Medicare (the single largest payer of services provided by home health agencies) and Medicaid account for about 80% of total home health care expenditures in the U.S. Home health services covered by Medicare include part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, speech-language therapy, and medical social work) that is ordered by a physician and is restricted to medical care provided in the home by home health agencies. Other non-medical types of services provided in the home such as Meals on Wheels, chore-worker services, or other custodial services may complement, but are not considered to be, “home health” services.

Medicare beneficiaries of home health care, largely Americans age 65 years and older, may also be eligible for Medicaid coverage based on income and disability status. While Medicare is a federal program governed by one set of rules applying across the states, Medicaid is a joint state and federal program. Home health care rules can vary among states and are affected by whether the state chose to expand Medicaid through the ACA.
health agencies. These are some of the factors that likely contribute to the finding that rural (non-metro) Medicare beneficiaries are less likely to use any post-acute care services, including home health, than urban (metro) beneficiaries.7

This report describes current issues affecting access to rural home health services based on insights from key informants from national, regional and local organizations involved with providing rural home health care. Because of Medicare’s dominance as a payer of home health care in the U.S., Medicare-reimbursed home health services were the main focus of the interviews. Challenges and barriers to rural home health care access as well as possible solutions are summarized in the study’s findings.

METHODS

In addition to reviewing the published research and gray literature on access issues related to rural home health care, we conducted telephone interviews with a purposive sample of 40 key informants from 19 states between May 2014 and March 2015. Key informants were distributed across all four U.S. Census regions and across four main categories of organizations: national policy/advocacy organizations representing or involved with home health care, home health care agencies serving rural populations, state/regional programs with rural home care ties, and other local health services organizations with connections with rural home health care service delivery (Table 1). From a list of rural hospitals from the American Hospital Association, we selected a stratified random sample of 40 rural hospitals with and without home health and from each Census region for contact. Health program leaders from national rural and health care organizations with an interest in rural home health care were contacted to obtain information that would help guide development of the interview protocol, and to ask about individuals and organizations to consider as key informants. Additional organizations were identified through the Google Web search engine using search phrases such as “Rural home health care,” “Home health care organizations,” “[State] Home health care” and through a scan of the membership directory of the National Association for Home Care and Hospice.

This study was determined “Exempt” from human subjects review by the University of Washington Institutional Review Board. Potential participants were contacted first by email, or by phone if an email address was unavailable. A second, follow-up email was sent approximately one week after first contact to potential participants who had not responded. A third and final contact was made by phone or email approximately three weeks after the first contact. Approximately half of the original contacts yielded interviews.

Interviewees included directors, administrators and/or financial officers of home health agencies serving rural communities and rural hospitals with home health agencies; administrators, executive directors and board members of professional and trade organizations representing home health agencies; and leaders from organizations with interests in rural care for elderly

<p>| Table 1: Distribution of rural home health care key informants (N = 40) by U.S. Census region and category of organization |</p>
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<th>State/regional programs with rural home health care ties</th>
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populations, such as Area Agencies on Aging. The Appendix lists the organizations to which interviewees were associated. Many of the interviewees described their history in home health services, and many had decades of direct home care, hospice, and related service prior to their administrative positions.

Two researchers conducted phone interviews of approximately 30 minutes in length with each participant. The semi-structured interview guide included three main sections: 1) interviewee organization and personal background in relation to rural home health care; 2) major challenges to delivering home health care services in rural communities; and 3) novel or exemplary models of delivering home health care in rural areas that help overcome the challenges. Probing to expand initial responses about rural home health care challenges and solutions included asking about payment and reimbursement, workforce, and technology.

Detailed notes were recorded during the interview, and the results were analyzed to determine key concepts and themes.

**FINDINGS FROM INTERVIEWS WITH KEY INFORMANTS**

The challenges and potential solutions to delivering home health services to rural Medicare beneficiaries as described by key informants fell into three general categories: (1) home health program regulation and reimbursement, (2) the rural home health care workforce, and (3) rural resources and populations.

**HOME HEALTH PROGRAM REGULATION AND REIMBURSEMENT**

Health care insurance/reimbursement policies and practices can help support access to needed home health care services, but the multitude and complexity of payers and policies can have unintended consequences. Navigating eligibility, coverage limits, qualified providers, and reimbursement processes across Medicare, Medicaid, Veterans Administration, private health insurance companies, long term care insurance, and special block grant and demonstration projects can have an impact on access to home health care services. Key informants for this study mostly addressed issues related to Medicare’s reimbursement rules and regulations.

**Face-to-face requirement**

**Challenges and Barriers Identified from Interviews**

Beginning in 2011, following implementation of the Affordable Care Act, home health agencies can only accept orders from a physician for Medicare-reimbursed home health services following a face-to-face encounter with the patient to document the patient's eligibility. The face-to-face visit must occur within 90 days before home health care starts or within 30 days after home health care starts. This visit must be performed by a physician or, to the extent state practice laws allow, non-physician practitioner (nurse practitioner (NP) or clinical nurse specialist working in collaboration with a physician per state law, certified midwife, or physician assistant (PA) working under supervision of a physician). If a non-physician provider performs the face-to-face visit, a certifying physician must document and sign a certification of the patient’s eligibility. Each provider must also keep copies of all qualifying documentation, which can be challenging in environments without extensive, inter-connected electronic health records. In rural areas, face-to-face encounters may occur via telehealth, in an approved originating site such as physicians’ offices, hospitals, and skilled nursing facilities – but not in a patient’s home. With regard to this requirement, following is a summary of key informants’ comments:

- The face-to-face requirement can lead to delays in care and in some rural areas, patients cannot get home health care at all because they live too far from a physician.
- More and more patients are being seen by NPs and PAs for their regular care, including in Patient Centered Medical Homes, rural Federally Qualified Health Centers, and rural clinics run by NPs, but these providers are not allowed to sign “plan of care” orders for home health care (485 forms). Requiring a physician to sign home health care orders adds a burden to patients under PA and NP care by making them establish a new care relationship.

“**Our NPs have prescriptive authority and a fair amount of autonomy, but they are unable to work with home health agencies.**"
relationship with a physician. A supervising doctor in facilities run by NPs may only come to the clinic once a month.

- Many physicians aren’t well informed about what home health can provide for patients. Home health agency staff spend considerable time educating physicians about home health care and how to document patients’ needs for home health services. The process is complex and requires a lot of hand-holding and follow-up by the agency. Physicians may be resistant to the additional paperwork (plan of care orders) that the face-to-face requirement imposes to the point of not referring patients to home health.

- If home health care referral forms are not completed by the physician, or if they are deemed inadequate by CMS, the home health agency bears the financial risk for any services already provided. The appeals process is backed up and slow.

Potential Solutions from Interviews

- Advocate for Congressional action to allow NPs, PAs and clinical nurse specialists to “prescribe” (order or certify) home health care, especially where patients have established relationships with NPs and PAs.

- Eliminate the face-to-face requirement entirely because the process is duplicative. While the requirement is an issue for all patients, the burden for rural patients is greater because of access issues involved in seeing a physician or non-physician practitioner who can complete the face-to-face visit and paperwork.

Homebound requirement

To be eligible for Medicare-reimbursed home health services, a patient must be “homebound.” Two criteria must be met to be considered homebound: the patient must need help from a supportive device or another person to leave their home or have a condition that makes leaving their home inadvisable, and there “must exist a normal inability to leave the home” and “leaving home must require a considerable and taxing effort.” Leaving the home infrequently, for short periods of time, for religious services, for unique or infrequent events, to attend adult day-care programs, or for needed health services does not preclude a person from being considered homebound.19

Challenges and Barriers Identified from Interviews

- Requiring patients to be homebound to receive home health care creates access problems in rural areas. As hospital stays shorten, patients are being discharged with greater care needs than in the past. Without access to reimbursement for home health care services, patients who need support after hospitalization are left unserved.

- Being completely homebound can be very difficult for rural patients because they do not have the types of services that may be available in urban areas, such as home meal delivery. While being “homebound” allows patients short ventures outside the home such as to church, the travel distances in many rural areas exceed Medicare’s time limits for these types of visits.

- For some rural patients the only way to get to a doctor’s appointment is to drive themselves, but Medicare regulations make it hard to explain why a “homebound” patient is able to drive. Many rural patients are not willing to agree to the strict Medicare homebound requirement because they expect to do some travel to meet their basic needs. As a result, they are discharged without home health services and end up being readmitted to the hospital.

Potential Solutions from Interviews

- While key informants did not provide specific solutions to these problems, the implication from their comments was that in rural areas some flexibility in the criteria for being “homebound” was needed.

Prospective payment and the rural add-on

The Medicare Prospective Payment System (PPS) applies a predetermined base payment for home health that is then adjusted for the health condition and care needs of the beneficiary (case-mix adjustment), as well as for the geographic differences in wages for home health agencies across the country.10 From April, 2010 through December, 2017 home health services performed in a rural area (non-Core Based Statistical Area (CBSA)) receive a 3% add-on to their reimbursement. Historically, the rural add-on was significantly higher: 10% from April 2001 to April 2003, then 5% through 2006.
when it expired. According to the Medicare Payment Advisory Commission (MedPAC), a high proportion of rural add-on payments had been paid to agencies with higher than average volume and not reaching populations who truly had access problems. Beginning January 1, 2015, some areas lost their “rural” status due to updated CBSAs approved by the Office of Management and Budget based on 2010 census data. Due to this switch, 105 counties previously designated as rural changed to urban and 37 urban counties were designated as rural. Those counties that lost their rural status also lost access to the rural add-on payments. All rural add-on payments cease at the end of 2017.

Challenges and Barriers Identified from Interviews

- To be successful with prospective payment, a service needs enough low-acuity patients to balance out the high-acuity ones. That’s not the case in many small rural communities.
- Rural inpatient PPS hospitals need to plan for effective post-discharge follow-up of their patients now that hospital readmissions are to be reduced. Unfortunately, home health agencies in rural communities have a difficult time providing that follow-up because post-discharge care is not well reimbursed.
- Changes in the way Medicare home health prospective payment is determined, with changes to the CBSAs, have caused some formerly rural areas to be classified as urban. The resulting loss of the rural add-on payments has left some home health care providers with fewer resources to serve their patients no longer classified as rural-residing.
- Hospitals are reaching out to prevent readmissions more in metropolitan areas than in rural.
- Our very rural state has a rapidly growing elderly population, and we don’t have a way to care for these people. But we are such a small part of the CMS pie that they don’t put us high on their priority list.
- Prospective payment doesn’t work in small, rural areas, which is why we lost 15 nursing homes.

Potential Solutions from Interviews

- “Cost based reimbursement is the only way to make these services stay alive.”
- “Do everything you can to make a hospital a last resort.”
- “We need a new model based on chronic disease. The ACA is trying to remove the silos and get us to work together.”
- Enhance communications and coordination between home health agencies and patient-centered medical homes.
- One interviewee used case managers in medical homes to connect the agencies, and home health nurses participate in primary care offices and attend monthly medical home patient case conference meetings.
- Create better connections with payers in the region, creating a pay-for-performance system to fund needed but non-reimbursed services. Alternative (to fee-for-service) payment models such as accountable care organizations and Medicare Advantage plans, encourage better coordination of care.
- “Optimize resources to bring patients from pretty ill status to stable in 40-60 days. We’ve been relatively frugal and put all of our resources into service, but now we’re beginning to struggle. Margins are becoming very thin. We hope that rural behaviors and processes will be looked at as a model – we have good experiences to share.”

Telehealth and information technology

Home health agencies are not prohibited from adopting telehealth, telemedicine or other technologies they think will promote efficiencies, but telehealth services or any services provided via a telecommunications system are not covered as part of Medicare’s home health benefits and home health prospective payment, although they are covered for other medical services under Medicare Part B. Following are descriptions of interviewees’ comments regarding their use of telehealth:

Challenges and Barriers Identified from Interviews

- While telehealth is not a substitute for human contact, it can be an asset in rural areas but the lack of adequate reimbursement hinders investments in technology, personnel, training, and maintenance.
In some rural areas, internet access or bandwidth is not adequate to use some telehealth equipment.

Telehealth users were concerned about their ability to maintain needed equipment if reimbursement/revenues decline.

Even if the only thing you can do for a patient is check up on the phone or Skype, that’s better than nothing. People really need people to check in but maybe don’t need a visit…they need to be called, talked to, asked ‘how are you doing today?’

**Potential Solutions from Interviews**

- Home health should receive support for the use of technology similar to what hospitals have received to implement EHRs. Home health is part of the clinical system and needs to be part of the seamless patient record, but money isn’t following the patient for this.

- Use remote monitoring of rural home health patients to prevent patient conditions from becoming worse, prevent re-hospitalizations, reduce the need for direct care services, and reduce costs and improve patient outcomes. Some larger services with more resources to invest in technology have used telehealth to monitor patients in the most remote locations and those who required more frequent monitoring between in-person visits. Telehealth enables nurses to determine whether or not the patient needed to visit a provider or have some other form of consultation.

- One agency used tablets allowing home health staff to do physician “e-visits,” initially with cardiac patients and later for diabetes care. Patients had 24/7 access to the home health services by pushing a button on the tablet. The tablet has been found to be more efficient than vital signs monitoring machines. With a tablet, many cost and time savings were possible – if reimbursement were available and face-to-face visit requirements were loosened.

- One agency had a Transitions of Care Program that used “transitions coaches” to help patients with self-care via telecare monitors in patient homes that monitored vital functions such as blood pressure. Coaches could call the patient if they saw, for example, a high blood pressure reading and ask questions about patient diet and medication compliance.

- “The promise of technology …is growing and rapid. It helps people stay at home and age in place [and] helps a problem from growing into a disability, becoming intractable. The sky's the limit. It makes you wonder why we haven’t immediately put money into it.”

**Durable medical equipment**

In order to be paid for durable medical equipment (DME), the patient’s physician must document that the physician, or qualifying non-physician provider, has had a face-to-face examination with a beneficiary in the six months prior to the written order for certain DME items. This face-to-face encounter can be conducted via telehealth. In addition, Congress mandated in 2003 that most DME be procured through a competitive bid process that was introduced first in urban areas and is scheduled to apply to all Medicare beneficiaries in 2016. Several key informants cited issues with these requirements, consistent with the criticisms of rural advocates who argue that, compared with providing DME in urban areas, suppliers of DME to rural areas face higher delivery costs and lack the economies of scale to offset the payment reductions of moving from fee-based to competitive bid payments.

**Challenges and Barriers Identified from Interviews**

- In rural areas, it can be very difficult to have DME and needed supplies delivered.

- The requirement to get competing bids for DME “has killed access to care.” “I can have oxygen for a patient but no nebulizer because of competitive bidding for DME.”

**Potential Solutions from Interviews**

- While key informants did not provide specific solutions to these problems, the implication from their comments was that some exceptions to the competitive bidding process were needed to ensure access to needed DME in rural areas with inadequate access to approved suppliers.

**Paperwork**

Several key informants expressed frustration with the administrative burden, or “paperwork,” required by Medicare. One specific Medicare requirement, completion of the Outcome and Assessment Information Set (OASIS) patient assessment form, was singled out. Completion of OASIS is required for home...
health patients in addition to regular physical assessments, plus admission forms. Comments from key informants were:

**Challenges and Barriers Identified from Interviews**

- There is too much paperwork - too much time spent dealing with denied claims.
- It can take up to two hours to complete all of the paperwork required by the admission process to home health.
- OASIS requires training and retraining when the forms change, and mistakes can result in having to refile forms or denial of claims.
- Now we’re plagued with having to answer correctly or it will backfire.
- Just when we think we’ve had enough training, it changes again and we have to do more training to fill it out correctly.

**Potential Solutions from Interviews**

While specific solutions were not directly stated by respondents, their comments support more efficient documentation and claims submission systems.

**General comments regarding home health, including regulation and reimbursement**

**Challenges and Barriers Identified from Interviews**

Interviewees made a number of general comments about home health care regulation, reimbursement, and role in the health care system:

- Home care services have been identified as having the highest patient satisfaction ratings of any care delivery model, but government payment systems have been working to reduce the use of home care services over the past four years by decreasing Medicare reimbursement rates and increasing regulation and monitoring.
- Patients dually eligible for Medicaid and Medicare often have much better access to home health services because Medicaid provides supportive home care services that complement the more skilled care that Medicare covers, though there is significant variation across states in coverage of Medicaid home and community-based services.
- Interviewees expressed frustration with payment denials and the perception that insurance companies worked to find loopholes to not pay for the billed services. Some pointed out a conflict between the high-level goal of keeping patients out of hospitals compared with their on-the-ground experience that the number of criteria for which home health services can be ordered was shrinking.
- One agency working in a community with significant managed care penetration received support from the overall community health system after demonstrating how the agency helped reduce length of stay and reduced readmissions in the local hospital. Others said that if the few home health agencies in rural communities became affiliated with managed care, patients not enrolled in those plans could be left without access to home health services.

- Although on average margins in home health have been high under PPS, some interviewees noted that they experienced small margins delivering rural home health care and as a result they lacked resources to be innovative and try creative solutions to their problems.
- As more patients move from traditional Medicare to Medicare managed-care programs, more decisions about appropriate care for patients are made by administrators and organizations outside of the community. Interviewees reported that Medicare managed-care plans approved home health care at lower rates than traditional Medicare.
- One agency recently converted to managed care, and was strained by slow payments that made recruiting and retaining staff, already at low levels of pay, even more difficult.
- Some interviewees noted a conflict between for-profit and not-for-profit home health agencies: for-profit agencies were reported to favor low-utilizer and private-pay clients who were likely to generate revenue, while the not-for-profit religious or hospital-based agencies were left with the financial burden of the poorer and high utilizer clients.

"OASIS initially made a lot of sense because the data provided a comprehensive overview of the patient and conditions. The problem is that no one predicted it would be tied to reimbursement. It’s quite onerous and burdensome.”
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In one state where home health agencies hold Certificates of Need (CoN) to serve specific areas, access is impaired when the CoN-holding agency has inadequate staff to serve the entire area and stops serving patients in the most remote areas while other agencies are prohibited from serving those patients.

Unless bordering states have reciprocity agreements, residents living close to a state border may not be able to get care from the nearest home health agency if it’s across the state border. Without reciprocity, agencies must obtain separate Medicare numbers in each state, which some may not choose to do, and providers working for the agency must be licensed or credentialed in both states.

Potential Solutions from Interviews

- Provide reimbursement or seed money for pilot studies to test different models of rural home health delivery.
- “We need a home health care system that is wider in scope: maybe split the services so one agency sees patients that are ‘homebound’ and another for those who are chronically ill at home but not homebound.”
- Combine hospice with home health care benefits, to allow the home health nurse to continue care as the hospice nurse.

“Home care and community-based care is perceived to be less expensive than institutional care, and it is. But if patients continue to be discharged from hospitals with significant care needs, the funding for home and community care needs to be appropriate for the care required.”

THE RURAL HOME HEALTH CARE WORKFORCE

Background: Home health care services for Medicare (and Medicaid) patients are generally provided by a combination of licensed health care workers and certified or registered workers. Skilled nursing care (e.g., delivering injections, tube feedings, catheter changes, wound care, managing and evaluating a patient’s care plan) must be performed by licensed registered nurses (RNs) or licensed practical nurses (LPNs) in order to be reimbursed by Medicare. Skilled therapy services include physical, speech and occupational therapy, which must be performed by a licensed therapist to be reimbursed. While not licensed as health care providers, home health aides and certified nursing assistants (CNAs) serving Medicare and Medicaid patients are required to meet federal and state training requirements and pass competency exams. When ordered by a physician, some medical social services (counseling or assistance accessing community resources) may be reimbursed by Medicare during episodes of home health care. In addition, informal caregivers (family members and other unpaid caregivers) deliver the majority of basic care for homebound patients. While not reimbursed for their services, support for informal caregivers to help alleviate their challenges can reduce the chances of homebound patients being admitted to nursing homes.

Key informants for this study provided many insights into the challenges of meeting rural home health workforce needs. Their comments are grouped below first into a general category of rural issues affecting workforce recruitment and retention, then by occupation type.

Challenges and Barriers Identified from Interviews

- Rural issues affecting workforce recruitment and retention
  - The general workforce issues affecting rural home health care that were identified by respondents included those commonly mentioned as affecting other rural health care sectors, including geographic isolation, transportation barriers, and small businesses’ limited financial resources,
  - The majority of interviewees reported that recruiting the workforce to deliver rural home health services was difficult. Some lacked adequate resources to pay a reasonable wage for home care aides and personal care assistants. Even nurses’ salaries “are not what they make in the big city.” Others reported their workforce was “pretty stable” and they had good resources to fill vacancies.

“We're paying so much more money to nurses for their mileage [compared with those in metropolitan areas]. Less is available for actual patient service time.”
Transportation is a barrier for both patients and the workforce. The logistics of transporting a patient from a rural or urban hospital to a rural home are challenging. The fact that there is little public transportation in rural areas means few options for a patient without a family member to transport her or him.

Not all home health care employers can provide employee benefits, but those that do have higher retention rates.

Potential workers often are deterred by the long drive times (“windshield time”) required to visit many rural clients, which in poor weather conditions or on poorly maintained roads can be very difficult. Some rural areas require the use of ferries to get to patients, which further extends drive times. Also many agencies provide services around the clock every day of the week, and it can be very hard on staff to see patients all day, and then drive long distances again if they are on call and have to return to a patient’s home.

Poor or no cell phone coverage in many rural areas is a safety risk for home health care providers.

Some interviewees commented that they perceived entering home environments to deliver services, especially in poorer communities, can pose personal safety risks for home health care workers. This perception, combined with the isolation of some rural care sites, can hinder home health care recruitment and retention.

The volume of services in some smaller rural areas may not be large enough to support full-time staff for certain occupations and positions.

In some areas where home health care is not available, public health nurses often step in. This “off label” use is problematic where budgets are stretched thin and nurses are taken away from their public health roles.

Many rural areas have highly diverse populations, and language/translation requirements can include Spanish, Farsi, Chinese, Vietnamese, Tagalog, among others. This can be very challenging for home health service agencies.

**Therapists**

- Home health care has to compete with hospitals for physical, occupational, and speech therapists, and while a hospital therapist might have a higher patient load than a rural home care therapist, most therapists would prefer to spend their time delivering patient care than driving to a patient’s home.

- The supply of physical therapists (PTs) has been effectively reduced by the increase in educational requirements for PTs, who now must complete a doctoral degree.

- One interviewee specifically cited an acute rural shortage of physical therapists. PTs and occupational therapists (OTs) have a lot of job options, and many pay better than home health care. Starting therapists seldom begin their careers in home health care: the lack of supervision in home care makes it poorly suited for a newly minted therapist. More often home health care is a mid-career switch, and more often eldercare by therapists occurs in skilled nursing facilities and other institutions rather than in the home.

- Contract therapists often have to be employed to fill needed positions.

- Rural agencies may risk losing cases to larger agencies if they lack the therapists included in the patient’s home health order.

- In rural communities where the local hospital shares therapy staff with home care services, hospital orders may take precedence over home health care because the hospital therapist visit may need to occur before the patient can be discharged.

**Registered nurses**

- Interviewee comments on RN supply ranged from reports of major shortages in rural areas, including home health RNs, to reports of fairly strong RN supply. Most, however, agreed that nurses can be difficult to recruit to rural home health. Home health nursing requires experience and is not a good starting position for a new graduate. RNs need strong assessment skills, a strong clinical foundation, experience with medications, and the ability to identify subtle changes in patient conditions. Home health frequently must compete with acute care facilities for highly skilled RNs.

- As the average age of rural nurses increases and experienced nurses begin to retire, there are concerns about recruiting their replacements. Young
nurses, in addition to having less of the experience needed to deliver high-quality home health care, may be deterred by the mounds of paperwork and the self-discipline needed to take on the highly autonomous work of home health care.

Paraprofessionals: Home health care aides, certified nursing aides/assistants

- Direct care workers (home health aides and CNAs) are occupations in high demand in home health care. Both home health aides and CNAs provide critical hands-on physical and mental support that many elderly and infirm require, as well as psychological support for patients whose only outside contact may be an aide.
- Access to training for paraprofessionals can be a huge problem. These workers are not highly compensated, resulting in concerns about their economic situations. Training frequently falls on home health aides’ co-workers. Innovative ways to train home care aides and CNAs are needed.

- Because of limitations placed by federal regulations, nursing homes but not home care agencies can be accredited as a training site for on-the-job training of their own nursing aides/assistants. Once working in a nursing home, CNAs generally do not prefer to return to home health care work.
- Recruitment and retention of aides can be more difficult in rural areas due to the same kinds of travel barriers and isolation that deter other health professionals.
- Low-wage earners frequently face an additional barrier of unreliable transportation.

Physicians

- Making physicians aware of what home health services can provide, and educating them on the regulations and processes involved in referring a patient to home health care, can be challenging.
- Physicians’ use of home health care services can be inhibited by lack of available workforce. “If the right therapist is not available, the physician might not give a patient a home health care referral.”
- Some physicians who have worked under prior regulatory environments may expect home health agencies to do what they used to do, such as check on the patient several times a day. When they learn that’s no longer possible because the agency won’t be reimbursed for extra visits, providers have been known to become frustrated and stop referring patients altogether.

Potential Workforce Solutions from Interviews

Therapists

- Enhance clinical rotations for therapists to include geriatric care, rural practice, and home health, in order to increase interest in and skills needed for working in these areas.
- Offer student loan repayment to therapists for providing rural home health care, similar to federal and state loan repayment programs for other healthcare occupations (e.g., physicians, nurse practitioners, dentists) providing service to underserved populations.
- Bring specialists/therapists to rural communities for grand rounds-style case presentation and discussion.
- Support creative workforce strategies to allow smaller agencies to retain clients. Small home health agencies can share therapists with other agencies or speech therapists with school districts, where they are frequently employed.
- Shift some tasks to other providers, such as nurses, who can initiate education for family members on safe transfers.
- Share therapy staff between rural home care agencies and the local hospital, as occurs with some hospital-based services, when agencies do not have the demand for a full position.

Registered nurses

- While specific solutions were not offered, interviewees implied that attracting RNs with the needed skills and experience for rural home health care work would be made easier if some of the other barriers (e.g., paperwork burden, adequate resources) were alleviated.

“There are rural and frontier places where they’ve had ads for over a year for CNAs without anyone applying.”

“It would be good if some of our therapists could work off their loans doing rural home care.”
Paraprofessionals

- Allow home health agencies to train their own CNAs so that these workers are more likely to remain in the home health sector.
- Support and supervise paraprofessional workers, such as home care aides, to ensure they are safe in the home environment.
- Consider applications of “community paramedicine” to complement home health care services available to rural patients by enlisting emergency medical personnel to provide additional preventive and primary care services and to connect patients to health resources not available through home health.

“Using technology can offer a cost-effective means to supervise paraprofessionals working in remote locations.”

Physicians

- Solutions suggested by interviewees to physician-related challenges include improving physicians’ understanding of the benefits of home health care for their patients as well as the administrative requirements of providing those services.

Other workforce solutions

- Shared roles among disciplines (cross-training) would be helpful, although it would require more cooperation and collaboration among the disciplines and resolution of any licensing/scope of practice issues.
- While it may cost home health agencies more per hour to hire contract workers than to employ them in regular positions, contracting can save money, because the agency pays by the visit and there may not be an obligation to pay for travel or benefits. In addition, higher contract rates may be attractive to some practitioners and allow rural home health agencies flexibility with census.
- Support career ladder programs that allow direct service workers (e.g., home health aides, certified nurse aides) to pursue career advancement opportunities that promote recruitment and retention.
- To comply with the face-to-face requirement for completing “plan of care” orders, create a “home healthist” model (similar to the hospitalist model) that uses advanced practice nurses working in the community who can write the orders based on patient home visits.

Technology

- While ideally the home health system would have resources for more home health staff to be in patients’ homes for monitoring and treatment, that is not likely to happen, especially in rural areas. As a result, having more telehealth resources for monitoring patients is very important.
- With appropriate financial incentives for technology, we may benefit from developing specific training for rural home health care workers to prepare them for using technology in patient care.

RURAL RESOURCES AND POPULATIONS

Key informants identified several issues affecting access to home health care that were related to the availability of community resources and the characteristics of rural life.

Community resources and health care organizations

Challenges and Barriers Identified from Interviews

- The merging and acquisitions of health care organizations occurring now may be a threat to rural home health care. Many for-profit agencies and national chains are purchasing smaller companies, putting the small, hospital-based and rural agencies in jeopardy if they are not perceived to be profitable or a source of patients who may generate revenue for the larger system.
- Family members and close friends of homebound patients are very frequently involved in their care, but resources to train and support these informal caregivers are much more limited or unavailable in rural compared with urban communities.

“Home health needs the hospitals in rural areas, and those hospitals need home health programs. But both are at risk.”
Demand for home health care in rural areas will likely continue to increase because critical access hospitals face increasing pressure to discharge patients earlier.

Patients with behavioral health problems frequently need higher levels and longer periods of service. This is especially challenging in rural areas where all types of services are less available than in urban areas, and there are not adequate numbers and types of mental health providers to meet client needs.

In small communities, many patients with behavioral health problems are well known to the limited provider network. Health care providers may avoid or refuse to follow the patient after discharge from a nursing home because of a lack of community resources suitable to treating the patient.

Potential Solutions from Interviews

- Partner with Area Agencies on Aging, where available, because most of these agencies are case managers in the local area and know their community.
- Support care coordination. One key informant reported starting a collaborative that coordinates among providers across the state to talk about discharge, education, referral, coordination of care, and transferring information. It involves hospitals, skilled nursing facilities, rehabilitation facilities, and home health care agencies, with the goal of ensuring patients don’t become lost in one of the silos.
- Support the education of rural discharge planners, skilled nursing facility providers, and others involved in making patient care decisions on home health care’s benefit and scope. Many people in these roles do not fully understand how to use home health care services.

Characteristics of rural patients and populations

Challenges and Barriers Identified from Interviews

- Though the majority of people may be very thankful to have health care services in their homes, some express reluctance. Many rural residents have independent spirits that hinder their willingness to accept home health services. This independent spirit also makes it hard for them to give up things they value, such as driving, in favor of allowing services to come to them.
- People often don’t understand the limitations of the insurance plans they purchase, and too often purchase Medicare plans that ration services.
- Despite being eligible for Medicaid coverage, many rural patients are not familiar with Medicaid and don’t enroll in it even if they’re eligible.
- Poverty is not uncommon in rural areas. Home health workers may encounter patients in homes without electricity or running water, complicating care. Elderly rural patients may be less educated, requiring home health workers to spend significant time teaching patients how to participate in their own care.
- Many clients are “near poor” – they don’t quite meet Medicaid coverage thresholds, but don’t have another insurance plan that covers the expensive care needs remaining when Medicare-reimbursed home health care ends. The home health agencies end up discharging the patient from their care, leaving the patient unsupported for the care they still need.

DISCUSSION AND POLICY IMPLICATIONS

This study’s key informants described formidable obstacles to home health care—financial, regulatory, workforce, and geographic—facing rural patients, providers, and communities.

THE FACE-TO-FACE REQUIREMENT AND PHYSICIAN CERTIFICATION OF HOME HEALTH ELIGIBILITY

While some key informants for this study acknowledged that it was important for CMS to take measures to reduce Medicare inefficiency, fraud and abuse, the impetus for the face-to-face requirement for home health eligibility documentation, the majority said the face-to-face requirement was a major challenge to efficient delivery of rural home health services. Since the late 1990s, advanced practice nurses and PAs have been authorized Medicare providers. But by current CMS rules, only certifying physicians can document the qualifying conditions of the patient even if advanced practice nurses or PAs conduct the face-to-face visit or are a patient’s usual source of care. This duplication of provider involvement can extend the time required to obtain certification.

“As younger rural residents migrate to jobs and lifestyles in more urban areas, rural patients have fewer family members to help with care.”
because of the difficulty finding available physicians in some areas, add to physicians’ workloads, and increase home health care costs. Concerns about these home health certification constraints are not limited to rural advocates, but the problem is exacerbated where access to physicians is limited in rural and underserved communities.

Legislation to amend a section of the Social Security Act (the Medicare law) in order to enable advanced practice nurses (NPs, clinical nurse specialists and certified nurse midwives) and PAs to certify patients’ eligibility for Medicare home health benefits after required face-to-face visits was re-introduced to both the U.S. House of Representatives and Senate early in 2015. Versions of the Home Health Care Planning Improvements Act of 2015 (S. 578 and H.R. 1342) have been introduced in the Senate five times since 2007 and three times in the House since 2012, each with bipartisan support, but none have been successful to date. Numerous organizations have called for the change proposed by this legislation, including the AARP and the Institute of Medicine. It appears that there is wide support for changing the face-to-face rule, but as with many policy improvements requiring Congressional action, political forces unrelated to the specific issue are likely to block resolution of the problem in the near term.

### TELEHEALTH AND TEMELEDUCINE

Telehealth and telemedicine are related terms, but telemedicine refers specifically to remote clinical services, while telehealth is a broader term that encompasses remote non-clinical services, such as training, meetings, and education, in addition to clinical services. This study found considerable support for the use of telehealth and telemedicine to address the challenges of delivering home health in rural areas – primarily the long drive times that stretch staffing resources beyond Medicare reimbursement levels. Interviewees also generally supported more use of distance technology (whether in rural or urban areas) in order to better monitor patients and identify changes in health status that merit home health visits or direct dispatch of emergency services. The main limitation to use of these technologies cited by interviewees was inadequate resources, especially for smaller rural home health agencies, to invest in needed systems. Some also noted that patients may not be receptive to using technology, and pointed out technological barriers such as limited cellular coverage and internet connections in rural areas.

There is evidence that using remote technology in home health care can lead to overall patient care cost savings and improve patient outcomes at a lower cost than traditional face-to-face home health care visits. Another study, however, on the implementation of telemonitoring in eight rural home health agencies, found that savings calculated only from lower utilization of skilled nursing visits did not offset the costs of the new technology, and that agencies must achieve savings from improved patient outcomes. The costs of the technology, depending on what and how it is used, are not inconsequential. But given the fast pace at which technology is advancing, cost-effective tools should be emerging that can help overcome many of the communication and monitoring challenges for rural home health care. Resources directed toward demonstration projects and evaluation of “tele”resources for rural home health care would likely speed the development and dissemination of effective practices.

### THE HOME HEALTH WORKFORCE

Key informants reinforced the generally known barriers to maintaining adequate health workforce in rural communities, including the difficulty of recruiting and retaining skilled workers in low-resource environments and problems accessing training resources. In addition, some mentioned challenges to retaining low-skilled workers due to competition with other health care employers. The need for large amounts of “drive time” was frequently mentioned as a barrier to recruitment, retention and being able to operate efficiently. There was a common theme among informants that many rural patients were receiving fewer monitoring and intervention services than was desirable because of the unreimbursed drive time, and the lack of resources to employ technology
that might supplement in-person visits. Several informants reported that workforce barriers to rural home health care delivery might be under-reported because in communities where types of providers are known to be in short supply (e.g., therapists), their services frequently were not ordered. Prior research found that rural (non-metro) home care patients were significantly less likely to use any physical therapy services than urban (metro) patients with the same diagnoses. Once again, resources that would enable more use of technology were a commonly mentioned means of overcoming workforce barriers, as were a variety of other initiatives to increase collaborative use of skilled providers such as therapists. These solutions would require changes to rural home health care payment.

RURAL HOME HEALTH CARE PAYMENT

In spring 2015, Medicare’s 3% add-on for rural home health payment was extended through 2017 by passage of the Medicare Access and CHIP reauthorization Act (MACRA). Interviews for this study occurred prior to and after passage of this Act. Many of those interviewed prior to MACRA’s passage were aware of an upcoming revenue reduction, and responses ranged from acceptance to concern. Most reported difficulties making ends meet at the current Medicare payment levels because of the issues described above (e.g., long drive times, low volume, difficulty recruiting and high turnover of lowest-paid staff). Small, non-profit rural home health agencies are likely to be providing safety net services for rural communities. Because of their size and non-profit status, these agencies are the most vulnerable to increasing costs and/or declining revenues. A large number of home health agency downsizings and closures were associated with implementation of the Interim Payment System and initial implementation of the Prospective Payment System. Extension of the rural add-on payment through 2017 will help alleviate some rural home health agency concerns.

CMS is considering employing more quality measures in home health payment in future years, such as a home health value-based purchasing program (HHVBP). MedPAC has expressed support for Medicare’s move toward these payment reforms, but offers cautions about the proliferation of quality measures associated with Medicare value-based purchasing. A strong theme from this study’s interviews was the growing burden of administrative requirements associated with reimbursement, which reinforces MedPAC’s cautions to CMS.

CONCLUSIONS

While not all of the challenges faced by rural Medicare beneficiaries needing to access home health can be overcome, there were some that surfaced from this study that appear to have fairly clear solutions. It is reasonable for homebound patients to want to receive care in their homes, and where such care is clinically appropriate, costs are much less than when delivered in institutions. Many of the barriers to home health care in rural areas could be reduced by using alternative ways to connect patients with their providers. To the extent approaches are supported by evidence that they are effective and efficient, patients should be supported to avoid travel that is medically unnecessary (e.g., face-to-face visits with physicians if an alternative provider can do the visit in person or if it can be completed in the patient’s home using telehealth technology). In rural areas, where therapy treatments are frequently underutilized, some aspects of therapy visits important for post-acute care recovery could be carried out by skilled nurses or credentialed therapy assistants if reimbursement were available.

Rural communities, especially those served by small and non-profit home health agencies, will likely benefit most from payment reforms that reward quality services while providing incentives to innovate and use best practices in home health care. Knowing which innovations should be more widely employed requires support (both in resources and in dispensation from conflicting regulations) to try new models, and research and evaluation to assess their outcomes.
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SUGGESTED CITATION
APPENDIX

ORGANIZATIONS ASSOCIATED WITH THE STUDY’S KEY INFORMANTS

Alaska State Hospital and Nursing Home Association
American Hospital Association
At Home Care
Cabell Huntington Hospital Home Health
Cameron Regional Medical Center
Central Montana Medical Center - Home Health Agency
Dignity Health Woodland Healthcare
Florida Association of Rural EMS Providers
Geisinger Health System
Georgia Association for Home Health Agencies
Group Health Cooperative
HCA of America
Hess Home Health
Home Care Association of New Mexico
Home Care Association of WA
Hudson Mohawk Area Health Education Center
Iowa HCA, Center for Assisted Living
Kansas Health Care Association
Lake Okeechobee Rural Health Network, Inc.
MHA: An Association of Montana Health Care Providers
Midwest Care Alliance and Universal Home Health and Hospice Care
National Association for Home Care and Hospice
National Association Home Care and Hospice
National Organization of State Offices of Rural Health
National Rural Health Association
North Central Texas Aging & Disability Resource Center
Ohio Council for Home Care and Hospice*
Olympia Area Agency on Aging
Regional West Medical Center
Stephens Memorial Hospital
Texas Association for Home Care and Hospice, Inc.
Texas Tech University F. Marie Hall Institute for Rural and Community Health
Valley Regional Hospital: Connecticut Valley Home Care and Hospice
VNA of South East Missouri
Missouri Alliance for Home Care
Washington Department of Social and Health Services, Aging and LTC Support
West Virginia Council of Home Care Agencies, Inc.